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Thursday
January 10, 1985

Selected Subjects

Air Pollution Control
Environmental Protection Agency

Animal Biologics
Animal and Plant Health Inspection Service

Aviation Safety
Federal Aviation Administration

Bridges
Coast Guard

Communications Common Carriers
Federal Communications Commission

Conflict of Interests
Personnel Management Office

Food Additives
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Freedom of Information
Customs Service

Government Contracts
Immigration and Naturalization Service

Hazardous Materials
Environmental Protection Agency

Intergovernment Relations
Land Management Bureau

Marketing Agreements
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Questions and requests for specific information may be directed to the telephone numbers listed under INFORMATION AND ASSISTANCE in the READER AIDS section of this issue.

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

OFFICE OF PERSONNEL MANAGEMENT

5 CFR Parts 734, 735, and 737

Public Financial Disclosure, Conflicts of Interest, and Standards of Conduct for Federal Employees

AGENCY: Office of Government Ethics, Office of Personnel Management.

ACTION: Final rule.

SUMMARY: This document makes final an interim rule published August 21, 1984, affecting 5 CFR Part 734 (concerned with financial disclosure statements required of certain Executive Branch officials), 5 CFR Part 735 (prescribing standards of conduct for officers and employees of the Executive Branch), and 5 CFR Part 737 (dealing with post-employment conflicts of interest). In particular, these amendments serve to conform the regulations in those parts to amendments of Titles II and IV of the Ethics in Government Act of 1978 enacted by Public Law 98–150 of November 11, 1983.

EFFECTIVE DATE: February 11, 1985.

FOR FURTHER INFORMATION CONTACT: F. Gary Davis or Norman B. Smith (202) 632–7642.

SUPPLEMENTARY INFORMATION: These regulations make final an interim rule which was published on August 21, 1984, at 49 FR 33115 with an invitation for the submission of written comments to the Office of Government Ethics (OGE) during a 60-day period ending October 22, 1984. The Director of the Office, pursuant to 5 U.S.C. 553(b)(3)(A), has found good cause for waiving the general notice of proposed rulemaking and the 30-day delay in effectiveness. This regulation is interpretive in nature, exempt from 5 U.S.C. 553.

Discussion of Comments

One comment received by OGE pointed out that an ethics agreement made by an official under the provisions of interim Subpart H of Part 734 might require or prohibit action on the part of the official that would be contrary to instructions issued by a superior based on an exclusive grant of power to the latter by statute. To avoid a clash of that kind, amendment 5 inserts an exception in final § 734.802(c) that specifically recognizes such statutory authority as controlling.

Another comment received by OGE recommended with regard to interim 5 CFR 735.104(d) that an agency's request for the approval of a regulation it proposes to issue under the authority of Part 735 should be directed both to the Office of Personnel Management and to OGE for scrutiny rather than to the latter only. The proposal has been adopted in final § 735.104(d). See Amendment 7.

A number of minor changes or additions to provisions of the interim rule have been made in the interests of clarity and style, some of which were recommended in comments.

Comments aside, interim § 734.803(c) has been amended in order to remedy the inadvertent omission of certain employees of the White House Office, the Office of the Vice President and the Executive Office of the President from the requirement that once an official within the coverage of the subsection enters into an ethics agreement, he or she must call it to OGE's attention. See Amendment 5.

E.O. 12291, Federal Regulation

OGE has determined that this is not a major rule as defined under section 1(B) of E.O. 12291, Federal Regulation.

Regulatory Flexibility Act

I certify that this regulation will not have a significant economic impact on a substantial number of small entities because it only affects Federal employees.

List of Subjects

5 CFR Part 734

Conflicts of interest, Government employees, Penalties, Reporting and recordkeeping requirements, Trusts and trustees.

5 CFR Part 735

Conflicts of interest, Government employees.

5 CFR Part 737

Conflicts of interest, Government employees.

Office of Government Ethics.
David H. Martin,
Director.

Accordingly, the interim rule amending 5 CFR Parts 734, 735 and 737 which was published August 21, 1984, at 49 FR 33115, is made final with the following changes:

PART 734—EXECUTIVE PERSONNEL FINANCIAL DISCLOSURE REQUIREMENTS

1. The authority citation for Part 734 is revised to read as follows:

Authority: Titles II and IV of Pub. L. 95–521 (October 26, 1978), as amended by Pub. L. 96–19 (June 13, 1979), 5 U.S.C. Appendix 994; Pub. L. 98–150 (November 11, 1983).

2. In § 734.105, the definition of "special Government employee" is revised to read as follows:

§ 734.105 Definitions.

* * * * *

Special Government employee. The term "special Government employee" has the meaning given that term by 18 U.S.C. 202(a).

* * * * *

3. Section 734.401(c) is revised to read as follows:

§ 734.401 Qualified trusts; general considerations.

* * * * *

(c) *Certification of pre-existing trusts.* Normally, trusts certified by the Director, Office of Government Ethics, under § 734.405 are newly created trust arrangements formulated by representatives of the interested parties in consultation with the staff of the Office to meet the established standards. However, in a case where the Director determines that such action is appropriate to assure compliance with applicable laws and regulations, an existing trust may be proposed for certification as a qualified blind trust or qualified diversified trust under the provisions of § 734.403 or § 734.404. In addition to the normally applicable rules of this Subpart D, there are other

considerations that pertain in the case of pre-existing trusts. Interested parties and their representatives are invited to contact the Office of Government Ethics for further information.

4. Section 734.604(d)(1) is revised to read as follows:

§ 734.604 Review of reports.

* * * * *

(d) *Updated disclosure of earned income and honoraria in the case of an individual nominated by the President to a position to which appointment is subject to confirmation by the Senate*—(1) *General Rule.* Each individual described in § 734.201(c) who is nominated by the President to a position to which appointment is subject to confirmation by the Senate shall, at or before the commencement of the first Senate Committee hearing to consider the nomination, submit to the Committee an amendment to his or her report previously filed under § 734.201(c) which shall update, through the period ending no earlier than five days prior to the date of the commencement of the hearing, the disclosure of items and other data with respect to (i) outside earned income, as defined in § 734.501(b), without application of its last sentence, and (ii) honoraria, as defined in § 734.105. Such individual shall transmit copies of the amendment to the designated agency ethics official referred to in paragraph (c)(1) of this section and to the Office of Government Ethics.

* * * * *

5. Subpart H of Part 734 is revised to read as follows:

Subpart H—Ethics Agreements

Sec.
734.801 Scope.
734.802 Requirements.
734.803 Notification of ethics agreements.
734.804 Notification of compliance.
734.805 Retention.

Subpart H—Ethics Agreements

§ 734.801 Scope.

This subpart applies to ethics agreements made by reporting individuals (see § 734.202) to resolve potential or actual conflicts of interest.

§ 734.802 Requirements.

(a) *Ethics Agreement defined.* Except as provided in subsection (c) of this section, the term "ethics agreement" shall for the purposes of this subpart include any undertaking to carry out one or more of the following actions:

(1) Recusal or disqualification from one or more particular matters or categories of official action;

(2) Divestiture of a financial interest or interests;

(2) Resignation from a non-federal business or other entity;

(4) Participation in one or more particular matters or categories of official action upon the issuance of an 18 U.S.C. 208(b)(1) waiver; or

(5) Establishment of a blind trust under this Act.

(b) *Time limit.* The ethics agreement shall specify that the individual must complete the action which he or she has undertaken within a period not to exceed 3 months from the date of the agreement, except in cases of unusual hardship as determined by the Office of Government Ethics.

(c) *Exception.* An ethics agreement shall not include an undertaking by a reporting individual to carry out an action listed in subsection (a) of this section if the power to permit or deny the action by such individual has been granted by statute to an agency or official who has not approved the undertaking. See, for example, Department of Energy Organization Act, Pub. L. 95–91, Sections 602(a) and 606 (a) and (b).

Example 1. An official of the Boeing Company is nominated to a Department of Defense position requiring the advice and consent of the Senate. As a condition of assuming the position the individual has agreed to divest himself of his Boeing stock which he recently acquired while he was an officer with the company. However, a Securities and Exchange Commission law and regulation preclude officers of public corporations from deriving a profit from the sale of stock in the corporation in which they hold office within 6 months of acquiring the stock, and direct that any such profit must be returned to the issuing corporation or its stockholders. Since meeting the usual 3-month time limit specified in this subpart might entail losing any profit that might be realized on the sale of the stock, the Boeing official requests that such limit be extended beyond the end of the 6-month period imposed by the Commission to enable any profits from the transaction to inure to his benefit. Written approval would have to be obtained from the Office of Government Ethics to extend the customary 3-month period.

§ 734.803 Notification of ethics agreements.

(a) *Nominees to positions requiring the advice and consent of the Senate.* (1) In the case of a nominee referred to in §734.201(c), the designated agency ethics official shall include with the report submitted to the Office of Government Ethics any ethics agreement which the nominee has made.

(2) A designated agency ethics official shall immediately notify the Office of Government Ethics of an ethics agreement of a nominee which is made or becomes known after the submission of the nominee's report to the Office of Government Ethics. This requirement includes an ethics agreement made by a nominee with the Senate confirmation committee. The nominee for his or her part shall immediately report to the designated agency official an ethics agreement he or she has made with the committee.

(3) With regard to any ethics agreements made between the nominee and the Office of Government Ethics, the Office of Government Ethics shall immediately apprise the designated agency ethics official and the Senate confirmation committee.

(b) *Incumbents of positions requiring the advice and consent of the Senate.* In the case of a position requiring the incumbent's confirmation by the Senate, the designated agency ethics official shall immediately apprise the Office of Government Ethics of any ethics agreement which the incumbent has made.

(c) *Designated agency ethics officials not covered by paragraph (a) or (b) and employees of the White House Office and other agencies referred to in § 734.602(c)(5).* A designated agency ethics official not covered by paragraph (a) or (b) of this section and each employee of the White House Office, the Office of Vice President, or the Domestic Policy Staff and Office of Administration (agencies in the Executive Office of the President) who is referred to in § 734.602(c)(5) shall include with his or her initial report submitted to the Office of Government Ethics any ethics agreement which such official or employee has undertaken and shall immediately apprise the Office of Government Ethics of any subsequent ethics agreement.

(d) *Other reporting individuals.* Other reporting individuals desiring to enter into ethics agreements may do so with the designated agency ethics official. Where an ethics agreement has been made with someone other than the designated agency ethics official, the officer or employee involved shall immediately apprise the designated agency ethics official of the agreement.

§ 734.804 Notification of compliance.

Requisite evidence of action taken. In the case of nominees to positions requiring the advice and consent of the Senate, evidence of the action taken by the nominee to carry out an ethics agreement shall be submitted to the Office of Government Ethics and the Senate confirmation committee by the designated agency ethics official

promptly upon receipt by the official of such evidence. In the case of incumbents of positions requiring the advice and consent of the Senate, evidence of action taken shall be submitted immediately by the designated agency ethics official to the Office of Government Ethics. Where a designated agency ethics official is neither a nominee nor an incumbent, such official must send evidence of his or her action to the Office of Government Ethics. In the case of other reporting individuals, evidence of action taken must be sent to the designated agency ethics official. The evidence of the action taken consists of any of the following:

(a) *Recusal.* A copy of the recusal agreement containing the specific matters to which the recusal shall apply, a statement of the process or method by which the recusal shall be enforced within the agency, and positions of those involved in its execution (i.e., the individual's immediate subordinates and supervisors).

Example (1): A member of the staff of the National Transportation Safety Board owns stock in UAL, Inc. (United Air Lines) and has agreed to recuse herself from participation in any investigations of accidents involving United Air Lines aircraft. A copy of this recusal would have to be given to her immediate subordinates and supervisors and to the designated agency ethics official. The staff member has also agreed to recuse herself from any particular matter (as defined in 18 U.S.C. 208) that might arise with respect to any of her present or future holdings. There would be no requirement to commit this type of general recusal to writing.

(b) *Divestiture, resignation, and reassignment.* Written notification that the divestiture, resignation, or reassignment has occurred.

(c) *18 U.S.C. 208(b)(1) waiver.* A copy of the waiver, signed by the appropriate supervisory official.

(d) *Blind trust.* Information required by Subpart D of this part submitted to the Office of Government Ethics for its approval of the blind trust instrument. Should the trust not be approved, the designated agency ethics official and, as appropriate, the Senate confirmation committee should be informed immediately.

§ 734.805 Retention.

Records of ethics agreements and actions described in this subpart shall be maintained with the individual's financial disclosure report at the agency and, where applicable, at the Office of Government Ethics.

PART 735—EMPLOYEES AND CONDUCT

6. The authority citation for Part 735 is revised to read as follows:

Authority: Titles II and IV of Pub. L. 95–521 (October 26, 1978), as amended by Pub. L. 96–19 (June 13, 1979); U.S.C. Appendix 1005; Pub. L. 98–150 (November 11, 1983); secs. 602, 701, 702; E.O. 11222, 3 CFR, 3 CFR, 1964–1965 Comp., p. 306, unless otherwise noted, 18 U.S.C. 201 note.

7. Paragraph (d) of § 735.104 is revised to read as follows:

§ 735.104 Issuance, approval and publication of agency regulations.

* * * * *

(d) Requests for approval of agency regulations to be issued under this part shall be directed both to the Office of Personnel Management, Office of the General Counsel, Washington, D.C. 20415, and the Office of Government Ethics, OPM, Washington, D.C. 20415.

* * * * *

PART 737—REGULATIONS CONCERNING POST EMPLOYMENT CONFLICT OF INTEREST

8. The authority citation for Part 737 is revised to read as follows:

Authority: Titles II and IV of Pub. L. 95–521 (October 26, 1978), as amended by Pub. L. 96–19 (June 13, 1979), 5 U.S.C. Appendix; Pub. L. 98–150 (November 11, 1983); 18 U.S.C. 207.

[FR Doc. 85–661 Filed 1–9–85; 8:45 am]
BILLING CODE 6325–01–M

DEPARTMENT OF AGRICULTURE

Federal Crop Insurance Corporation

7 CFR Part 408

[Docket No. 1884S]

Eastern U.S. Apple Crop Insurance Regulations

AGENCY: Federal Crop Insurance Corporation, USDA.

ACTION: Notice of Further Extension of Sales Closing Date.

SUMMARY: Under the authority contained in the Federal Crop Insurance Act, as amended, the Federal Crop Insurance Corporation (FCIC) herewith gives notice of the further extension of the closing date for accepting applications for Eastern U.S. Apple Crop Insurance Regulations (7 CFR Part 408), effective for the 1985 crop year. This action is necessary because of additional delays in processing the issuance of an amended Fresh Fruit Option to provide the insured producer with a quality provision for the type of apples insured under this option when such apples do not grade U.S. No. 1 or do not grade 80 percent fancy or better under USDA standards. The intended effect of this notice is to advise all interested parties of the extension of the sales closing date and to comply with the provisions of the Eastern U.S. Apple Crop Insurance Regulations with respect to the authority of the Manager, FCIC, to extend closing dates.

EFFECTIVE DATE: January 10, 1985.

FOR FURTHER INFORMATION CONTACT: Peter F. Cole, Secretary, Federal Crop Insurance Corporation, U.S. Department of Agriculture, Washington, D.C., 20250, telephone (202) 447–3325.

SUPPLEMENTARY INFORMATION: Under the provisions contained in the Eastern U.S. Apple Crop Insurance Regulations (7 CFR Part 408), the closing date for accepting applications is November 20. Because of a delay in processing an amendment to the Fresh Fruit Option to such regulations effective for the 1985 and succeeding crop years, FCIC published a notice in the **Federal Register** on Wednesday, November 28, 1984, extending the closing date for accepting applications through the close of business on December 31, 1984, effective for the 1985 crop year only.

Further delays in processing the fresh fruit option make it necessary to extend the closing date for accepting applications through the close of business on January 15, 1985, effective for the 1985 crop year only.

The amendment in question provides a fresh fruit option amendment to insured growers who wish to insure quality, not presently contained in the policy for insuring apples under 7 CFR Part 408, when the apples do not grade U.S. No. 1 or do not grade 80 percent fancy or better under U.S. Department of Agriculture standards.

Notice

Accordingly, pursuant to the authority contained in the Federal Crop Insurance Act, as amended (7 U.S.C. 1501 *et seq.*), the Federal Crop Insurance Corporation herewith gives notice that the closing date for accepting applications for apple crop insurance under the provisions of 7 CFR Part 408 is further extended, effective for the 1985 crop year only, through the close of business on January 15, 1985.

Done in Washington, D.C., on January 3, 1985.

Peter F. Cole,

Secretary, Federal Crop Insurance Corporation.

Approved by:

Edward Hews,

Deputy Manager.

Dated: January 3, 1985.

[FR Doc. 85-716 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-08-M

Agricultural Marketing Service

7 CFR Part 910

[Lemon Reg. 496, Amdt. 1]

Lemons Grown in California and Arizona; Limitation of Handling

AGENCY: Agricultural Marketing Service, USDA.

ACTION: Final rule.

SUMMARY: This action increases the quantity of fresh California-Arizona lemons that may be shipped to the fresh market to 235,000 cartons during the period December 30, 1984–January 5, 1985. Such action is needed to provide for orderly marketing of fresh lemons for the period specified due to the marketing situation confronting the lemon industry.

DATES: Effective for the period December 30, 1984–January 5, 1985.

FOR FURTHER INFORMATION CONTACT: William J. Doyle, Chief, Fruit Branch, F&V, AMS, USDA, Washington, D.C. 20250, telephone 202–447–5975.

SUPPLEMENTARY INFORMATION: This final rule has been reviewed under Secretary's Memorandum 1512–1 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 final rule is issued under Marketing Order No. 910, as amended (7 CFR Part 910) regulating the handling of lemons grown in California and Arizona. The order is effective under the Agricultural Marketing Agreement Act of 1937, as amended (7 U.S.C. 601–674). The action is based upon the recommendations and information submitted by the Lemon 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 currently in effect. The committee met by telephone on January 3, 1985, to consider the current and prospective conditions of supply and demand and recommended an increase in the quantity of lemons deemed advisable to be handled during the specified week. The committee reports that the demand for lemons has improved.

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 amendment is based and the effective date necessary to effectuate the declared policy of the act. This amendment relieves restrictions on the handling of lemons. It is necessary to effectuate the declared purposes of the act to make these regulatory provisions effective as specified, and handlers have been apprised of such provisions and the effective time.

List of Subjects in 7 CFR Part 910

Marketing agreements and orders, California, Arizona, Lemons.

PART 910—[AMENDED]

1. Section 910.796 Lemon Regulation 496 is revised to read as follows:

§ 910.796 Lemon regulation 496.

The quantity of lemons grown in California and Arizona which may be handled during the period December 30, 1984, through January 5, 1985, is established at 235,000 cartons.

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

Dated: January 4, 1985.

Thomas R. Clark,

Deputy Director, Fruit and Vegetable Division, Agricultural Marketing Service.

[FR Doc. 85-700 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-02-M

Farmers Home Administration

7 CFR Parts 1930, 1944 and 1965

Security Servicing for Multiple Family Housing Loans

AGENCY: Farmers Home Administration, USDA.

ACTION: Final rule; correction.

SUMMARY: The Farmers Home Administration (FmHA) corrects a final rule published December 21, 1984 (49 FR 49587). In the preamble to FmHA's revised regulations regarding Security Servicing for Multiple Family Housing Loans, the "Effective Date" was incorrectly printed as "Date." The intent of this action is to correct this error.

FOR FURTHER INFORMATION CONTACT: Dean Greenwalt, Branch Chief, Multiple Family Housing Servicing and Property Management Division, Room 5321–S, Farmers Home Administration, USDA, 14th and Independence Avenue, SW., Washington D.C. 20250. Telephone (202) 382–1615.

SUPPLEMENTARY INFORMATION: The following correction is made in FR Doc. 84–33205 appearing on pages 49587 to 49610 in the issue of December 21, 1984. In the first column on page 49588, the title "Date" is corrected to read "Effective Date."

Authority: 42 U.S.C. 1480; 7 CFR 2.23; 7 CFR 2.70.

Dated: January 3, 1985.

Dwight O. Calhoun,

Acting Associate Administrator, Farmers Home Administration.

[FR Doc. 85-759 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-07-M

DEPARTMENT OF JUSTICE

Immigration and Naturalization Service

8 CFR Part 238

Contracts With Transportation Lines; Addition of Aerolineas Nicaraguenses, S.A. (Aeronica)

AGENCY: Immigration and Naturalization Service, Justice.

ACTION: Final rule.

SUMMARY: This rule adds Aerolineas Nicaraguenses, S.A. (Aeronica) to the list of carriers which have entered into agreements with the Service to guarantee the passage through the United States in immediate and continuous transit of aliens destined to foreign countries.

EFFECTIVE DATE: December 17, 1984.

FOR FURTHER INFORMATION CONTACT: Loretta J. Shogren, Director, Policy Directives and Instructions, Immigration and Naturalization Service, 425 I Street, NW, Washington, D.C. 20536 Telephone: (202) 633–3048.

SUPPLEMENTARY INFORMATION: The Commissioner of Immigration and Naturalization entered into an agreement with Aerolineas Nicaraguenses, S.A. (Aeronica) on December 17, 1984 to guarantee passage through the United States in immediate and continuous transit of aliens destined to foreign countries.

The agreement provides for the waiver of certain documentary requirements and facilitates the air travel of passengers on international flights while passing through the United States.

Compliance with 5 U.S.C. 553 as to notice of proposed rulemaking and delayed effective date is unnecessary because the amendment merely makes an editorial change to the listing of transportation lines.

In accordance with 5 U.S.C. 605(b), the Commissioner of Immigration and Naturalization certified that the rule will not have a significant impact on a substantial number of small entities.

This order constitutes a notice to the public under 5 U.S.C. 552 and is not a rule within the definition of section 1(a) of E.O. 12291.

List of Subjects in 8 CFR Part 238

Airlines, Aliens, Government contracts, Travel, Travel restriction.

Accordingly, Chapter I of Title 8 of the Code of Federal Regulations is amended as follows:

PART 238—CONTRACTS WITH TRANSPORTATION LINES

§ 238.3 [Amended]

In § 238.3 Aliens in immediate and continuous transit, the listing of transportation lines in paragraph (b) *Signatory lines* is amended by: Adding in alphabetical sequence, Aerolineas Nicaraguenses, S.A. (Aeronica).

* * * * *

(Secs. 103 and 238 of the Immigration and Nationality Act, as amended; (8 U.S.C. 1103 and 1228))

Dated: January 7, 1985.

Andrew J. Carmichael, Jr.,

Associate Commissioner, Examinations, Immigration and Naturalization Service.

[FR Doc. 85-703 Filed 1-9-85; 8:45 am]

BILLING CODE 4410-10-M

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Part 92

[Docket No. 84-121]

Importation of Certain Animals; Harry S Truman Animal Import Center

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Notice of deadline for receipt of applications for special authorization, date, time and place of drawing, and schedule of fees for importation of cattle through the Harry S Truman Animal Import Center.

SUMMARY: This document establishes a specific date for receipt of applications for special authorization to be drawn on a lottery basis for the allotment of quarantine space for the next two groups of cattle to be imported through the Harry S Truman Animal Import Center (HSTAIC), and establishes the date, time, and place of the drawing. It also lists the geographic areas from which cattle will be considered for importation and the schedules of fees for importation of such cattle. This action is being taken to notify potential applicants of the lottery and fee schedule in accordance with the regulations.

DATES: Deadline for receipt of applications: March 8, 1985. Date and time of drawing: March 14, 1985 at 9 a.m.

ADDRESSES: Place of drawing: Room 643A, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782.

Application forms may be obtained upon request from and completed applications and deposits should be sent to Import-Export Animals and Products Staff, VS, APHIS, USDA, 6505 Belcrest Road, Room 838, Hyattsville, MD 20782.

FOR FURTHER INFORMATION CONTACT: Dr. Allan A. Furr, VS, APHIS, USDA, Room 846, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301-436-8170.

SUPPLEMENTARY INFORMATION: Procedures are established in § 92.41 of Title 9, Code of Federal Regulations (9 CFR 92.41), concerning the allocation of space at the HSTAIC. These procedures include holding a drawing to determine from submitted applications which interested persons will have a right to attempt to qualify animals to enter the United States through the HSTAIC. The HSTAIC is intended to process animals from countries in which exotic diseases exist and which are not otherwise eligible for importation into the United States.

The regulations require that at least 30 days prior notice be provided in the **Federal Register** of the date, time, and place of the drawing; the geographic areas from which animals will be considered for importation; and the fee schedule for the proposed importation (9 CFR 92.41(a)(1)). The Department has determined that it would be too complicated and would pose unnecessary disease risks to allow cattle from Europe and South America to be combined in one importation. Therefore, cattle from Europe and South America shall be imported in separate importations. Importers of cattle from Europe are much more limited than importers from South America in when they can have their cattle qualified for importation into the HSTAIC. This is because of several factors including the severe winter weather and certain vaccination programs required by European countries but not found in South America. Cattle which have been vaccinated cannot enter the HSTAIC, so an importation of European cattle must occur before the cattle reach an age where they must, by law, be vaccinated. Based on these factors the Department anticipates that the next importation of cattle from South America should be able to enter the HSTAIC on or about August 15, 1985, and any cattle that will qualify for importation from Europe should be able to enter the HSTAIC on or about December 15, 1985. The drawing for cattle from South America is scheduled for March 14, 1985, at 9 a.m. in Room 643A, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782. The drawing for cattle from Europe will begin immediately after the drawing for cattle from South America is completed.

Each applicant for importation shall complete an application for importing cattle through the HSTAIC which shall be received by Veterinary Services at least 5 days prior to the date of the drawing. Application forms may be obtained upon request from and completed applications must be sent to and received by Import-Export Animals and Products Staff, VS, APHIS, USDA, 6505 Belcrest Road, Room 838, Hyattsville, MD 20782.

Each application for South America or Europe shall be accompanied by a certified check, money order, or letter of credit payable to the United States Department of Agriculture, Animal and Plant Health Inspection Service, in the amount of one thousand dollars ($1,000), for each animal for which special authorization is requested on the application. If a letter of credit is utilized, the effective date on the letter of credit accompanying an application for the importation of cattle from South America must run to December 1, 1985, and the effective date on the letter of credit accompanying an application for the importation of cattle from Europe must run to April 1, 1986. (The $1,000 deposit per animal does not apply to applications for exclusive use, pursuant to 9 CFR 92.41(b)(1)).

In the event the applicant does not receive special authorization for cattle for which the applicant has applied, the amount deposited with the application for each animal not so authorized will be refunded. If the applicant receives special authorization, the deposited

amount shall be applied against the total cost of importation of each animal. However, the $1,000 per head deposit is nonrefundable for each animal granted special authorization.

All applicants or their designated legal agents or representatives shall be required to appear in person at the drawing. Each designated legal agent or representative shall have a notarized statement of authority signed by the applicant. In accordance with these procedures, it should be emphasized that no person will be allowed to participate in the lottery as a designated legal agent or representative without a notarized statement of authority signed by the applicant. On the day of the drawing, the applicants selected or their legal agents or representatives shall be required to execute a cooperative agreement and pay the required fee in accordance with the provisions of the cooperative agreement.

If the total number of cattle for which special authorizations are requested is not at least 50, there shall not be a lottery or importation pursuant to 9 CFR 92.41(a) and the deposits shall be refunded to the applicants.

Special authorization for the exclusive use of the HSTAIC shall be issued in accordance with 9 CFR 92.41(b) when the HSTAIC is not scheduled for use for an importation of cattle pursuant to 9 CFR 92.41(a).

The fee schedules presented below are graduated depending on the number of cattle for which authorization is granted to qualify the cattle for entrance into the USDA approved embarkation facility and depending upon the number of cattle which go through the quarantine period at the USDA approved embarkation facility and the HSTAIC. To calculate the total deposit required for importation, the cost per head for qualifying or attempting to qualify cattle on the premises of origin must be added to the cost per head for 50 cattle to be quarantined in the USDA-approved embarkation facility and the HSTAIC. The fees are as follows:

COST OF QUALIFYING OR ATTEMPTING TO QUALIFY CATTLE EUROPE—ON PREMISES OF ORIGIN

No. of cattle	Total fixed cost (dollars)	In country: Fixed cost per head (dollars)	In country: Variable cost per head (dollars)	Total cost per head (dollars)
50 to 55	104,935	2,099	166	2,265
56 to 60	106,456	1,937	166	2,103
61 to 65	111,977	1,836	166	2,002
66 to 70	115,499	1,750	166	1,916
71 to 75	119,020	1,676	166	1,842
76 to 80	122,541	1,612	166	1,778
81 to 85	126,062	1,556	166	1,722
86 to 90	129,583	1,507	166	1,673
91 to 95	133,105	1,463	166	1,629
96 to 100	136,626	1,423	166	1,589
101 to 105	140,147	1,388	166	1,554
106 to 110	143,191	1,351	166	1,517
111 to 115	146,236	1,317	166	1,483
116 to 120	149,280	1,287	166	1,453
121 to 125	152,325	1,259	166	1,425
126 to 130	155,369	1,233	166	1,399
131 to 135	158,413	1,209	166	1,375
136 to 140	161,458	1,187	166	1,353
141 to 145	164,502	1,167	166	1,333
146 to 150	172,685	1,183	166	1,349
151 to 155	170,591	1,130	166	1,296
156 to 160	173,874	1,115	166	1,281
161 to 165	177,157	1,100	166	1,266
166 to 170	180,440	1,087	166	1,253
171 to 175	183,723	1,074	166	1,240
176 to 180	187,006	1,063	166	1,229
181 to 185	190,288	1,051	166	1,217
186 to 190	193,571	1,041	166	1,207
191 to 195	196,854	1,031	166	1,197
196 to 200	205,805	1,050	166	1,216
201 to 205	203,420	1,012	166	1,178
206 to 210	204,125	991	166	1,157
211 to 215	204,830	971	166	1,137
216 to 220	205,534	952	166	1,118
221 to 225	206,239	933	166	1,099
226 to 230	206,944	916	166	1,082

COST OF QUARANTINING CATTLE—EUROPE BREST AND HSTAIC

No. of cattle	Total fixed cost (dollars)	In quarantine: Fixed cost per head (dollars)	In quarantine: Variable cost per head (dollars)	Total cost per head (dollars)
50 to 55	310,818	6,216	897	7,113
56 to 60	314,339	5,613	897	6,510
61 to 65	317,860	5,211	897	6,108
66 to 70	321,321	4,869	897	5,766
71 to 75	324,903	4,576	897	5,473
76 to 80	328,424	4,321	897	5,218
81 to 85	331,945	4,098	897	4,995
86 to 90	335,466	3,901	897	4,798
91 to 95	338,968	3,725	897	4,622

COST OF QUARANTINING CATTLE—EUROPE BREST AND HSTAIC—Continued

No. of cattle	Total fixed cost (dollars)	In quarantine: Fixed cost per head (dollars)	In quarantine: Variable cost per head (dollars)	Total cost per head (dollars)
96 to 100	342,509	3,568	897	4,465
101 to 105	377,021	3,733	897	4,630
106 to 110	380,065	3,586	897	4,483
111 to 115	383,110	3,451	897	4,348
116 to 120	386,154	3,329	897	4,226
121 to 125	389,199	3,217	897	4,114
126 to 130	392,243	3,113	897	4,010
131 to 135	395,287	3,017	897	3,914
136 to 140	398,332	2,929	897	3,826
141 to 145	401,376	2,847	897	3,744
146 to 150	404,421	2,770	897	3,667
151 to 155	488,562	3,236	897	4,133
156 to 160	491,845	3,153	897	4,050
161 to 165	495,128	3,075	897	3,972
166 to 170	498,411	3,002	897	3,899
171 to 175	501,694	2,934	897	3,831
176 to 180	504,977	2,869	897	3,766
181 to 185	508,259	2,808	897	3,705
186 to 190	511,542	2,750	897	3,647
191 to 195	514,825	2,695	897	3,592
196 to 200	518,108	2,643	897	3,540
201 to 205	552,166	2,747	897	3,644
206 to 210	552,871	2,684	897	3,581
211 to 215	553,576	2,624	897	3,521
216 to 220	554,280	2,566	897	3,463
221 to 225	554,985	2,511	897	3,408
226 to 230	575,714	2,547	897	3,444

COST OF QUALIFYING OR ATTEMPTING TO QUALIFY CATTLE BRAZIL—ON PREMISES OF ORIGIN

No. of cattle	Total fixed cost (dollars)	In country: Fixed cost per head (dollars)	In country: Variable cost per head (dollars)	Total cost per head (dollars)
50 to 55	79,937	1,599	216	1,815
56 to 60	83,458	1,490	216	1,706
61 to 65	86,979	1,426	216	1,642
66 to 70	90,501	1,371	216	1,587
71 to 75	94,022	1,324	216	1,540
76 to 80	97,543	1,283	216	1,499
81 to 85	101,064	1,248	216	1,464
86 to 90	104,585	1,216	216	1,432
91 to 95	108,107	1,188	216	1,404
96 to 100	111,628	1,163	216	1,379
101 to 105	114,602	1,135	216	1,351
106 to 110	117,646	1,110	216	1,326
111 to 115	120,691	1,087	216	1,303
116 to 120	123,735	1,067	216	1,283
121 to 125	126,780	1,048	216	1,264
126 to 130	129,824	1,030	216	1,246
131 to 135	132,868	1,014	216	1,230
136 to 140	135,913	999	216	1,215

COST OF QUALIFYING OR ATTEMPTING TO QUALIFY CATTLE BRAZIL—ON PREMISES OF ORIGIN—Continued

No. of cattle	Total fixed cost (dollars)	In country		Total cost per head (dollars)
		Fixed cost per head (dollars)	Variable cost per head (dollars)	
141 to 145	138,957	986	216	1,202
146 to 150	142,002	973	216	1,189
151 to 155	146,835	972	216	1,188
156 to 160	150,118	962	216	1,178
161 to 165	153,401	953	216	1,169
166 to 170	156,684	944	216	1,160
171 to 175	159,967	935	216	1,151
176 to 180	163,250	928	216	1,144
181 to 185	166,532	920	216	1,136
186 to 190	169,815	913	216	1,129
191 to 195	173,098	906	216	1,122
196 to 200	176,381	900	216	1,116
201 to 205	179,162	891	216	1,107
206 to 210	179,867	873	216	1,089
211 to 215	180,572	856	216	1,072
216 to 220	181,276	839	216	1,055
221 to 225	181,981	823	216	1,039
226 to 230	180,301	798	216	1,014

COST OF QUARANTINING CATTLE—BRAZIL CANNANEIA AND HSTAIC

No. of cattle	Total fixed cost (dollars)	In quarantine		Total cost per head (dollars)
		Fixed cost per head (dollars)	Variable cost per head (dollars)	
50 to 55	312,730	6,255	996	7,251
56 to 60	316,251	5,647	996	6,643
61 to 65	319,772	5,242	996	6,238
66 to 70	323,294	4,898	996	5,894
71 to 75	326,815	4,603	996	5,599
76 to 80	330,336	4,347	996	5,343
81 to 85	333,857	4,122	996	5,118
86 to 90	337,378	3,923	996	4,919
91 to 95	340,900	3,746	996	4,742
96 to 100	344,421	3,588	996	4,584
101 to 105	374,822	3,711	996	4,707
106 to 110	377,866	3,565	996	4,561
111 to 115	380,911	3,432	996	4,428
116 to 120	383,955	3,310	996	4,306
121 to 125	387,000	3,198	996	4,194
126 to 130	309,044	3,096	996	4,092
131 to 135	393,088	3,001	996	3,997
136 to 140	396,133	2,913	996	3,909
141 to 145	399,177	2,831	996	3,827
146 to 150	402,222	2,755	996	3,751
151 to 155	484,847	3,211	996	4,207
156 to 160	488,130	3,129	996	4,125
161 to 165	491,413	3,052	996	4,048
166 to 170	494,696	2,980	996	3,976
171 to 175	497,979	2,912	996	3,908
176 to 180	501,262	2,848	996	3,844
181 to 185	504,544	2,788	996	3,784
186 to 190	507,827	2,730	996	3,726
191 to 195	511,110	2,676	996	3,672
196 to 200	514,393	2,624	996	3,620
201 to 205	547,342	2,723	996	3,719
206 to 210	548,047	2,660	996	3,656
211 to 215	548,752	2,601	996	3,597
216 to 220	549,456	2,544	996	3,540
221 to 225	550,161	2,489	996	3,485
226 to 230	573,857	2,539	996	3,535

Done at Washington, D.C., this 4th day of January 1985.

K.R. Hook,

Acting Deputy Administrator, Veterinary Services.

[FR Doc. 85-763 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-34-M

FEDERAL DEPOSIT INSURANCE CORPORATION

12 CFR Part 346

Foreign Banks; Clarification and Definition of Deposit Insurance Coverage

Correction

In FR Doc. 84-33279 beginning on page 49614 in the issue of Friday, December 21, 1984, make the following correction:

§ 346.23 [Corrected]

On page 49623, in § 346.23, first column sixteenth line, "December 21, 1987" should have read "January 22, 1988".

BILLING CODE 1505-01-M

CIVIL AERONAUTICS BOARD

14 CFR Ch. II

Transfer, Removal, and Reissuance of Regulations to Transportation Department

Correction

In FR Doc. 85-261, beginning on page 451 in the issue of Friday, January 4, 1985, make the following correction:

On page 452, second column, the eighteenth entry in the table reading "Part 218 Tariffs" should have read "Part 221 Tariffs".

BILLING CODE 1505-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

21 CFR Part 176

[Docket No. 84F-0106]

Indirect Food Additives: Paper and Paperboard Components; Components of Paper and Paperboard in Contact With Aqueous and Fatty Foods

AGENCY: Food and Drug Administration.

ACTION: Final rule.

SUMMARY: The Food and Drug Administration (FDA) is amending the food additive regulations to provide for the safe use of ethanedial, polymer with tetrahydro-4-hydroxy-5-methyl-2(1*H*)pyrimidinone, propoxylated, as a starch insolubilizer for paper and paperboard which will contact aqueous and fatty food. This action responds to a petition filed by Sun Chemical Corp.

DATES: Effective January 10, 1985; objections by February 11, 1985.

ADDRESS: Written objections to the Dockets Management Branch (HFA-305), Food and Drug Administration, Rm. 4-62, 5600 Fishers Lane, Rockville, MD 20857.

FOR FURTHER INFORMATION CONTACT: Andrew D. Laumbach, Center for Food Safety and Applied Nutrition (HFF-334), Food and Drug Administration, 200 C St. SW., Washington, DC 20204, 202-472-5690.

SUPPLEMENTARY INFORMATION: In a notice in the **Federal Register** of April 26, 1984 (49 FR 18044), FDA announced that a food additive petition (FAP 4B3782) had been filed by Sun Chemical Corp., P.O. Box 70, Chester, SC 29706, proposing that § 176.170 *Components of paper and paperboard in contact with aqueous and fatty foods* (21 CFR 176.170) be amended to provide for the safe use of ethanedial, polymer with tetrahydro-4-hydroxy-5-methyl-2(1*H*)pyrimidinone, propoxylated, as a starch insolubilizer for paper and paperboard which will contact aqueous and fatty food.

The food additive is currently regulated for use under paragraph (b)(2) of § 176.180 *Components of paper and paperboard in contact with dry food* (21 CFR 176.180) with the chemical name propylene glycolated poly(*N*-1',2'-dihydroxyethlyene-4-hydroxy-5-methylpyrimid-2-one) copolymer. That regulation, in response to a food additive petition (FAP 2B3651) by the Sun Chemical Corp., was published in the **Federal Register** of July 15, 1983 (48 FR 32340).

Subsequently, during the review of petition FAP 4B3782, proposing the same additive for a new use under §176.170, the agency determined that the correct

and more chemically precise name for the additive should be ethanedial, polymer with tetrahydro-4-hydroxy-5-methyl-2(1*H*) pyrimidinone, propoxylated.

Therefore, in the regclation set forth below, the agency is amending the chemical name of the additive under § 176.180 to correct it and to make it consistent with the name of the additive being regulated in this final rule for use under § 176.170. FDA concludes that no additional opportunity for comments is necessary because the chemical name change constitutes a minor editorial amendment and is not a substantive change.

FDA has evaluated data in the petition (FAP 4B3782) and other relevant material and concludes that the proposed use of the food additive is safe and that the regulations should be amended as set forth below.

In accordance with § 171.1(h) (21 CFR 171.1(h)), the petition and the documents that FDA considered and relied upon in reaching its decision to approve the petition are available for inspection at the Center for Food Safety and Applied Nutrition (address above) by appointment with the information contact person listed above. As provided in 21 CFR 171.1(h), the agency will delete from the documents any materials that are not available for public disclosure before making the documents available for inspection.

The agency has carefully considered the potential environmental effects of this action and has concluded that the action will not have a significant impact on the human environment and that an environmental impact statement is not required. The agency's finding of no significant impact and the evidence supporting that finding may be seen in the Dockets Management Branch (address above) between 9 a.m. and 4 p.m., Monday through Friday.

List of Subjects in 21 CFR Part 176

Food additives, Food packaging, Paper and paperboard.

Therefore, under the Federal Food, Drug, and Cosmetic Act (secs. 201(s), 409, 72 Stat. 1784–1788 as amended (21 U.S.C. 321(s), 348)) and under authority delegated to the Commissioner of Food and Drugs (21 CFR 5.10) and redelegated to the Director of the Center for Food Safety and Applied Nutrition (21 CFR 5.61), Part 176 is amended as follows:

PART 176—INDIRECT FOOD ADDITIVES: PAPER AND PAPERBOARD COMPONENTS

1. In § 176.170(b)(2) by alphabetically inserting a new item in the list of substances to read as follows:

§ 176.170 Components of paper and paperboard in contact with aqueous and fatty foods.

* * * * *

(b) * * *
(2) * * *

List of substances	Limitations
* * * * *	
Ethanedial, polymer with tetrahydro-4-hydroxy-5-methyl-2(1*H*)pyrimidinone, propoxylated.	For use only as an insolubilizer for starch-based coatings and limited to use at a level not to exceed 0.2 percent by weight of the coating solids.
* * * * *	

2. In § 176.180(b)(2) by revising the name of the item "Propylene glycolated poly(*N*-1',2'-dihydroxyethylene-4-hydroxy-5-methylpyrimid-2-one) copolymer" and alphabetically inserting its revised name to read as follows:

§ 176.180 Components of paper and paperboard in contact with dry food.

* * * * *

(b) * * *
(2) * * *

List of substances	Limitations
* * * * *	
Ethanedial, polymer with tetrahydro-4-hydroxy-5-methyl-2(1*H*)pyrimidinone, propoxylated.	
* * * * *	

Any person who will be adversely affected by the foregoing regulation may at any time on or before February 11, 1985 submit to the Dockets Management Branch (address above) written objections thereto and may make a written request for a public hearing on the stated objections. Each objection shall be separately numbered and each numbered objection shall specify with particularity the provision of the regulation to which objection is made. Each numbered objection on which a hearing is requested shall specifically so state; failure to request a hearing for any particular objection shall constitute a waiver of the right to a hearing on that objection. Each numbered objection for which a hearing is requested shall include a detailed description and analysis of the specific factual information intended to be presented in support of the objection in the event that a hearing is held; failure to include such a description and analysis for any particular objection shall constitute a waiver of the right to a hearing on the objection. Three copies of all documents shall be submitted and shall be identified with the docket number found in brackets in the heading of this regulation. Received objections may be seen in the office above between 9 a.m. and 4 p.m., Monday through Friday.

Effective date. This regulation is effective January 10, 1985.

(Secs. 201(s), 409, 72 Stat. 1784–1788 as amended (21 U.S.C. 321(s), 348))

Dated: January 3, 1985.

Sanford A. Miller,

Director, Center for Food Safety and Applied Nutrition.

[FR Doc. 85-674 Filed 1-9-85; 8:45 am]

BILLING CODE 4160-01-M

PENSION BENEFIT GUARANTY CORPORATION

29 CFR Part 2622

Payment of Premiums and Employer Liability for Single Employer Plan Terminations; Rules Pertaining to Withdrawals From and Terminations of Plans to Which More Than One Employer Contributes Other Than Multiemployer Plans

Correction

In FR Doc. 84-32882 beginning on page 49091 in the issue of Tuesday, December 18, 1984, make the following correction:

Appendix A–Late Payment and Overpayment Interest Rates [Corrected]

On page 49092, in the middle column, in Appendix A to Part 2622, in the table, the date "July 1, 1985" should read "Jan. 1, 1985".

BILLING CODE 1505-01-M

DEPARTMENT OF DEFENSE

Department of the Navy

32 CFR Part 706

Certifications and Exemptions Under the International Regulations for Preventing Collisions at Sea, 1972; Amendment; USS Caron and USS Elliot

AGENCY: Department of the Navy, DOD.

ACTION: Final rule.

SUMMARY: The Department of the Navy is amending its certifications and exemptions under the International Regulations for Preventing Collisions at Sea, 1972 (72 COLREGS), to reflect that

the Secretary of the Navy has determined the USS CARON (DD 970) and USS ELLIOT (DD 967) are vessels of the Navy which, due to their special construction and purpose, cannot comply fully with certain provisions of the 72 COLREGS without interfering with their special functions as naval destroyers. The intended effect of this rule is to warn mariners in waters where 72 COLREGS apply.

EFFECTIVE DATE: 24 December 1984.

FOR FURTHER INFORMATION CONTACT: Captain Richard J. McCarthy, JAGC, U.S. Navy, Admiralty Counsel, Office of the Judge Advocate General, Navy Department, 200 Stovall Street, Alexandria, VA 22332-2400, Telephone number: (202) 325-9744.

SUPPLEMENTARY INFORMATION: Pursuant to the authority granted in 33 U.S.C. 1605 and Executive Order 11964, the Department of the Navy amends 32 CFR Part 706. This amendment provides notice that the Secretary of the Navy has certified that USS CARON (DD 970) and USS ELLIOT (DD 967) are vessels of the Navy which, due to their special construction and purpose, cannot comply fully with 72 COLREGS: Annex I, section 3(a), pertaining to the placement of the forward masthead light in the forward quarter of the ship, and Annex I, section 3(a), pertaining to the placement of the after masthead light and the horizontal distance between the forward and after masthead lights, without interfering with their special functions as naval destroyers. The Secretary of the Navy has also certified that the above-mentioned lights are located in closest possible compliance with the applicable 72 COLREGS requirements.

Moreover, it has been determined, in accordance with 32 CFR Parts 296 and 701, the publication of this amendment for public comment prior to adoption is impracticable, unnecessary, and contrary to public interest since it is based on technical findings that the placement of lights on these ships in a manner differently from that prescribed herein will adversely affect the ships' abilities to perform their military functions.

List of Subjects in 32 CFR Part 706

Marine safety, Navigation (Water), Vessels.

Accordingly, 32 CFR Part 706 is amended as follows:

§ 706.2 [Amended]

1. Table Five of § 706.2 is amended by adding the following Navy ship to the list of vessels therein to indicate the certifications issued by the Secretary of the Navy:

Vessel	Number	Forward masthead light less than required height above hull. Annex I, sec. 2(a)(i)	Aft masthead light less than 4.5 meter above forward masthead light. Annex I, sec. 2(a)(ii)	Masthead lights not over all other lights and obstructions. Annex I, sec. 2(f)	Vertical separation of masthead lights used when towing less than required by Annex I, sec. 2(e)(i)	Aft masthead lights not visible over forward light 1,000 meters ahead of ship in all normal degrees of trim Annex I, sec. 2(b)	Forward masthead light not in forward quarter of ship. Annex I, sec. 3(a)(i)	After masthead light not less than ½ ship's length aft of forward masthead light. Annex I, sec. 3(a)(i)	Percentage horizontal separation attained
USS Caron	DD 970						X	X	46.4
USS Elliot	DD 967						X	X	46.4

Authority: Executive Order 11964; 33 U.S.C. 1605.

Dated: December 24, 1984.

Approved:

John Lehman,

Secretary of the Navy.

[FR Doc. 85-749 Filed 1-9-85; 8:45 am]

BILLING CODE 3810-AE-M

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32 CFR Part 706

Certifications and Exemptions Under the International Regulations for Preventing Collisions at Sea, 1972; Amendment; USS Joseph Strauss, et al.

AGENCY: Department of the Navy, DOD.

ACTION: Final rule.

SUMMARY: The Department of the Navy is amending its certifications and exemptions under the International Regulations for Preventing Collisions at Sea, 1972 (72 COLREGS), to reflect that the Secretary of the Navy has determined that USS JOSEPH STRAUSS (DDG 16), USS GOLDSBOROUGH (DDG 20), and USS BENJAMIN STODDERT (DDG 22) are vessels of the Navy which, due to their special construction and purpose, cannot comply fully with certain provisions of the 72 COLREGS without interfering with their special functions as naval destroyers. The intended effect of this rule is to warn mariners in waters where 72 COLREGS apply.

EFFECTIVE DATE: 19 December 1984.

FOR FURTHER INFORMATION CONTACT: Captain Richard J. McCarthy, JAGC, U.S. Navy, Admiralty Counsel, Office of the Judge Advocate General, Navy Department, 200 Stovall Street, Alexandria, VA 22332-2400, Telephone number: (202) 325-9744.

SUPPLEMENTARY INFORMATION: Pursuant to the authority granted in Executive Order 11964, the Department of the Navy amends 32 CFR Part 706. This amendment provides notice that the Secretary of the Navy has certified that USS JOSEPH STRAUSS (DDG 16), USS GOLDSBOROUGH (DDG 20), the USS BENJAMIN STODDERT (DDG 22) are vessels of the Navy which, due to their special construction and purpose, cannot comply fully with 72 COLREGS: Annex I, section 2(a)(i), regarding the height above the hull of their forward masthead lights, without interfering with their special functions as naval destroyers. The Secretary of the Navy has also certified that the above-mentioned lights are located in closest possible compliance with the applicable 72 COLREGS requirements.

Notice is also provided to the effect that USS JOSEPH STRAUSS (DDG 16), USS GOLDSBOROUGH (DDG 20), and USS BENJAMIN STODDERT (DDG 22) are members of the DDG 2 class of ships for which certain exemptions, pursuant to 72 COLREGS, Rule 38, have been previously authorized by the Secretary of the Navy. The exemptions pertaining to that class, found in the existing tables

of section 706.3, are equally applicable to these three ships.

Moreover, it has been determined, in accordance with 32 CFR Parts 296 and 701, that publication of this amendment for public comment prior to adoption is impracticable, unnecessary, and contrary to public interest since it is based on technical findings that the placement of lights on these ships in a manner differently from the prescribed herein will adversely affect the ships' abilities to perform their military functions.

List of Subjects in 32 CFR Part 706

Marine safety, Navigation (Water), Vessels.

Accordingly, 32 CFR Part 706 is amended as follows:

§ 706.2 [Amended]

1. Table One of § 706.2 is amended by adding the following vessels for which navigational light certifications are being herewith issued by the Secretary of the Navy:

Vessel	Number	Distance[1]
USS Joseph Strauss	DDG-16	2.4
USS Goldsborough	DDG-20	2.4
USS Benjamin Stoddert	DDG-22	2.4

[1] Distance in meters of forward masthead light below minimum required height. Section 2(a)(i), annex I.

Authority: Executive Order 11964; 33 U.S.C. 1605.

Dated: December 19, 1984.

Approved:

John Lehman,

Secretary of the Navy.

[FR Doc. 85-750 Filed 1-9-85; 8:45 am]

BILLING CODE 3810-AE-M

32 CFR Part 706

Certifications and Exemptions Under the International Regulations for Preventing Collisions at Sea, 1972; Amendment; USS Hawes, et al.

AGENCY: Department of the Navy, DOD.

ACTION: Final rule.

SUMMARY: The Department of the Navy is amending its certifications and exemptions under the International Regulations for Preventing Collisions at Sea, 1972 (72 COLREGS), to reflect that the Secretary of the Navy has determined that USS HAWES (FFG 53) is a vessel of the Navy which, due to its special construction and purpose, cannot comply fully with certain provisions of the 72 COLREGS without interfering with its special function as a naval frigate. The intended effect of this rule is to warn mariners in waters where 72 COLREGS apply.

EFFECTIVE DATE: 19 December 1984.

FOR FURTHER INFORMATION CONTACT: Captain Richard J. McCarthy, JAGC, U.S. Navy, Admiralty Counsel, Office of the Judge Advocate General, Navy Department, 200 Stovall Street, Alexandria, VA 22332-2400. Telephone number: (202) 325-9744.

SUPPLEMENTARY INFORMATION: Pursuant to the authority granted in 33 U.S.C. 1605 and Executive Order 11964, the Department of the Navy amends 32 CFR Part 706. This amendment provides notice that the Secretary of the Navy has certified that USS HAWES (FFG 53) is a vessel of the Navy which, due to its special construction and purpose, cannot comply fully with 72 COLREGS: Rule 21(a), regarding the arc of visibility of its forward masthead light; Annex I, section 2(a)(i), regarding the height above the hull of its forward masthead light; and Annex I, section 3(b), regarding the horizontal relationship of its side lights to its forward masthead light, without interfering with its special function as a naval frigate. The Secretary of the Navy has also certified that the above-mentioned lights are located in closest possible compliance with the applicable 72 COLREGS requirements.

Notice is also provided to the effect that USS HAWES (FFG 53) is a member of the FFG 7 class of ships for which certain exemptions, pursuant to 72 COLREGS, Rule 38, have been previously authorized by the Secretary of the Navy. The exemptions pertaining to that class, found in the existing tables of section 706.3, are equally applicable to this ship.

Moreover, it has been determined, in accordance with 32 CFR Parts 296 and 701, that publication of this amendment for public comment prior to adoption is impracticable, unnecessary, and contrary to public interest since it is based on technical findings that the placement of lights on this ship in a manner differently from that prescribed herein will adversely affect the ship's ability to perform its military functions.

List of Subjects in 32 CFR Part 706

Marine safety, Navigation (Water), Vessels.

Accordingly, 32 CFR Part 706 is amended as follows:

§ 706.2 [Amended]

1. Table One of § 706.2 is amended as follows to indicate the certifications issued by the Secretary of the Navy:

Vessel	Number	Distance[1]
USS Hawes	FFG-53	1.6

[1] Distance in meters of forward masthead light below minimum required height. Section 2(a)(i), annex I.

2. Table Four of § 706.2 is amended by adding to the existing paragraph 8 the following vessel for which navigational light certification is herewith issued by the Secretary of the Navy:

On the following ship the arc of visibility of the forward masthead light required by Rule 23(a)(i) may be obstructed through 1.6° arc of visibility at the points 021° and 339° relative to the ship's head: USS HAWES FFG 53.

3. Table Four of § 706.2 is amended by adding to the existing paragraph 9 the following vessel for which navigational light certification is herewith issued by the Secretary of the Navy:

Side lights on the following ship do not comply with Annex I, section 3(b):

Vessel	Number	Distance[1]
USS Hawes	FFG-53	2.75

[1] Distance of side lights forward of masthead lights in meters.

Authority: Executive Order 11964; 33 U.S.C. 1605.

Date: December 19, 1984.

Approved:

John Lehman,

Secretary of the Navy.

[FR Doc. 85-751 Filed 1-9-85; 8:45 am]

BILLING CODE 3810-AE-M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 117

[CGD 08-84-05]

Drawbridge Operation Regulations; Patout Bayou, Louisiana

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: At the request of the Louisiana Department of Transportation and Development (LDOTD), the Coast Guard is changing the regulation governing the swing span bridge on LA83 over Patout Bayou, mile 0.4, near Weeks, Iberia Parish, Louisiana, by requiring that at least four hours advance notice be given for an opening of the draw at all times. The bridge presently is required to open on signal from 5:00 a.m. to 9:00 p.m and on 12 hours notice from (9:00 p.m. to 5:00 a.m. This change is being made because of

infrequent requests for opening the draw.

This action will relieve the bridge owner of the burden of having a person constantly available to open the draw from 5:00 a.m. to 9:00 p.m. and will still provide for the reasonable needs of navigation.

EFFECTIVE DATE: This regulation becomes effective on February 11, 1985.

FOR FURTHER INFORMATION CONTACT: Perry Haynes, Chief, Bridge Administration Branch, telephone (504) 589-2965.

SUPPLEMENTARY INFORMATION: On 1 November 1984, the Coast Guard published a proposed rule (49 FR 43975) concerning this amendment. The Commander, Eighth Coast Guard District, also published the proposal as a Public Notice dated 6 November 1984. In each notice interested persons were given until 17 December 1984 to submit comments.

Drafting Information

The drafters of this regulation are Perry Haynes, project officer, and Steve Crawford, project attorney.

Discussion of Comments

There were two responses to the public notice and the **Federal Register.** Comments of no objection were received from the U.S. Fish & Wildlife Service and the National Marine Fisheries Service.

Economic Assessment and Certification

This regulation is considered to be non-major under Executive Order 12291 on Federal Regulation and nonsignificant under Department of Transportation regulatory policies and procedures (44 FR 11034; February 26, 1979).

The economic impact has been found to be so minimal that a full regulatory evaluation is unnecessary. The basis for this conclusion is that the bridge averaged only 10 openings per month (one opening every three days) in 1983. In 1982, 1981 and 1980, there were 270, 132 and 324 openings, respectively. These few vessels can reasonably provide four hours notice for a bridge opening by placing a collect call at any time to the LDOTD District Office in Lafayette, Louisiana, telephone (318) 233-7404.

Scheduling their arrival at the appointed time would involve little or no additional expense to the mariners. Since the economic impact of this regulation is expected to be minimal, the Coast Guard certifies that it will not have a significant economic impact on a substantial number of small entities.

List of Subjects in 33 CFR Part 117

Bridges.

Regulations

In consideration of the foregoing, Part 117 of Title 33, Code of Federal Regulations, is amended by revising § 117.485 to read as follows:

PART 117—DRAWBRIDGE OPERATION REGULATIONS

§ 117.485 Patout Bayou.

The draw of the S83 bridge, mile 0.4 near Weeks, shall open on signal if at least four hours notice is given.

(33 U.S.C. 499; 49 CFR 1.46(c)(5); 33 CFR 1.05-1(g)(3))

Dated: December 24, 1984.

T.T. Matteson,

Captain, U.S. Coast Guard, Acting Commander, Eighth Coast Guard District.

[FR Doc. 85-743 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-14-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[A-5-FRL-2754-1]

Approval and Promulgation of Implementation Plans; Ohio

AGENCY: Environmental Protection Agency (USEPA).

ACTION: Final rulemaking.

SUMMARY: As requested by the State of Ohio, USEPA is approving two revisions to the Ohio State Implementation Plan (SIP) for volatile organic compounds (VOC) for Uniroyal Plastic Products (UPP) and Packaging Corporation of America (PCA). These revisions consist of three types of chnages for eight vinyl coating lines at UPP in Ottawa County, Ohio, and for five rotogravure printing lines at PCA in Wayne County, Ohio: alternative emission control plans (weighted averaging bubbles), extended compliance schedules, and a change from daily to monthly averaging for demonstrating compliance with the current VOC emissions limitations. Both sources are located in ozone attainment areas. These revisions will allow UPP and PCA additional time to convert to waterborne inks and coatings.

EFFECTIVE DATE: This final rulemaking becomes effective on February 11, 1985.

ADDRESS: Copies of this revision to the Ohio SIP are available for inspection at:

The Office of the Federal Register, 1100 L Street, NW., Room 8401, Washington, D.C. 20408

Public Information Reference Unit, US EPA, 401 M Street, SW, Washington, DC 20460.

Copies of the SIP revision, public comments on the notice of proposed rulemaking and other materials relating to this rulemaking are available for inspection at the following addresses: (It is recommended that you telephone Uylaine E. McMahan, at (312) 353-0396, before visiting the Region V Office).

Environmental Protection Agency, Region V, Air and Radiation Branch, 230 South Dearborn Street, Chicago, Illinois 60604

Ohio Environmental Protection Agency, Office of Air Pollaction Control, 361 East Broad Street, Columbus, Ohio 43216.

SUPPLEMENTARY INFORMATION: On July 5, 1983, USEPA directly approved two revisions to the Ohio VOC SIP without a prior notice in the **Federal Register** proposing approval (48 FR 30628 and 30629). These revisions provided an alternative emission control program (weighted averaging bubbles), an extended compliance schedule, and a change from daily to monthly averaging for demonstrating compliance with the current VOC emissions limitations, for eight vinyl lines located at UPP, and for five rotogravure printing lines located at PCA. However, USEPA stated in these notices that, if comments were received within 30 days , it would withdraw its approval and repropose them for public comment. On August 3, 1983, the Natural Resources Defense Council submitted comments regarding USEPA's action and, therefore, requested that USEPA repropose these revisions. Therefore, on February 24, 1984, USEPA withdrew its approval (49 FR 6896) and reproposed to approve these SIP revision (49 FR 6924). During the 30-day public comment period, USEPA received no comments.

Public Comments

The August 3, 1983, letter from the Natural Resources Defense Council, Inc., raised several questions regarding USEPA's July 5, 1983 **Federal Registers** (49 FR 30628 and 30629) which were directed at specific technical factual aspects of the weighted averaging bubbles for the two sources.

On October 21, 1983, USEPA responded to NRDC's letter and submitted several documents which included a September 13, 1983, letter from Ohio EPA which responded to each of the technical questions raised by NRDC. The October 21, 1983, letter is included in the docket as support for this rulemaking action. Despite NRDC's notification in its August 3, 1983, letter

that it might also address additional issues in subsequent comments, during the reopening of the public comment period, no comments were received by USEPA.

These revisions include three basic sets of changes to the SIP. First, the revisions will allow each company to comply with its respective VOC emission limitation by showing that a weighted average of emission rates from all of the affected lines does not exceed the SIP emission rate limit. Second, these revisions will allow UPP and PCA additional time to convert to waterborne coatings and inks. UPP must ultimately achieve an emission limitation of 4.8 pounds of VOC per gallon of coating and inks employed, excluding water. This represents a 68 percent VOC reduction from the uncontrolled emission level. The current SIP compliance date for UPP is December 31, 1982. Under the revision, if UPP cannot achieve compliance with the emission limitations by July 1, 1985, solely through the use of waterborne coatings and inks, UPP is required to proceed with the installation of carbon adsorption or incineration for VOC emissions controls, according to a schedule contained in the variance, to achieve final compliance by October 1, 1987. PCA must ultimately achieve an emission limitation of 1.31 pounds of VOC per gallon of coating and inks solids. This represents a 75 percent VOC reduction from the uncontrolled emission level. The current SIP compliance date for PCA is December 31, 1982. Under the revision, if PCA cannot achieve compliance solely through the use of waterborne coatings and inks, PCA is required by January 1, 1985, to commence installation carbon adsorption or incineration for VOC emissions controls, according to a schedule contained in the variance, to achieve final compliance by July 1, 1987. Finally, these revisions will allow the companies to demonstrate compliance with the SIP emission rate limit by averaging emissions over a monthly period instead of the daily period allowed under the current SIP.

USEPA Evaluation

In USEPA's February 24, 1984, reproposal to approve Ohio's submittals for UPP and PCA, USEPA mistakenly suggested that, if Wayne and Ottawa Counties were redesignated from nonattainment to attainment for ozone, control of these VOC sources to the (RACT) levels required in the current SIP would no longer be required. It would have been more accurate to state that generally an area must retain its SIP requirements despite a redesignation to attainment, because the area may need those requirements to maintain the national ambient air quality standards. USEPA approved the redesignation of Ottawa and Wayne Counties to attainment for ozone on June 12, 1984 (49 FR 24124). The Agency has accordingly reviewed the basis of the current SIP for these areas to see whether the revisions will interfere with maintenance of the ozone standard.

Before the redesignation, the two counties were designated rural ozone nonattainment areas. In its approval of the Part D ozone SIPs for these areas on October 31, 1980 (45 FR 72145), USEPA stated that the counties could rely for attainment and maintenance on a combination of the requirements in upwind urban area SIPs and the requirements for reasonably available control technology (RACT) on certain major stationary sources in the counties. USEPA did not require the state to submit a quantified demonstration that these provisions would assure maintenance in rural nonattainment areas. Rather, the Agency concluded essentially that substantial additional emission reductions amounting to RACT on major sources in the rural areas would be sufficient, with the urban area controls, to attain the standard and, once the areas had reached attainment, to prevent the backsliding into nonattainment that might result from minor source growth. When USEPA proposed to redesignate Ottawa and Wayne Counties on August 19, 1983 (48 FR 36277), it concluded that the current attainment situation would be maintained, citing, among other things, the substantial reductions required from achieving RACT-level controls on the rural area major sources.

USEPA has reviewed the UPP and PCA revisions to see whether, even with the change from daily to monthly averaging, they would continue to require these substantial reductions. For the reasons described in USEPA's Technical Support Documents, which are available at the Region V address listed above, the Agency has concluded, through its case-specific review, that even with these revisions the Ohio SIP will continue to require substantial reductions that USEPA believes are RACT. Moreover, USEPA believes that the proposed compliance schedule extensions are as expeditious as practicable, and will continue to assure that the ozone standard is maintained in these areas.

Finally, except with respect to the averaging time issue mentioned above, the weighted averaging bubble aspects of the revisions are consistent with the weighted averaging bubble principles USEPA announced in the December 8, 1980 **Federal Register** notice on the can coating industry (45 FR 80824). Therefore, as proposed, USEPA is taking final action to approve the UPP and PCA SIP revisions.

Petitions for judicial review of this action under section 307(b)(1) of the Act must be filed in the United States Court of Appeals for the appropriate circuit by March 11, 1985. This action may not be challenged later in proceedings to enforce its requirements. (See 307(b)(2).)

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, Hydrocarbons, Incorporation by reference, Intergovernmental relations.

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

This notice is issued under authority of secs. 110 and 172 of the Clean Air Act, as amended (42 U.S.C. 7410 and 7502).

Dated: January 3, 1985.

William D. Ruckelshaus,

Administrator.

PART 52—APPROVAL AND PROMULGATION OF IMPLEMENTATION PLANS; OHIO

Title 40 of the Code of Federal Regulations, Chapter I, Part 52 is amended as follows:

Subpart KK—Ohio

1. In § 52.1870 paragraphs (c)(46) and (c)(48) are revised to read as follows:

§ 52.1870 Identification of Plan.

* * * * *

(c) * * *

(46) On August 26, 1982, the Ohio Environmental Protection Agency submitted a variance which would establish an alternative emission control program (weighted averaging bubble) for eight vinyl coating lines at Uniroyal Plastic Products in Ottawa County, Ohio, and an alternative compliance schedule which will allow Uniroyal Plastic Products additional time to convert to waterborne coatings and inks. The final compliance date is October 1, 1987.

* * * * *

(48) On August 31, 1982, Ohio Environmental Protection Agency submitted a variance which would

establish an alternative emission control program (weighted averaging bubble) for five rotogravure printing lines at Packaging Corporation of America (PCA) in Wayne County, Ohio and an alternative compliance schedule which will allow PCA additional time to convert to waterborne coatings and inks. The final compliance date is July 1, 1987.

* * * * *

[FR Doc. 85-706 Filed 1-9-85; 8:45 am]
BILLING CODE 6560-50-M

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40 CFR Part 704

[OPTS-82012; FRL 2605-5]

Reporting and Recordkeeping Requirements Category of Chemical Substances Known as Chlorinated Naphthalenes; Submission of Notice of Manufacture or Import

Correction

In FR Doc. 84-22535 beginning on page 33649 in the issue of Friday, August 24, 1984, make the following correction:

§ 704.83 [Corrected]

On page 33654, in the first column, paragraph (f), in the first line, insert "(1)" before the word "persons".

BILLING CODE 1505-01-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 13

Elimination of Verification Cards

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action eliminates § 13.73 of the Commission's rules concerning verification cards (Form 756) issued to licensed commercial radio operators. With the adoption of Docket 83-322, license and permit documents may now be copied and used to verify the holder's license status. This obviates the need for the Commission to issue cards for the same purpose.

This action is taken pursuant to the Commission's policy of continually reviewing its rules and regulations to eliminate those which are no longer necessary. The elimination of verification cards will result in cost savings to the Commission and reduce licensee paperwork.

EFFECTIVE DATE: January 3, 1985.

FOR FURTHER INFORMATION CONTACT: Damon Martin, Field Operations Bureau (202) 632-7240.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 13

Commercial radio operators, Radio.

Order

In the matter of Editorial Amendment of Part 13 to Eliminate Verification Cards.

Adopted: January 2, 1985.
Released: January 3, 1985.

1. Consistent with a major Commission goal of eliminating unnecessaary rules and regulations, we are amending Part 13 of the Commission's Rules to delete Rule 13.73. Under Rule 13.73 the Commission issued verification cards (Form 758-F) to holders of diploma-form commercial radio operator licenses and permits. Since the adoption of the Order stating that Rule 13.70 only prohibits duplicating radio operator license documents for fraudulent purposes (General Docket 83-322, 49 FR 20658, May 3, 1984), it has been clear that licensees are allowed to duplicate their documents for any legitimate purpose. One legitimate purpose for anyone to duplicate their license document is to prove that they are a Commission licensee. Since radio operator licensees may now duplicate their own licenses to verify their licensee status, Rule 13.73 authorizing Commission issuance of verification cards has become superfluous and obsolete and is hereby removed. Elimination of verification cards will result in cost savings to the Commission and reduce licensee paperwork. We conclude, for the reasons set forth above, that this revision will service the public interest.

2. Authority for this action is contained in section 4(i) and 303(r) of the Communications Act of 1934, as amended, and § 0.231(d) of the Commission's Rules. Since this amendment is editorial in nature, the public notice, procedure and effective date provisions of 5 U.S.C. 553 do not apply.

3. In view of the above, it is ordered, That § 13.73 of the rules is amended in accordance with the attached appendix, effective January 3, 1985.

4. For further information on this Order, contact Damon Martin, Field Operations Bureau (202) 632-7240.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154,. 303)

Federal Communications Commission.
Edward J. Minkel,
Managing Director.

Appendix

PART 13--[AMENDED]

§ 13.73 [Removed]

Part 13 of Chapter I of Title 47 of the Code of Federal Regulations is amended to remove § 13.73.

[FR Doc. 85-731 Filed 1-9-85; 8:45 am]
BILLING CODE 6712-01-M

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47 CFR Part 61

[CC Docket No. 79-252; FCC 84-566]

Rates for Competitive Common Carrier Services and Facilities Authorizations Therefor

AGENCY: Federal Communications Commission.

ACTION: Policy Statement (Sixth Report and Order).

SUMMARY: In this order the Commission requires the cancellation of forborne carrier tariffs and also orders that no future forborne carrier tariffs be filed at the Commission. This action further defines the Commission's policy to forbear from requiring tariffs and facilities authorization applications of certain carriers and will greatly reduce administrative burdens.

EFFECTIVE DATES: February 11, 1985.

FOR FURTHER INFORMATION CONTACT: Joanne M. Salvatore, Tariff Division, Common Carrier Bureau (202) 632-6917.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 61

Communications common carriers, Radios, Tariffs, Telegraph, Telephone.

In the matter of Policy and Rules Concerning Rates for Competitive Common Carrier Services and Facilities Authorizations Therefor (CC Docket No. 79-252).

Sixth Report and Order

Adopted: November 21, 1984.
Released: January 4, 1985.

By the Commission: Commissioner Rivera issuing a separate statement.

I. Introduction

1. Through the Competitive Carrier Rulemaking[1] which began in 1979, the

[1] Policy and Rules Concerning Rates and Facilities Authorizations for Competitive Carrier Services (CC Docket No. 79-252), Notice of Inquiry and Proposed Rulemaking, 77 FCC 2d 308 (1979), First Report and Order, 85 FCC 2d 1 (1980), (*First Report*), Further Notice of Proposed Rulemaking, 84 FCC 2d 445

Continued

Commission has reduced or eliminated unnecessary regulatory burdens on non-dominant common carriers, those facing strong competition in the marketplace. As to certain of these non-dominant carriers, the Commission decided that they could be treated by forbearance because the Section 208 complaint process, market forces and the Commission's power to reimpose tariff filing and facilities authorization requirements were sufficient to check these carriers' ability to charge unjust, unreasonable or discriminatory rates.[2] Thus, carriers subject to forbearance are not required to file tariffs or to obtain Section 214 approval for acquisition of domestic communication facilities.[3] In the *Fourth Further Notice* in this rulemaking, we sought to determine whether it would be in the public interest to discontinue the maintenance of forborne carrier tariffs at the Commission. We proposed that these forborne carrier tariffs be cancelled to dispel any idea of a Commission "stamp of approval," to avoid unnecessary application of traditional regulatory tools which might inhibit development of competition and to reduce administrative costs. This proposal, if adopted, would result in the cancellation of all forborne carrier tariffs currently on file at the Commission and would eliminate future federal tariff filings by carriers treated by forbearance.

2. Eighteen parties filed comments in response to the *Fourth Further Notice* and ten parties filed reply comments.[4] These comments reflected both support for and opposition to the Commission proposal described in the *Fourth Further Notice*. After careful consideration of the record assembled and for the reasons set forth below, we have concluded that the public interest and the goals of the Communications Act would best be promoted by cancellation of all forborne carrier tariffs on file at the Commission within six months of the effective date of this Order.[5]

II. Comments

3. In opposition to the *Fourth Further Notice* proposal, commenters argued that the Commission lacks statutory authority to cancel forborne carrier tariffs. Several commenters referred to Section 203(a) of the Communications Act, 47 U.S.C. 203(a), and asserted that this provision requires common carriers to file tariffs.[6] Comments also cited Section 203(c), 47 U.S.C. 203(c), as evidence that a carrier is prohibited from providing common carrier services unless it has a tariff on file.[7] Some commenters maintained that, although the Commission had discretion pursuant to Section 203(c) to modify certain statutory requirements such as notice periods, it could not abrogate its responsibility to accept tariffs for filing.[8] Commenters also rejected the idea of substituting contracts or other arrangements for tariffs.[9]

(1981), (*Further Notice*), Second Report and Order, 91 FCC 2d 59 (1982), (*Second Report*), *recon.*, FCC No. 83-69, released March 21, 1983, Second Further Notice of Proposed Rulemaking, FCC No. 82-187, released April 21, 1982, Third Further Notice of Proposed Rulemaking, Mimeo No. 33547, released June 14, 1983, 48 FR 28292 (June 21, 1983), Third Report and Order, Mimeo No. 012, released October 6, 1983, 48 FR 46791 (October 15, 1983), Fourth Report and Order, 95 FCC 2d 554 (1983), (*Fourth Report*), Fourth Further Notice of Proposed Rulemaking, FCC No. 84-82, released March 22, 1984, 49 FR 11856, (March 28, 1984), (*Fourth Further Notice*), Fifth Report and Order, FCC No. 84-394, released August 27, 1984, 49 FR 34824, September 4, 1984, (*Fifth Report*), (Competitive Carrier Rulemaking)

[2] In the *Second Report*, the Commission decided to forbear from requiring tariffs or facilities applications from terrestrial resellers. In the *Fourth Report*, the Commission determined that it would treat by forbearance the specialized common carriers and all resellers, including the domestic satellite resellers, resellers owned by or affiliated with exchange telephone companies and domestic record carrier resellers not covered by the interconnection requirements of the Reord Carrier Competition Act. [Pub. L. 97-130, 95 Stat. 1687 (1981), 47 U.S.C. 222.] In the *Fifth Report*, the Commission decided to include the following types of carriers in the forborne category: Domestic satellite carriers providing domestic interstate services, miscellaneous common carriers, carriers providing domestic, interstate and interexchange digital transmission networks (DEMS systems) and affiliates of exchange carriers providing interstate, interexchange services. The term "forborne carrier" used in this Order pertains to all carriers noted above and any carriers deemed to be treated by forbearance in the future through the Competitive Carrier Rulemaking.

[3] A tariff filing option for forborne carriers was established in the *Second Report*, 91 FCC 2d at 74 and repeated in the *Fourth Report*, 95 FCC 2d at 34 and the *Fifth Report*, 49 FR at 34831. The Commission stated "* * * that carriers treated by forbearance as defined in this order are given permission to cancel their tariffs on file with this Commission."

[4] The following parties filed comments: Aeronautical Radio, Inc. (ARINC), American Satellite Company (ASC), Association of Long Distance Telephone Companies (ALTEL), E.L.A. Cooperative (ELA) GTE Sprint Communications Corporation (GTE Sprint), International Business Machines Corporation (IBM), International Communications Association (ICA), Lexitel Corporation (Lexitel), MCI Telecommunications Corporation (MCI), Network I, Inc. (Network I), PACNET Communications Corporation (PACNET), RCA American Communications (RCA), Satellite Business Systems (SBS), State of Hawaii (Hawaii), Tele-Link Communications, Inc., Netcom International, Inc. and Compact Video Services, Inc. (Earth Station Operators), Teltec Saving Communications Co. (Teltec), Telecommunications Research and Action Center and National Association for Better Broadcasting (TRAC) and United States Transmission Systems, Inc. (USTS). Reply comments were filed by: Ad Hoc Telecommunications Users Committee (Ad Hoc), ALTEL, American Telephone and Telegraph Company (AT&T), GTE Sprint, Hawaii, IBM, ICA, MCI, PACNET and TRAC. GTE Sprint, Network I and ALTEL filed separate petitions for leave to file late comments in this proceeding. These carriers separately supported their petitions with a showing of good cause and stated that no parties opposed these petitions. For these reasons, we grant the petitions of GTE Sprint, Network I and ALTEL and accept their late-filed pleadings.

[5] Ad Hoc filed a Motion for Additional Pleading Cycle on the Final day of the reply comment period. Ad Hoc argued in support of its Motion that the *Fourth Further Notice* "appeared to be purely ministerial in nature and that initial comments to the *Fourth Further Notice* raised important legal and policy questions as to the Commission's authority to subject certain carriers to forbearance and to the relationship between contracts and tariffs." As indicated in paras. 12-14 of this Order, the Commission has established its authority for forbearance in the *Further Notice* and has requested and reviewed public comment at each decision step of the Competitive Carrier Rulemaking. For these reasons, we deny Ad Hoc's Motion for an Additional Pleading Cycle.

[6] Section 203(a) provides in pertinent part that "Every common carrier, shall file with the Commission * * * schedules showing all charges for itself and its connecting carriers * * *." ALTEL also argued that the courts have uniformly held that common carriers are required to file tariffs with the Commission and cited the following cases: American Telephone & Telegraph Co. v. FCC, 572 F.2d 17, 25 (2d Cir. 1978); Essential Communication v. American Telephone & Telegraph Co., 446 F. Supp. 1090, 1098 (D.N.J. 1978); American Telephone & Telegraph Co. v. Florida-Texas Freight, Inc., 357 F. Supp. 977, 979 (S.D. Fla. 1973); Carter v. American Telephone & Telegraph Co., 365 F.2d 486, 496 (5th Cir. 1966). Teltec cited Bell Telephone Company of Pennsylvania v. FCC, 503 F.2d 1250 (3d Cir. 1974), *cert. denied*, 422 U.S. 1026 (1975), to support its contention that carriers must operate by tariff unless otherwise authorized by the Act.

[7] This section states in part, "No carrier * * * shall engage or participate in such communication unless schedules have been filed * * * and no carrier shall (1) charge, demand, collect, or receive a greater or less or different compensation, for such communications, or for any service in connection therewith, between the points named in any such schedule than the charges specified in the schedule then in effect * * *."

[8] The commenters argued that the pertinent part of Section 203 (c) that gives the Commission this discretionary authority is "No carrier, *unless otherwise provided by or under authority of this Act*, shall engage or participate in such communication unless schedules have been filed * * *." (Emphasis added.) Commenters cited the following cases to support this argument: AT&T v. FCC, 487 F.2d 864 (2d Cir. 1973) and AT&T v. FCC, 503 F.2d 612 (2d Cir. 1974). USTS cited Farmers Union Central Exchange, Inc. v. FERC, Nos. 82-2412 et al., Slip op. 36 (D.C. Cir. March 9, 1984), for the view that "Discretion must be bridled in accordance with statutory mandate."

[9] MCI cited the *Armour Packing* case for the principle that a tariff rate is the only legal rate and no indirect and uncertain methods of ratemaking could be substituted. Armour Packing Company v. United States, 209 U.S. 56, 81 (1912). It also cited the following cases in support of its argument that contracts could not be substituted for tariffs and that statutory obligations could not be shirked: Resale and Shared Use, 60 FCC 2d 261, 314 (1976), *recon.*, *62 FCC 2d 588 (1977), off'd sub nom.*, AT&T

Continued

4. Further statutory arguments centered around the Commission's obligation to regulate rates under the mandates of the Act.[10] Not only did commenters emphasize that carriers without tariffs on file would be tempted to depart from just and reasonable ratemaking, but they also argued that the Commission would be effectively eliminating public review of carrier rates and rate information essential to the proper administration of the Section 208, 47 U.S.C. 208, complaint process. Commenting parties stated that the required tariff filings foster carrier compliance with the Act and allow the Commission to accumulate valuable information for the informal monitoring of carrier ratemaking and of industry trends. USTS submitted that if the Commission proposal were adopted, carriers would still have to develop rate support and justification in order to be prepared for any subsequent Commission inquiry.

5. Commenters also raised concerns as to whether the proposed cancellation of forborne carrier tariffs would have an adverse effect on consumers and whether the Commission had sufficiently analyzed how the public might be affected by elimination of these filings.[11] They urged the Commission to retain these tariffs, arguing that the public benefits associated with them far outweigh any burdens on the Commission staff. One major benefit, according to the commenters, is the provision of a central resource point where the public can readily obtain information on carrier rates and charges. The commenters argued that the public needs this information in order to detect discriminatory practices, to challenge new or changed tariff rates and to compare service offerings. Several commenters contended that researchers, consumer advocates, reporters and analysts need this resource center to facilitate the collection of data in order to digest and simplify it for consumers.[12] They considered the option of obtaining information at the carrier's premises to be inadequate because information would be available only at the carrier's discretion and a carrier's public offices are sometimes difficult to identify. With the advent of equal access and other new carrier-customer relationships, commenters claimed that an increase in the availability of specific tariff information was necessary.

6. In addition to the burden which would be placed on the public by the proposed tariff cancellation, the commenting parties insisted that this action would increase burdens on carriers substantially. They argued that carriers would sustain increased administrative costs to negotiate contracts with individual customers and to replace certain protections that they believe the tariff filing process currently affords them.[13] USTS contended that administrative convenience would be lost because the Commission proposal, if adopted, would remove uniform guidelines for tariffs and encourage disparate tariff filing requirements at the state level.

7. Many parties suggested that less drastic measures could be taken to effectuate the competitive and administrative goals outlined in the *Fourth Further Notice*. Several commenters alleged that cancellation of forborne carrier tariffs would not, in fact, result in significant cost reductions to the Commission.[14] They argued that any cost savings would be offset by additional costs incurred as a result of increased investigations of complaints, increased staff time spent responding to individual customer inquiries and increased time required to review petitions for rulings on discriminatory practices. These commenters suggested several alternatives which would reduce Commission staff time and storage space without requiring the cancellation of tariffs. Commenters recommended that forborne carriers undertake increased obligations by themselves updating tariffs which they choose to keep on file at the Commission. Furthermore, they suggest, these tariffs could be provided in a more compact form such as on microfilm, floppy disks or tapes. The cost of any equipment needed to use a new tariff filing format could be passed on to the public and the carriers by way of a nominal fee, according to the commenting parties. They also recommended that a simplified tariff form under Part 61 of the Commission's Rules be created for forborne carriers.[15] Other commenters suggested that the Commission could relieve its administrative burden by requiring carriers to provide only a current copy of each tariff to the Commission and to maintain the total tariff history at their own premises; by resolving the proceedings before it regarding detariffing of special construction services and streamlining of recordkeeping;[16] and finally, by requiring carriers to keep their general tariff terms and conditions on file for public reference but allowing them to specify rates on an individual customer basis.

8. With respect to the Commission's argument that allowing forborne carriers to continue to keep tariffs on file might mislead the public, the commenters recommended that a boldfaced disclaimer be placed on the front of each tariff proclaiming that the tariff is on file for informational purposes only and has not been reviewed or approved by the Commission.[17] Moreover, commenters

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v. FCC, 572 F.2d 17 (2d Cir.), *cert. denied*, 439 U.S. 675 (1978); Midwestern Relay Company, 69 FCC 2d 409, 415 (1978); American Broadcasting Cos. Inc. v. FCC, 643 F.2d 818, 826 (D.C. Cir. 1980). Teltec asserted that there were no substitutes for tariffs and that the Communications Act did not contemplate that carrier-customer relations be governed by contract. United Video, Inc. 55 FCC 2d 516, 517–18 (1975).

[10] The comments cited the following sections of the Act: 47 U.S.C. 151, "to regulate interstate and foreign commerce in communication * * * with adequate facilities at reasonable charges * * *"; 201(a), "* * * to furnish such communication service upon reasonable request"; 201(b), "All charges * * * shall be just and reasonable * * *" and 202(a), "* * * unlawful for any common carrier to make any unjust or unreasonable discrimination in charges * * *."

[11] TRAC asserted that the Commission did not give adequate consideration to the public benefits of forborne carrier tariff filings and likened this situation to the Commission's action of eliminating program logs for radio stations. Office of Communication of the United Church of Christ v. FCC, 707 F.2d 1413 (D.C. Cir. 1983). TRAC pointed out that the Court in this case remanded the issue of what information must be made available to the public.

[12] Network I recognized that the Commission information would not be comprehensive since some forborne carriers (*i.e.* resellers) are not presently filing tariffs due to the *Fourth Report's* relaxation of this requirement. Even without total information, however, Network I asserted that the tariffs filed at the Commission provide ready access to the most information available in one central location.

[13] For example, PACNET asserted that a carrier would lose instant identification as a common carrier upon the cancellation of its tariffs at the Commission. PACNET also argued that contracts would be governed under state laws which sometimes allow five years for recovery or undercharges of overcharges by carriers or their customers versus the two years liability for such actions allowed by federal law. Tele-Valuation, Inc. v. AT&T, 73 FCC 2d 450 (1979. GTE Sprint stated that "mandatory detariffing of interstate services would place interexchange carriers in the anomalous position of having to offer the interstate portions of their services on a non-tariffed basis while their intrastate services would be subject to tariff requirements that varied from state to state."

[14] The commenters supporting this premise were: GTE Sprint, ICA, Lexitel, MCI, Network I, Teltec, TRAC and USTS.

[15] MCI suggested that Commission rules related to cross-referencing (Section 61.74) and tariff form (§ 61.54) be relaxed for forborne carriers which would also result in the elimination of special permission applications for waiver of detailed procedural rules.

[16] PACNET cited CC Docket No. 84–369 on special construction and CC Docket No. 84–283 on the streamlining of recordkeeping requirements as proceedings that would eliminate unnecessary costs.

[17] The same commenters listed in note 14 *supra* proposed the use of a disclaimer.

contended that the segment of the public seeking tariff information is knowledgeable about the tariff process and is aware of the Commission review policies. Some commenters suggested that the Commission has not misled the public because tariffs contain carrier-made rates rather than Commission-made rates and are presumed lawful without extensive Commission review. Several commenting parties suggested that if the *Fourth Further Notice* proposal were adopted, a phase-in period of six months to one year should be implemented to allow time for the establishment of new business practices and for the preparation, negotiation and execution of contracts to replace tariffs.[18] GTE Sprint also pointed out that time would be needed to alert other parties such as government agencies that limit procurements to carriers regulated by tariffs.[19]

9. Parties arguing in favor of the Commission's proposal in the *Fourth Further Notice*[20] commented that the continuing practice of accepting forborne carrier tariffs at the Commission was inconsistent with the prior decisions in the Competitive Carrier Rulemaking. In particular, they stated, the publication of rates and terms prior to their effective date inhibited development of a vigorously competitive market. They agreed that forborne carrier tariffs should be cancelled to eliminate confusion as to Commission review and approval and also to eliminate uncertainty of state regulatory commissions as to the scope of their interstate regulatory obligations and responsibilities. ARINC alleged that on several occasions carriers had refused its reasonable and specific service requests stating that their tariffs did not permit such services to be sold. ARINC concluded that these refusals constitute evidence of carriers' widespread reluctance to be exposed to the rigors of marketplace competition and thereby, frustrate Commission goals in the Competitive Carrier Rulemaking. Many commenters voiced their objections to carriers using tariffs to their market advantage by projecting the image of a Commission "stamp of approval." In addition, commenters cited the reduction in Commission staff time and storage space as a positive effect of the cancellation of these tariffs.

10. AT&T asserted in its reply comments that carriers cannot have "the trappings of regulatory approval without the reality of regulatory supervision."[21] According to AT&T, the Commission has broad authority to modify any requirements made by or under authority of Section 203, 47 U.S.C. 203, and the Commission can use this broad discretion in deciding how to regulate the forborne carriers.[22] AT&T distinguished many of the cases cited by commenting parties as not relevant to the issues connected with the cancellation of forborne carrier tariffs.[23] AT&T also commented that the principal policy argument of the commenters opposed to the Commission proposal that the continued filing of tariffs will aid in the prevention of anti-competitive price discrimination was without merit and demonstrated a fundamental misunderstanding of the competitive process. The simple answer to this contention, AT&T asserted, is that a non-dominant carrier, by definition does have "sufficient market power to be able to engage in improper price discrimination without suffering the discipline of the marketplace."[24] In conclusion, AT&T contended that if carriers are to enjoy the advantages of a competitive marketplace, they must also bear some of the responsibilities and costs.

III. Discussion

11. After serious consideration of all issues raised by the commenters, the Commission has decided to exercise its authority to order the cancellation of forborne carrier tariffs. We are not persuaded by the commenters' arguments that the retention of forborne carrier tariffs is necessary to effectuate the goals and purposes of the Communications Act.[25] By ordering this cancellation, the Commission is in no way abdicating its oversight responsibility with regard to forborne carriers. This decision furthers our objectives to achieve just and reasonable rates in the marketplace. The Commission will continue to administer the Section 208 complaint process and will reimpose tariff requirements if necessary.[26] Carriers have an obligation to keep material on file at their offices that can be produced readily upon inquiry from the Commission in order to substantiate the reasonableness and justness of their rates, terms and conditions. Specific requirements for document retention are described below in paragraph 25.

12. The Commission thoroughly considered the statutory and public benefit arguments raised by the commenting parties in several steps of this Competitive Carrier Rulemaking.[27] The regulatory objectives of the Commission as stated in Section 1 of the Communications Act, 47 U.S.C. 151, are to assure that communications service is widely available to the public, efficiently produced and reasonably priced. It is well established that the

[18] Commenters favoring a phase-in period were: ASC, Earth Station Operators, GTE Sprint and RCA Americom.

[19] Hawaii urged that GTE Sprint be exempt from any detariffing requirement so that its tariffs could be monitored for compliance with rate-and-service integration conditions in the GTE/SPCC Acquisition Order, 94 FCC 2d 235 (1983). The *Fifth Report and Order*, 49 FR at 34828, responded directly to this request and GTE Sprint is required "to make reasonably available sufficient information about its rates and rate structures so that the State of Hawaii and the Commission can ascertain whether the carrier is complying with these conditions." The Commission did not specify the format of this information.

[20] The parties commenting in favor of this proposal were SBS, ELA, IBM, ARINC, AT&T and Earth Station Operators.

[21] AT&T comments at page 1.

[22] AT&T stated that this statutory language interpretation is squarely supported by AT&T v. FCC, 503 F.2d 812 (2d Cir. 1974).

[23] For example, AT&T argued that *Armour Packing*, see note 9 *supra*, was patently distinguishable because the Interstate Commerce Act contained no general modification clause similar to Section 203(b)(2) in its statute and the Interstate Commerce Commission's power to cancel tariffs was not at issue. AT&T argued that the *Resale and Shared Use* decision, see note 9 *supra*, only analyzed the general requirement that carriers should file tariffs and did not address the Commission's power to alter this requirement under Section 203(b)(2). The Special Permission case, AT&T v. FCC, 487 F.2d 864 (2d Cir. 1973), was concerned with protecting carriers' freedom to change rates, and according to AT&T, the Commission's proposed action would, in fact, enhance that freedom. AT&T also asserted that MCI's discussion of cases involving the filing of customer-carrier contracts under the Communications Act is not related to the issues at hand because these cases concerned the relationship between the making of rates by tariffs and pre-existing contracts between the affected parties. (See note 9 *supra* for cases cited.) Lexitel's reference to the legislative history of the Act's 1976 amendments is also irrelevant, according to AT&T, because it was concerned only with the Commission's power to alter the notice period.

[24] AT&T comments at page 6.

[25] Although carriers opposition to the cancellation of tariffs must be given considerable weight, it is the "ultimate consumer 'who pays for the inefficiencies and restrictions created by tariffs.'" *See* National Small Shipments v. Civil Aeronautics Board, 618 F.2d 819, 826 (D.C. Cir. 1980) (*National Shipments*).

[26] Pending before the Commission is a Petition for Reconsideration and Clarification of the Fifth Report and Order filed by Showtime/The Movie Channel, Inc. which seeks, *inter alia*, clarification of the standards and procedures used in the Section 208 complaint process. We will address this petition in a separate Reconsideration of the Fifth Report.

[27] See *Further Notice of Proposed Rulemaking*, 84 FCC 2d at 478–91, *Second Report and Order*, 91 FCC 2d at 65–70 and *Fifth Report and Order*, 49 FR 34827. We do not agree with commenters' contentions that the cases cited in note 6, *supra*, support a statutory mandate for tariffs to be filed. These cases consider the issue of when a tariff c onclusively and exclusively controls the rights and liabilities between parties and how a tariff differs from a contract. See *AT&T v. Florida-Texas Freight, Inc.* at 979.

Commission has "broad discretion in choosing how to regulate."[28] Sections 201 through 205 and 214 of the Act were enacted to control monopoly abuse or imprudent investments by the carriers which could impose increased costs on consumers. We have previously stated that non-dominant carriers have insufficient market power to engage in activities that Congress sought to prevent.[29] Section 203(b)(2), 47 U.S.C. 203(b)(2), gives the Commission the express authority to exempt carriers from tariff filing requirements where appropriate.[30] In addition the *Further Notice*, we determined that the plain meaning of the statutory language allowed the Commission to modify any requirement of the section and that no clear evidence of contrary legislative intent existed.[31] In addition to 203(b)(2) of the Act, we rely on the broad exemptive language contained in 203(c)(1), 47 U.S.C. 203(c)(1), as authority for forborne carrier tariff cancellation.[32] Furthermore, we have determined that tariffs are not essential to our ability to ensure that non-dominant carriers do not unjustly discriminate in their rates. We have other means to ensure our enforcement of mandates of the Act.[33] In particular, we shall continue to investigate and adjudicate complaints under § 208.[34] Pursuant to this complaint process or upon our own determination, we can require the filing of the rates, charges, terms and conditions utilized by a carrier in the course of its business to ascertain whether a carrier is in violation of any section of the Act. In addition, carriers and non-carrier customers can enter into contracts, agreements and arrangements, and under Section 211 of the Act, 47 U.S.C. 211, the Commission can require these documents to be filed when it deems necessary.

13. The arguments that the Commission has not adequately weighed the public benefits and detriments of tariff filings are incorrect. The *Further Notice* discusses extensively the harm to both non-dominant carriers and consumers resulting from continued tariff filing by forborne carriers.[35] Required tariff filings can produce the following effects: "(1) Taking away carriers' ability to make rapid, efficient responses to changes in demand and cost; (2) impeding and removing incentives for competitive price discounting; (3) imposing costs on carriers that attempt to make new offerings; and (4) increasing the costs of the Commission's operations."[36] The first three effects are anti-competitive and can harm consumers through higher prices and services which do not meet their needs. The continuation of tariffs for forborne carriers also presents an opportunity for collusive pricing by competing carriers. Since carriers can ascertain their competitors' existing rates and keep track of any changes in those rates by reviewing the filed tariffs, carriers may be encouraged to maintain rates at an artificially high level. Without forborne carrier tariffs on file, carriers may initiate price cutting or generally institute rates at a lower level to meet directly customer demand.

14. The fourth harmful effect noted above results in the Commission resources and costs associated with the maintenance of forborne carrier tariffs being inevitably passed on to the public that the Commission has the obligation to protect through higher fees by the users of these resources.[37] The public interest can be better served by the Commission devoting these resources to determine the most effective regulation of carriers having market power. Mere streamlined regulation of non-dominant carriers does not remove any of the harmful effects and offers the consumers less benefit, and imposes unnecessary costs on such carriers, their subscribers, and society generally.

15. We have concluded that pricing and service offering flexibility for such carriers subject, of course, to the overriding duties of section 201 and 202, 47 U.S.C. 201, 202, serves the public interest in two ways. First, subscribers will have the opportunity to seek services that meet their specific needs and, thus, be able to obtain the best price/quality combination available. Secondly, by promoting the availability of competitive market forces, the development of innovative service offerings will be encouraged.

16. We believe that the opportunity for abuse of the marketplace is minimal. During our three years of experience with non-dominant carriers now subject to forbearance, we found no such carrier in violation of the Act with respect to discriminatory rates. We, therefore, believe that this experience substantiates our evaluation of market abuse potential. In all instances, we retain our regulatory oversight authority

[28] 572 F.2d at 28. *See also* discussion of legal considerations in the *First Report*, 85 FCC 2d at 12, and *Further Notice*, 84 FCC 2d at 473 and n. 56.

[29] *Further Notice*, 84 FCC 2d at 458. Firms lacking market power have no ability or incentive to charge unlawful rates. Customers can always obtain service from competitors if rates exceed prevailing market prices. "The pattern of the legislative history, although not wholly unambiguous, gives strong support to the Congressional intent we have inferred from the language of the Act." *Id.* at 462. Federal Communications Commission: Hearings on H.R. 8301 Before the Committee on Interstate and Commerce, 73d Cong. 2d Sess. 15 (1934). The Study of Communications by an Interdepartmental Committee, Report of the Secretary of Commerce, 1934 and Preliminary Report on Communications, H. Rep. No. 1273, 73d Cong., 2d Sess. (1934) were discussed in the *Further Notice* at 459–62.

[30] The statute states in pertinent part: "The Commission, may, in its discretion and for good cause shown, modify any requirement made by or under authority of this section either in particular circumstances or by general order applicable to special circumstances or conditions except that the Commission may not require the notice period specified in paragraph (1) to be more than ninety days."

[31] See *Further Notice*, 84 FCC 2d at 462, 479. Court interpretations of this section have not limited our authority with respect to the action undertaken herein. See AT&T v. FCC, 503 F.2d 612, 617 (2d Cir. 1974), in which the court determined: "We can only conclude that the plain language employed was intended to mean what it says. The legislative history in no place at all indicated any intent to give the FCC only the power to reduce the notice period."

[32] See *Further Notice*, 84 FCC 2d at 481. Section 203(c)(1), in pertinent part, provides: "No carrier, *unless otherwise provided by or under authority of this Act*, shall engage in or participate in such communication unless schedules have been filed and published in accordance with the provisions of the Act * * *." (emphasis added)

[33] It is apparent that as a result of Commission decisions and the Modified Final Judgment, [United States v. American Telephone and Telegraph Co., 552 F. Supp. 131 (D.D.C. 1982), *aff'd sub nom.* Maryland v. United States, 103 S. Ct. 1240 (1983)], the telecommunications industry structure today is drastically different from the one that existed in 1934 when the Communications Act was enacted. Throughout this rulemaking, we have determined that enforcement of Section 201 and 202 objectives of just and reasonable rates could be effectuated for certain carriers without the filing of tariffs and through market forces and the administration of the complaint process. We, therefore, believe that our actions ensure the perpetuation of the public interest objectives of the Act. See Farmers Union Central Exchange, Inc. v. FERC, Nos. 82-2412 et al., Slip op. at 49 (D.C. Cir. March 9, 1984), which states that "Moving from heavy to lighthanded regulation within the boundaries of an unchanged statute can, of course, be justified by a showing that under the circumstances the goals and purposes of the statute will be accomplished through substantially less regulatory oversight."

[34] Very few complaints have been filed against non-dominant carriers and those complaints that have been reviewed by the Commission have been found to be without merit. See *Fourth Report*, 95 FCC 2d at 578, n.79 and *Fifth Report*, 49 FR at 34825–26 and n.17. It also should be noted that approximately twenty forborne carriers have cancelled their tariffs and several new forborne carriers have chosen not to file tariffs for their services. (*e.g.* resellers) No complaints regarding these carriers have been received.

[35] 84 FCC 2d at 453–55.

[36] These risks to the public benefit related to the filing of tariffs were summarized in the *Fifth Report and Order*, 49 FR 34827, n.24.

[37] As the *Fourth Further Notice* stated, the maintenance of these documents at the Commission's offices entail certain costs such as the cost of storage space and the cost of staff time necessary to review the form of filed tariffs, to organize the materials for public inspection, to review special permission requests and to respond to questions from members of the public concerning the tariffs.

to reimpose tariff filing requirements in the event that through our complaint process monitoring, we find that abuses of market power occur or that the predictions based on our experience concerning competition in the telecommunications industry prove invalid.

17. All of our decisions to extend forbearance to certain carriers have been based on the premise that consumers will benefit and that a forborne carrier's ability to charge unlawful rates profitably would be checked by market forces and our complaint process.[38] These decisions have been made by a step-by-step proceeding through which we have gained considerable experience with the careful reduction of regulatory burdens.[39] With the tariff mechanism no longer available, carriers accustomed to dealing with their customers by tariff rather then by other methods traditionally used by non-regulated businesses might perceive some increased administrative burdens, at least initially. Our foremost duty, however, is to ensure that just, reasonable and non-discriminatory rates are available to the public.

18. The use of tariffs can restrict consumers from seeking out the most advantageous service arrangements. A tariff may be restrictive because it fosters an image that all possible service arrangements are defined within its text. Customers may be reluctant to ask for arrangements outside of the tariff because they may think such specific arrangements are unavailable or technically not feasible or are not willing to wait for the required lengthy tariff update procedures to be completed. The cancellation of tariffs will naturally force forborne carriers to be more competitive and they would be more apt to adapt general service offerings as their customers' needs change. As noted in ARINC's comments,[40] forborne carriers have allegedly used tariffs to deny reasonable service requests.

19. The tariff process certainly introduces delay and additional costs when carriers responding to market changes must stop and take the time to reflect their adjustments to general service offerings in tariff filings. The public, therefore, will have greater options in obtaining service in a freer open marketplace when not constrained by a formal document, and the Communications Act's Section 1 goals for a more efficient and economically priced telecommunications system will be promoted.

20. Another major concern is that the public and state commissions are being mislead by the existence of forborne carrier tariffs on file at the Commission.[41] The presence of effective tariffs on Commission premises may suggest that the Commission has, in fact, substantively evaluated them and found no objection. Since the forborne carrier tariffs on file are presumed lawful on filing and receive minimal review, it is unfair to the public to present an appearance of Commission approval. Moreover, maintenance of tariffs is likely to inhibit the development of the "informed consumer" who diligently studies industry trends and prices. We expect this type of consumer development to be fostered in this competitive environment.

21. We have also considered the commenters' suggested alternatives to the cancellation of tariffs. We find that the use of a disclaimer, although viable and probably effective for those parties that look at the tariffs at the Commission's premises, does not eliminate the erroneous impression of FCC approval to those parties not having a tariff in front of them. The alternatives proposing a shift of tariff filing and maintenance responsibilities from the Commission staff to the carriers themselves seem unduly burdensome and are directly contrary to our stated goal of decreasing regulation wherever possible. The regular availability of rate information to other forborne carriers together with the timely notification of competitors whenever a rate changes can have anticompetitive effects including the facilitation of price fixing and collusion among forborne carriers. In addition, our experience with requests for tariff information in the Public Reference Room on the fifth floor of the main building of the Commission shows that the overwhelming majority of inquiries are made by carriers or their representatives and not by the general public that the commenters argue are in need of a central information point. By our decision today, we do not minimize the need of the general public to obtain information as to rates and terms and conditions of service of forborne carriers. We believe, however, that these carriers, in the interest of preserving their competitive positions will make their rates and other information, formerly contained in tariffs, available to the public.[42]

22. Many commenters pointed out that an extended period of time would be needed to replace existing tariffs with separate contracts. For this reason, we have determined that a six month phase-in period will be allowed for this process. Procedural details as to how this process will take place are given below. It is our belief that his six month period will be adequate time for an efficient transition. We do not, however, envision that a carrier will have to negotiate entirely new rates, terms and conditions with each customer. Tariffs are not the only way to operate in a competitive business environment. Major companies employ several different methods of providing service to their customers that forborne carriers could use.[43] The argument that rates, terms and conditions can and will be changed as a result of tariff cancellation is invalid. Under the existing tariff process, a forborne carrier may at any time file a new tariff with changed rates, terms and/or conditions. These changes whether or not made through the tariff process are still required to be just and reasonable under the Act.

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[38] Second Report, 91 FCC 2d at 69–70. *See also* extensive market power analysis in Fourth Report, 95 FCC 2d at 557–562.

[39] See summary of this approach in *Fourth Report*, 95 FCC 2d at 554–56 and *Fifth Report*, 49 FR 34824.

[40] *See* para. 9 *supra*.

[41] Orders of state commissions have sometimes contained provisions which appear to rely on certain tariffs that were filed with the Federal Communications Commission. A case in point is a recent California Public Utilities Commission decision with regard to competitive interexchange carriers which said, "If any applicant has an effective FCC approved tariff, it may file a notice adopting such FCC tariff with a copy of the FCC tariff included in the filing." Order Instituting Investigation, 84–06–113 at 103 (1984). Carriers themselves have been subjects of complaints that allege misuse of "FCC approval statements." *See* In the Matter of Hart Industries, Inc. Revisions to Tariff F.C.C. No. 1, Transmittal No. 3, Mimeo No. 3323, released September 11, 1981.

[42] The District Court of the District of Columbia analyzed this issue in National Small Shipments Traffic Conference, Inc. v. Civil Aeronautics Board 618 F.2d 819, 824 (D.C. Cir. 1980), and determined that "the economic self-interest of the carriers would ensure that tariff information is made available to potential custmers." The Court further noted the C.A.B.'s finding that" a carrier's ability to successfully market its services to the public depends in part on its success in informing potential customers what its charges will be and what services it offers."

[43] Alternatives that carriers may wish to follow include issuing a short standard agreement to all customers. Tariffs that contain terms and rates for extended periods of time, such as between domestic satellite carriers and cable television companies, can be incorporated into contracts without changes. With respect to these tariffs containing provisions involving long-term offerings, the standards for determining the reasonableness of applicable rates would still apply. *See* RCA American Communications, Inc., 86 FCC 2d 1197, 1201–02 (1981), *aff'd.*, 94 FCC 2d 1338 (1983), *aff'd. mem.* RCA American Communications, Inc. v. Federal Communications Commission [judgment D.C. Cir. No. 81–1558 (March 8, 1984)]. The complaint process can be used to determine whether such rate changes are unreasonable.

23. In order to comply with this Report and Order, forborne carriers must file supplements to cancel their tariffs on file with the Commission within six months of the effective date of this Order. The supplements shall be effective upon five days' notice and shall reference this Order as authority for cancellation. Those carriers that have "mixed" tariffs[44] on file at the Commission shall comply with this Order by doing either of the following: (1) Cancel the entire tariff and refile a new tariff for only those services subject to dominant or streamlined regulation; or (2) Issue revised pages cancelling the material in the tariff which pertains to services or service points subject to forbearance. All cancelled pages and tariffs will remain in the Tariff Public Reference Room on the fifth floor of the main building of the Commission for a period of two years. Appendix A contains a list of carriers which currently have tariffs on file and are affected by this Order.[45]

24. During the six month transition period, new tariffs of forborne carriers that do not currently have any tariffs on file will not be accepted by the Commission. Those forborne carriers that have existing services under tariff on file at the Commission must provide those services consistent with the tariff until they choose to cancel those tariffs. In the alternate, we expect that carriers will update tariffs still on file during the six month transition period. This requirement will eliminate any confusion to the consumer who will rely on the stated rates in the tariff until it is cancelled.

25. Carriers affected by this Order are required to maintain at their premises price and service information that they can submit to the Commission if requested.[46] This information can be in any form that the carrier chooses. The carrier must also maintain copies of service contracts and documentation of agreements and arrangements with all customers. When the Commission, as a result of a complaint filed or upon its own motion, requests specific information from a carrier, that carrier must be able to produce it fully within a reasonable amount of time.[47] We believe that this requirement is not unduly burdensome on the affected carriers because the documents expected to be retained are those records used by carriers in the normal course of administering their business. Maintenance of these documents will provide the Commission with adequate data in order to meet its statutory duty of ensuring that carriers' rates are just and reasonable. Further, this information retention requirement will enable the carriers to meet their public interest obligations.

IV. Conclusion and Ordering Clause

26. We believe that the actions ordered today will benefit the public by promoting competition and reducing regulatory burdens since other statutory and regulatory tools are at our disposal and are adequate to ensure that just and reasonable rates will be maintained. Indeed, we believe the detariffing of forborne carriers will lead to lower rates and higher quality services for the consumers. We stress that we will monitor the effects of the cancellation of forborne carrier tariff filings on the marketplace and that we will take action as necessary to continue the development of a competitive environment for telecommunications services. If we determine that the action taken today disrupts the marketplace or is in any other way detrimental to the public interest, we stand ready to reimpose the tariff filing requirements on forborne carriers.

27. It is therefore ordered, pursuant to Sections 4 (i) and (j) and 201–205, of the Communications Act of 1934, as amended, 47 U.S.C. 154 (i) and (j), and 201–205, and Section 553 of the Administrative Procedure Act, 5 U.S.C. 553, that the policies set forth herein are adopted and that they will become effective February 11, 1985.

Federal Communications Commission.

William J. Tricarico,

Secretary.

Appendix A—List of Affected Carriers

Specialized Common Carriers

Access Code, Inc.
Allnet Communications Services, Inc.
Altcom
Alternative Communications Corp.
Americall LDC, Inc.
American Interstate Communications Inc.
American Motor Inns
American Private Line Services, Inc.
AMERTEL Company
AMTEL, Inc.
Business Telephone System, Inc.
Call-ex International
Central Delivery Service of Washington, Inc.
Centranet Communications Corp.
Chernow Communications Inc.
Communications Center, Inc.
Communications Equipment Corp.
CommuniGroup, Inc.
Compath Network Serv.
Comprehensive Communication Systems, Inc.
Compusultants, Inc.
Comtel Industries, Inc.
Continental Telecommunications Systems, Inc.
Crowley, Charles Edward
Dag, Inc.
Datel Communications Systems, Inc.
Delta Communications Inc.
DHL Communications, Inc.
Discount Long Distance, Inc.
Eastern Microwave, Inc.
Electronic Office Centers of America
Energy Communications Corp.
Family Telephone Network
Florida Telcom Long Distance Company
F.M. Cable, Inc.
GCI Network Inc.
Graphnet Inc.
Griswold's
GTE Sprint Communications Co.
GTE Business Communication Systems, Inc.
GTE Telenet Communications Corp.
Hart Industries, Inc.
Heins Systems, Inc.
Holywell Telecommunications Company
Ho-Tel, Inc.
Hyatt Corporation
Industry Hills Visitor Accommodation Partnership
Interstate Communications, Inc.
JSL/Toll Management
Kiawah Island Communications Company, Inc.
Lexitel Corporation
Liberty Bell Communications, Inc.
LINTEL Systems, Inc.
Long Distance Savers, Inc.
Long Distance/USA, Inc.
MCI Telecommunications Corp.
Microtel, Inc.
Mid-Continent Communications Corp.
Morris Long Distance Telephone Co.
National Communications Corp.
National IMS Corp.
National Telecommunications Network, Inc.
Network I, Inc.
North American Telephone Co., Inc.
Northland Telephone Systems Ltd.

[44] A "mixed" tariff is one which contains rates, terms and/or conditions for services or service points that are subject to differing degrees of regulation (i.e., tariffs containing both international and domestic off-shore service points).

[45] After reviewing the more than 900 tariffs currently on file at the Commission, we believe that the attached list is substantially complete. The fact that a carrier's name does not appear on this list does not, however, release that carrier from the obligation of complying with this Order.

[46] This requirement is not to be confused with posting requirements contained in Part 61 of the Commission's Rules, 47 CFR 61.72. Forborne carriers may keep this information at whatever company location they desire.

[47] The customary amount of time allowed for response to Commission inquiries concerning complaints is thirty days. This time may be shortened or extended by the Commission depending on the circumstances.

NTS Communications Ltd.
Number Please Ltd.
(The) Offshore Telephone Co.
Olympia Communications Co., Inc.
Pacific Network Communications
P.A.T.H. Finders
Pathfinders Communications
Pease & Associates Network Serv. Div.
Penn Telecom, Inc.
QWest Microwave, Inc.
RCI Corporation
Rotelcom, Inc.
Satelco, Inc.
Sharecom, Inc.
Shentel Service Company
Southland Systems, Inc.
Tel-a-Marketing Communications, Inc.
Telecall, Inc.
Telecom Equipment Corp.
Telecom Systems, Inc.
Telecommunications Facilities Management, Inc.
Telecommunications Service Corp.
Teleconnect Company, Inc.
Telephone Management Systems, Inc.
Telephone Warehouse Inc.
Tele-Sav Communications
Telshare, Inc.
Tel Systems Management Corp.
Teltec Saving Communications Co.
TODCO Communications Co.
Transamerica Systems, Inc.
Transnational Network, Inc.
Transportation Microwave Corp.
United Network Service, Inc.
United Services Administration
U.S. Telephone, Inc.
U.S. Transmission Systems, Inc.
Vector Communications, Inc.
Watsphone Company
Westel, Company
Western Tele-Communications Inc.
Wylon
YOGAO, Inc.

Digital Transmission Network (DEMS)

Local Area Telecommunications, Inc.

Earth Station and Transportable Service

American Television & Communications Corp.
Atlantic Sat. Comm. Inc.
Channels of Blessings
Colony Satellite Services, Inc.
Communications Carrier, Inc.
CPI Satellite Tele-Communications, Inc.
Eastern Microwave, Inc.
First Television Corporation
Great Trails Broadcasting Corporation
Greater Star Link Corp.
Golden West Broadcasters
Kansas Uplink Serv. Inc.
Koplar Commun., Inc.
Midwest Cable and Satellite Inc.
NEP Communications, Inc.
New England Microwave, Inc.
Pappas Satellite Serv.
San Joaquin TV Service, Inc.
Satellite Networks, Inc.
Satellite Transmission and Receiving Co.
Sjoberg's Inc.
South Florida Cable Television Corp.
Sunbeam T.V. Corp.
Taft Broadcasting Co.
Tele-Link Communications, Inc.
Teleprompter Corp.
Transportable Earth Stations, Inc.
U.S. Satellite Corp., Inc.
Western Satellite Corp.
Western Tele-Communications Inc.
Wold Communications, Inc.

Miscellaneous Microwave

Alabama Microwave, Inc.
ALIEF Communications
ALLNET Communications Services, Inc.
American Microwave & Communications, Inc.
American Mobilphone Co.
American Television & Communications Corp.
American Television Relay, Inc.
Andrews Tower Rental, Inc.
Arizona Micro-Wave System Co.
ATS Mobile Telephone, Inc.
Black Hills Video Corp.
Brentwood Company
Brentwood Company/Microwave System Company
Business Telecommunications Corporation
Capital Cities Cable, Inc.
Centel Videopath, Inc.
Columbia Communications Co.
Contact New Mexico, Inc.
Continental Telephone Company of Texas
Eastern Microwave, Inc.
Eastern Shore Microwave Relay Company
East Texas Transmission Company

Others

FTC Communications, Inc.
ITT World Communications, Inc.
RCA Global Communications, Inc.
TRT Telecommunications Corporation
Western Union International, Inc.
Western Union Telegraph Co.
First Television Corp.
Florida Micro-Communications
Garden State Micro Relay, Inc.
General Communications, Inc.
Grayson Enterprises, Inc.
H & B Microwave Corporation
Hi-Desert Microwave, Inc.
Kelly Co.
Maine Microwave, Inc.
Mercury Communications
Microcom, Inc.
Micro-Relay, Inc.
Micro-Video, Inc.
Microwave Express, Inc.
Microwave Mobile Systems
Microwave Service Company
Microwave Service Company of Florida, Inc.
Microwave Transmission Service, Inc.
Mid-Kansas, Inc.
Midwestern Relay Co.
Mississippi Valley Microwave
National Telephone Company
New England Microwave Corp.
New England Microwave, Inc.
Newhouse Alabama Microwave, Inc.
North Canadian Microwave Corporation
Northco Microwave, Inc.
Pacific Telatronics, Inc.
Penn Service Microwave Company
Pilot Butte Transmission Company, Inc.
St. Lawrence Microwave Company
Southeast Kansas Microwave, Inc.
Southeast Microwave, Inc.
Southwest Texas Transmission Company
Telehop Microwave Telecommunications
Teleplex Microwave Systems, Inc.
Teleprompter Transmission of Kansas, Inc.
Teleprompter Transmission of Oregon, Inc.
Television Microwave, Inc.
Tex-Mex Communications Co.
Tower Communications Systems Corporation
Trans-Muskingum, Inc.
Transtel Corporation
TVE Transmission, Inc.
United Microwave Corp.
United Video, Inc.
United Wehco, Inc.
Video Service Company
Warner Cable Corporation
Western Tele-Communications, Inc.
Western TV Relay, Inc.
West Texas Microwave Company, Inc.
Wyoming Microwave Corporation
Yankee Microwave, A Division of Karlen Communications, Inc.

Domestic Satellite Service

Allstate Communications Company
American Satellite
ASN, Inc.
Atlantic Transport Company
Bonneville Satellite Corporation
Compact Video Services, Inc.
Eastern Microwave, Inc.
Equatorial Communications
General Communications Inc.
GTE Satellite Corp.
GTE Spacenet Corp.
Hi-Net Communications, Inc.
Hughes Communications Carriers Services, Inc.
ISACOMM, Inc.
IT & E Overseas
Meredith Corporation
Metropolitan Communications Network Company
Midwestern Relay Company
Netcom International
RCA American Communications
RCA/Joint

Satellite Business Systems
Satellite Communications Network, Inc.
Satellite Data Broadcast Networks, Inc. (SATNET)
Southern Satellite Systems, Inc.
United Video, Inc.
USAA Satellite Communications Company
VideoStar Connections, Inc.
Western Telecommunications, Inc.
Western Union Telegraph Company

November 21, 1984.

Separate Statement of Commissioner Henry M. Rivera

Re: Sixth Report and Order In Re Competitive Carrier Policies

For the reasons outlined in the *Sixth Report and Order*, our decision to mandate detariffing of certain carriers is wise policy. I agree that permitting these carriers to continue filing "tariffs" undermines the objectives of our forbearance decisions by facilitating anticompetitive behavior.

While I recognize that the instant decision is not legally risk free, I am convinced it is legally defensible. Section 203 (b)(2) bestows upon the Commission the discretion to modify the statutory tariff duty. We have found that modification, *ie.*, dispensing with tariffs for forborne carriers, will enhance the pro-competitive environment. Modification is, therefore, in the public interest.

That we have the discretion to dispense with tariff filings, however, does not absolve the the Commission from continuing to assure that the rates and practices of all common carriers within our jurisdiction are just reasonable in accordance with sections 201 and 202. This latter duty is not a matter of agency discretion. Good faith administration of the complaint process will enable the Commission to oversee the practices of forborne carriers toward this end and is, therefore, the legal *sine qua non* of this deregulatory experiment. It is essential that the Commission move promptly to adopt procedures and standards that will adopt to assure the effectiveness of the complaint process and we will soon have that opportunity. *See Sixth Report and Order* note 26. When it comes time to adopt such procedures and standards, I will strive to be certain that the process is meaningful for interested parties.[1]

[FR Doc. 85-734 Filed 1-9-85; 8:45 am]

BILLING CODE 6712-01-M

[1] *Cf. Second Report and Order* in BC docket 79-219 (Deregulation of Radio), 49 FR 19019 (May 4, 1984).

47 CFR Part 73

[MM Docket No. 84-711; RM-4749]

TV Broadcast Station in Troy, AL

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein assigns UHF TV Channel 67 to Troy, Alabama, as that community's first television assignment in response to a petition filed by Troy Television, Inc.

EFFECTIVE DATE: March 11, 1985.

FOR FURTHER INFORMATION CONTACT: D. David Weston, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Television broadcasting.

Report and Order (Proceeding Terminated)

In the Matter of Amendment of § 73.606(b), Table of Assignments, TV Broadcast Stations (Troy, Alabama) MM Docket No. 84-711, RM-4749.

Adopted: December 19, 1984.
Released: January 3, 1985.

By the Chief, Policy and Rules Division.

1. Before the Commission for consideration is its *Notice of Proposed Rule Making*, 49 FR 30539, published July 31, 1984, requesting the assignment of UHF TV Channel 64 to Troy, Alabama, as that community's first local television assignment. The *Notice* was adopted in response to a petition filed by Troy Television, Inc. ("petitioner"). Petitioner filed comments reaffirming its intention to apply for the channel, if assigned. Supporting comments were also filed by Shelley Broadcasting Co., Inc. No other comments or oppositions to the proposal were received.

2. Although the *Notice* proposed to assign UHF TV Channel 64 to Troy that channel is short-spaced to a proposal for TV Channel 64 in Destin, Florida (MM Docket No. 84-710), and a recent assignment of TV Channel 64 in Macon, Georgia (MM Docket No. 84-713). A staff study indicates that UHF TV Channel 67 can be assigned to Troy consistent with the minimum distance separation requirements of § 73.610 of the Rules. Since another TV channel is available which will resolve the conflict, we have substituted TV Channel 67 for TV Channel 64 herein. The channel substitution will enable the early inauguration of television service at Destin and Macon as well as satisfy the expressions of interest in providing a first local television service to Troy.

3. In view of the foregoing, we believe that the public interest would be served by assigning UHF Television Channel 67 to Troy, Alabama. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective March 11, 1985, the Television Table of Assignments, § 73.606(b) of the Rules, is amended with respect to the community listed below:

City	Channel No.
Troy, AL	67

4. It is further ordered, that this proceeding is terminated.

5. For further information, please contact D. David Weston, Mass Media Bureau, (202) 634-6530.

(Secs. 4, 303, 48 Stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85-723 Filed 1-9-85; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 84-457; RM-4729]

FM Broadcast Station in Port St. Joe, FL

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein assigns FM Channel 228A to Port St. Joe, Florida, as that community's second FM assignment in response to a petition filed by Edward F. Perry, Jr. and William C. Blackmore.

EFFECTIVE DATE: March 11, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: D. David Weston, Mass Media Bureau, (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Report and Order (Proceeding Terminated)

In the matter of amendment of § 73.202(b), Table of Assignments, FM Broadcast Stations (Port St. Joe, Florida), MM Docket No. 84-457, RM-4729.

Adopted: December 5, 1984.
Released: January 2, 1985.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration the *Notice of Proposed Rule Making*, 49 FR 21963, published May 24, 1984, proposing the assignment of FM Channel 228A to Port St. Joe, Florida, as that community's second FM assignment. The *Notice* was issued in response to a petition filed by Edward F. Perry, Jr. and William C. Blackmore ("petitioners"). Supporting comments have been filed by petitioners reaffirming their intention to apply for the channel, if assigned. No opposition or other comments expressing an interest in the proposal were received.

2. The channel can be assigned in compliance with the Commission's minimum distance separation and other requirements. However, as the *Notice* stated, the use of FM Channel 228A at Port St. Joe will be contingent upon Station WJST–FM commencing operation on FM Channel 233.[1]

3. In view of the above, we believe the public interest would be served by assigning FM Channel 228A to Port St. Joe, Florida, since it could provide a second FM service to the community. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective March 11, 1985, the FM Table of Assignments, § 73.202(b) of the Rules, is amended for the following community:

City	Channel No.
Port St. Joe, FL	228A, 233

4. It is further ordered, that this proceeding is terminated.

5. For further information concerning the above, contact D. David Weston, Mass Media Bureau, (202) 634–6530.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85–725 Filed 1–9–85; 8:45 am]

BILLING CODE 6712–01–M

[1] See *Report and Order*, MM Docket No. 83–350, 48 FR 37414, published August 18, 1983, wherein the Commission granted a request for modification of the license for Station WJST–FM from Channel 228A to Class C Channel 233.

47 CFR Part 73

[MM Docket No. 84–713; RM–4751]

TV Broadcast Station in Macon, GA

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein assigns UHF TV Channel 64 to Macon, Georgia, as that community's fifth local television assignment, at the request of Larry G. Fuss, Sr.

EFFECTIVE DATE: March 11, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Television broadcasting.

Report and Order Proceeding Terminated

In the Matter of Amendment of § 73.606(b), Table of Assignments, Television Broadcast Stations (Macon, Georgia) MM Docket 84–713, RM–4751.

Adopted: December 19, 1984.
Released: January 3, 1985.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration the *Notice of Proposed Rule Making*, 49 FR 30547, published July 31, 1984, soliciting comments on the request of Larry G. Fuss, Sr. ("petitioner") to assign UHF TV Channel 53 to Macon, Georgia. The assignment could provide Macon with its fourth commercial television service. Comments and reply comments were submitted by the petitioner and WFLI, Inc. ("WFLI").[1] WFLI's comments also contained several counterproposals.

2. As pointed out in the *Notice*, Channel 53 can be assigned to Macon in compliance with the Commission's minimum distance separation requirements with the imposition of a site restriction of at least 9.5 miles southeast. This site restriction is necessary to avoid short-spacing to unused Channel 53 at Cleveland, Tennessee.

3. The petitioner, in his comments, reiterated his intention to promptly file an application for the channel at Macon, if assigned. WFLI, in its comments, does not oppose the assignment of an additional channel at Macon. It does, however, object to the assignment of Channel 53, with the required 9.5 mile southeast site restriction. WFLI is one of several applicants for Channel 53 at Cleveland, Tennessee, which have been designated for comparative hearing.[2] It acknowledges that the assignment at Macon, as proposed, complies with the Commission's minimum distance separation requirements if the distance is measured to Cleveland's city reference point. However, the distance between WFLI's proposed transmitter site and the restricted Macon site would not conform to the required distance separation. Rather, a 19-mile short-spacing would exist. It states that if channel 53 is assigned, as proposed, it will be forced to either amend its application to specify a new site which will conform to the required distance separation vis-a-vis the Macon allocation or seek a waiver of the 19-mile short-spacing. WFLI states that its site was carefully chosen as it would provide service to currently unserved areas. This provision of a first television service to previously unserved areas achieves "the paramount objective of the Commission's television allocation policies—the provision of at least one television service to all parts of the country," according to WFLI. It implies that if it has to amend its application to specify another site, this unserved area will remain without service. It concludes that either avenue could jeopardize the successful prosecution of its application.

4. WFLI Claims that the Commission can avoid this conflict between its application and the provision of an additional service at Macon. It proposes that Channel 35 be assigned to Macon in lieu of Channel 53. It submits an engineering study showing that the channel can be assigned if a site restriction of 15.09 miles southeast is imposed. The site restriction will obviate a short-spacing to noncommercial educational Channel *35 at Lafayette, Georgia. Alternatively, if Channel 53 is assigned to Macon, it

[1] Petitioner submitted a "Request for Leave to File Late Comments and Additional Reply Comments" after the record closed. Upon review of the pleading, we find that it contains no information which has not already been timely presented and considered. Therefore, this late-filed pleading will not be accepted. WFLI's "Motion for Leave to Supplement Counterproposal" was also untimely filed. Upon review, we find that it contains a clarification of the amount of unserved area which would be eliminated if a Cleveland station operates from WFLI's proposed antenna site. The information presented is not of a determinative nature in light of our decision herein. Therefore, it also will not be accepted.

[2] The following applications for use of Channel 53 have been accepted and designated for comparative hearing: Richard Towe and Darel Selvey (BPCT–840406KE); Philip B. George (BPCT–840521KE); Cleveland Community Television, Ltd. (BPCT–840524KE); Cleveland Television, Ltd. (BPCT–840530KG); and WFLI, Inc. (BPCT–840530KM). Docket Nos. 84–836–840.

requests that a 28 mile site restriction, in lieu of the 9.5 miles, be imposed so as not to interfere with its application at Cleveland.

5. The petitioner filed reply comments opposing WFLI's counterproposals. He does not oppose the assignment of Channel 35 at Macon, *per se*. His objection lies with the imposition of a 15-mile southeast site restriction. He states that the area proposed by WFLI is in very close proximity to the Robins Air Force Base at Warner Robins, Georgia. In fact, petitioner contends that the site coordinates specified by WFLI are within 2 miles of the Robins Air Force Base runway. This proximity would thus limit an applicant to use of a relatively low tower. Additionally, he claims that the area in question is very swampy low-lying land, which is unsuitable for the erection of a transmitter tower. Likewise, the imposition of a 28 mile site restriction on the use of Channel 53 at Macon would cause undue hardship, according to the petitioner. He states that the 9.5 mile southest site restriction imposed on Channel 53 would enable an applicant to locate his tower in the general vicinity of the "antenna farm" currently being used by Macon's three existing television stations. This would allow Macon's residents to receive the signal of the new station without the necessity of redirecting their outdoor antennas. Petitioner asserts that if a new UHF operation on either Channel 35 or 53 is forced to locate its transmitter away from this "antenna farm," it would be placed at a severe disadvantage and would greatly restrict the number of potential viewers, thus possibly affecting the economic viability of a new station. He requests that if Channel 35 is assigned to Macon, it be done with a site restriction which would allow use of a site in the vicinity of Macon's "antenna farm." Thus, he suggests that Channel *35 at Lafayette, Georgia, which is unoccupied and unapplied for, be deleted, with or without replacement. If this were done, WFLI could continue prosecuting its application at its preferred site, without having to seek a waiver of the mileage separation requirements, and a new television service could be instituted at Macon using the desirable "antenna farm" location.

6. WFLI responded by stating that the 15-mile southeast site restriction which would be imposed on the use of Channel 35 at Macon, would not cause the siting problems outlined by the petitioner. It contends that the area available is quite large, extending over 14 miles long and 2 miles wide. WFLI concludes by reiterating its assertion that the use of its proposed Cleveland site would further a primary Commission objective, the provision of a first television service to currently unserved areas. Since the Macon proponent has not claimed such a like benefit to the public, WFLI contends that its application should be accorded greater weight than petitioner's desire to co-locate with other Macon stations for purely competitive reasons.

7. In an effort to resolve this conflict in a manner which best serves the public interest, the staff conducted an engineering study to see if another channel could be assigned to Macon and used in the vicinity of its "antenna farm" and also provide the required mileage separation to WFLI's antenna site. We found that Channel 64 could be assigned and applied for at coordinates in the vicinity of Macon's "antenna farm" as well as negating the conflict with WFLI's proposed antenna site for Channel 53 at Cleveland.[3] With this solution available, we will not rule on the comparative merits of either petitioner's or WFLI's arguments.

8. Therefore, we believe that the public interest would be served by the assignment of Channel 64 to Macon, as that community's fourth local commercial television assignment. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, That effective March 11, 1985, the Television Table of Assignments, § 73.606(b) of the Rules, is amended with respect to the community listed below, to read as follows:

City	Channel No.
Macon, GA	13+, 24+, 41+, *47+, 64—

9. It is further ordered, that this proceeding is terminated.

10. For further information concerning this proceeding, contact Leslie K. Shapiro, Mass Media Bureau, (202) 634-6530.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

[3] In MM Docket 84-711, 49 FR 30539, published July 31, 1984, we proposed the assignment of UHF TV Channel 64 to Troy, Alabama, at the request of Troy Television, Inc. Our engineering study revealed that if Channel 67 were assigned to Troy, a short-spacing to Channel 64 could be avoided at Macon. A recent *Report and Order* has been adopted assigning Channel 67 to Troy.

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules, Division, Mass Media Bureau.

[FR Doc. 85-728 Filed 1-9-85; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 84-181; RM-4587]

TV Broadcast Stations in Junction City, Dodge City, and Ensign, KS

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein, at the request of James Patrick Young, assigns VHF Television Channel 6 to Junction City, Kansas, as that community's first television service.

EFFECTIVE DATE: March 11, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Patricia Rawlings, Mass Media Bureau (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Television broadcasting.

Report and Order (Proceeding Terminated)

In the matter of Amendment of § 73.606(b), Table of Assignments, TV Broadcast Stations (Junction City, Dodge City, and Ensign, Kansas) MM Docket No. 84-181, RM-4587.

Adopted: December 19, 1984.

Released: January 3, 1985.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration the *Notice of Proposed Rule Making and Order to Show Cause*, 49 FR 8635, published March 8, 1984, proposing the assignment of VHF Television Channel 6 to Junction City, Kansas, as that community's first television service and an offset change for KTVC, Channel 6, Ensign, Kansas, in response to a petition filed by James Patrick Young ("petitioner"). Supporting comments were filed by petitioner reaffirming his intention to apply for the channel, if assigned. Attached thereto was a "Determination of No Hazard to Air Navigation" from the Federal Aviation Administration ("FAA"). Comments were also filed by KOTV, Inc. ("KOTV"), Southwest Kansas Television Co., Inc. ("Southwest"), and Montgomery Publications, Inc., ("Montgomery"). Petitioner filed reply comments in response to the comments.

Chronicle Broadcasting Co. ("Chronicle") filed late reply comments.[1]

2. In opposing comments, KOTV, licensee of Station KOTV (TV), Channel 6, Tulsa, Oklahoma, suggests that Channel 46 or 52 be assigned to Junction City instead of Channel 6. KOTV argues that assignment and the change in offset for KTVC will cause significant new interference to their mutual service area; additional service will be lost due to interference with translators for KOTV; siting area will be limited and remote from the community; and a very tall tower would be required which may not be approved by the FAA. KOTV states that if Channel 6 is assigned to Junction City, some of the interference can be avoided by the use of precise offset.

3. Southwest, licensee of Station KTVC–TV, Ensign, Kansas, agrees to the offset change proposed for its station. However, Southwest states that it had recently been required to make such a change and believes it should never again be subjected to the inconvenience of an offset change.

4. Montgomery, licensee of low power television Station KO6KZ, Channel 6, Junction City, in its opposition comments states that this action would terminate its LPTV service. While recognizing that such service is secondary, Montgomery believes that the combination of the disruption of LPTV service and the problems introduced by the severe site restriction should preclude the proposed assignment.

5. Petitioner responds that it is willing to reimburse the licensee of Station KTVC–TV, at Ensign, for the offset change if he is the successful permittee for Channel 6 at Junction City. Petitioner states he has obtained FAA approval for the required transmitter tower as indicated in the attachment to his comments. Petitioner indicates that the proposed assignment meets all technical requirements and will provide a city grade (74 dBu) contour coverage over Junction City, Kansas. Therefore KOTV's concern about additional interference and attendant loss of competitiveness is not relevant.

6. Junction City (population 19,305),[2] the seat of Geary County (population 29,852) is located in northeastern Kansas, approximately 190 kilometers (118 miles) west of Kansas City. Currently, it is devoid of any local television broadcast service.

7. We have carefully considered the proposal and found no valid argument against it. The Commission believes the public interest would be served by the assignment of a first television service to Junction City, Kansas. The channel can be assigned in compliance with the Commission's minimum distance separation requirements and other technical criteria, provided there is a site restriction of 26.8 miles southwest of the community to avoid shortspacing to Station WOWT–TV (Channel 6+), in Omaha, Nebraska. The FAA has given approval of the required transmitter tower. The proposed assignment is contingent upon the relocation of Station KOTV–TV (Channel 6+), Tulsa, Oklahoma, to the site specified in its construction permit. There also must be a change in offset on Channel 6 for Station KTVC, Ensign, Kansas. The assignment of Channel 6 to Dodge City, Kansas, is being moved to Ensign to reflect its use there.

8. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective March 11, 1985, the Television Table of Assignments, § 73.606(b) of the Commission's Rules is amended for the following communities:

City	Channel No.
Dodge City, KS	*21–
Ensign, KS	6+
Junction City, KS	6–

9. It is further ordered, pursuant to the authority contained in section 316 of the Communications Act of 1934, as amended, that the license of Station KTVC (TV), Ensign, Kansas, is modified to specify operation on Channel 6+ subject to the following conditions:

(a) The licensee shall file with the Commission a minor change application for a construction permit (Form 301), specifying the new facility.

(b) Upon grant of the construction permit, program tests may be conducted in accordance with § 73.1620.

(c) Nothing contained herein shall be construed to authorize major change in transmitter location or to avoid the necessity of filing an environmental impact statement pursuant to § 1.301 of the Commission's Rules.

10. It is further ordered, that this proceeding is terminated.

11. For further information concerning this proceeding, contact Patricia Rawlings, Mass Media Bureau, (202) 634–6530.

[1] The late-filed reply comments of Chronicle were not accepted for consideration herein because they were not accompanied by a request for their acceptance nor was a reason given for the untimely filing.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85–722 Filed 1–9–85; 8:45 am]

BILLING CODE 6712–01–M

47 CFR Part 73

[MM Docket No. 83–1296; RM–4568; RM–4762]

FM Broadcast Stations in Moberly and Macon, MO

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action assigns Channel 260A to Macon, Missouri, in response to a petition filed by Charles C. Earls, and Channel 288A to Moberly, Missouri, in response to a petition filed by Phillip A. Chirillo. The assignments could provide a first service to Macon and a second broadcast service to Moberly.

EFFECTIVE DATE: March 31, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Kathleen Scheuerle, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Report and Order (Proceeding Terminated)

In the matter of Amendment of § 73.202(b), Table of Assignments, FM Broadcast Stations (Moberly and Macon,[1] Missouri), MM Docket No. 83–1296, RM–4568, RM–4762.

Adopted: December 19, 1984.
Released: January 3, 1985.
By the Chief, Policy and Rules Division.

1. The Commission herein considers the *Notice of Proposed Rule Making*, 48 FR 55589, published December 14, 1983, which invited comments on a proposal to assign FM Channel 288A to Moberly, Missouri, in response to a petition filed by Phillip A. Chirillo ("petitioner"). The assignment could provide a second FM service to the community. Petitioner submitted comments in support of the *Notice* and expressed an interest in applying for the channel, if assigned. Mrs. Imogene Ebert ("Ebert") also filed supporting comments. Charles C. Earls ("Earls") filed a counterproposal (RM–4762) requesting that Channel 288A be

[1] This community has been added to the caption.

assigned to Macon, Missouri, instead of Moberly. Petitioner filed reply comments saying that while Channel 288A is the only channel that could be assigned to Moberly, Channel 261A or 300 could be assigned to Macon with site restrictions.[2] Earls filed a reply to the reply of Chirillo which has not been considered because Commission policy does not allow for the filing of a reply after the reply pleading cycle.

2. Our staff has determined that Channel 260A can be assigned to Macon, Missouri, as that community's first local service. Channel 288A can be assigned to Moberly, Missouri, as its second FM service. This assignment would limit the 16 kilometer buffer zone of Station KZNN, Rolla, Missouri.[3]

3. Accordingly, pursuant to the authority contained in sections 4(i), 5(c)(1), 303 (g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective March 11, 1985, the FM Table of Assignments, § 73.202(b) of the Commission's Rules, is amended as follows:

City	Channel No.
Macon, MO	260A
Moberly, MO	284, 288A

4. It is further ordered, that this proceeding is terminated.

5. For further information concerning the above, contact Kathleen Scheuerle, Mass Media Bureau, (202) 634–6530.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85–721 Filed 1–9–85; 8:45 am]

BILLING CODE 6712-01-M

[2] On March 1, 1984, the Commission adopted the *Notice of Proposed Rule Making* in MM Docket 84–231, 49 FR 11214, published March 26, 1984, proposing to allot new FM channels at 884 communities. Channel 260A was proposed for Macon, Missouri, on that original list. However, due to a lack or timely-filed comments for Channel 260A at Macon, Missouri, in that proceeding, the community has been removed from the list released on July 23, 1984. Nevertheless, Channel 260A can be assigned to Macon, Missouri, in this proceeding in order to satisfy the interest expressed by Earls.

[3] Existing Class C stations with less than a 300 meter antenna height are now permitted a 16 kilometer buffer zone. However, this requirement does not apply to proceedings initiated before March 1, 1984. See BC Docket 80-90, 94 F.C.C. 2d 152 (1983), *recons.* 49 FR 10460, published March 20, 1984.

47 CFR Part 73

[MM Docket No. 84-267; RM-4625]

FM Broadcast Station in Watonga, OK

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: Action taken herein assigns Channel 228A to Watonga, Oklahoma, as that community's first local FM broadcast service in response to a request from Sherry Parham and Timothy Hawks and supporting comments filed by KRVZ, Inc.

EFFECTIVE DATE: March 11, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: D. David Weston, Mass Media Bureau (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Radio broadcasting.

Report and Order (Proceeding Terminated)

In the matter of Amendment of § 72.202(b) Table of Assignments, FM Broadcast Stations (Watonga, Oklahoma) MM Docket No. 84–267, RM–4625.

Adopted: November 16, 1984.
Released: January 3, 1985.

By the Chief, Policy and Rules Division.

1. The Commission has before it for consideration the *Notice of Proposed Rule Making*, 49 FR 10315, published March 20, 1984, in response to a petition filed by Sherry Parham and Timothy Hawks ("petitioners"), requesting the assignment of FM Channel 228A to Watonga, Oklahoma, as that community's first local FM service. Petitioners filed comments reaffirming their intention to apply for the channel, if assigned. Comments in support of the proposal where also filed by KRVZ, Inc. No other comments or oppositions to the proposal were received.

2. The channel can be assigned in conformity with the minimum distance separation requirements § 73.207 of the Rules. In view of the above considerations, and having found no policy objections to the proposal, we believe that the public interest would be served by the assignment of Channel 228A to Watonga since it could provide a first local FM broadcast service to that community.

3. Accordingly, pursuant to the authority contained in sections 4(i), 5(d)(1), 303(g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.281 and 0.204(b) of the Commission's Rules, it is ordered, that effective March 11, 1985, the FM Table of Assignments, § 73.202(b) of the Commission's Rules, is amended with respect to the community listed below as follows:

City	Channel No.
Watonga, OK	228A

4. It is further order, that this proceeding is terminated.

5. For further information concerning this proceeding, contact D. David Weston, Mass Media Bureau (202) 634–6530.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85–724 Filed 1–9–85; 8:45 am]

BILLING CODE 6712-01-M

47 CFR Part 73

[MM Docket No. 84-32]

TV Broadcast Stations in Arecibo, Cayey, San Juan, and Utuado, PR

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This action assigns UHF television Channel 60 to Arecibo, Puerto Rico, as its second commercial channel assignment, in response to comments from Hector Nicolau and Bocanegra Girald Broadcasting Group. Proposed channels for San Juan and Utuado were dismissed for lack of interest.

EFFECTIVE DATE: March 11, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Arthur D. Scrutchins, Mass Media Bureau, (202) 634–6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Television broadcasting.

Report and Order (Proceeding Terminated)

In the matter of Amendment of § 73.606(b), Table of Assignments, TV Broadcast Stations (Arecibo, Cayey, San Juan, and Utuado, Puerto Rico) MM Docket No. 84–32.

Adopted: December 5, 1984.
Released: January 3, 1985.

By the Chief, Policy and Rules Division.

1. The Commission has before it the Notice of Proposed Rule Making, 49 FR 4524, published February 7, 1984, issued on the Commission's own motion, proposing the deletion of UHF television Channels 80, 76, *74, and *70 from Arecibo, Cayey, San Juan and Utuado, respectively, and the substitute assignments of Channel *62 to San Juan, and Channel 60 either to Arecibo, as a commercial channel, or to Utuado, as a reserved noncommercial educational channel. In response to the *Notice*, comments were filed by the Ana G. Mendez Educational Foundation ("Mendez"), permittee of noncommercial educational Station WMIJ (Channel 40), Fajardo, Puerto Rico, and an applicant for noncommercial educational Channel *26, Ponce, Puerto Rico: Hector Nicolau ("Nicolau"); Angel F. Bocanegra, Ernestine Bocanegra, Maria Elizette Camps, Francisco A. Bocanegra, and Estrelle Bocanegra d/b/a Bocanegra/Girald Broadcasting Group ("BGB"), permittee of Channel 68 at Humacao, Puerto Rico; and Association of Maximum Service Telecasters, Inc.

2. In the *Notice*, we proposed two options. Option I and Option II both proposed the assignment of Channel *62 to San Juan as a replacement for Channel *74 with a site restriction of 15 miles east to avoid short spacing to a construction permit on Channel 58 in Cajuas. Option I also proposed the replacement of Channel 80 with Channel 60 in Arecibo.[1]

3. Concerning the proposed assignments of Channel *62 to San Juan and Channel 60 to Utuado, we received no expressions of interest in the proposed assignments. Therefore these proposals will be dismissed.

4. Mendez supports the assignment of Channel 60 to Arecibo. Mendez states that Channel 60 in Arecibo would provide television service to northwest Puerto Rico and Utuado without requiring a waiver of the Commission's Rules. Mendez points out that it would be difficult to find a site in Utuado that would meet the 4.3 mile site restriction to protect the construction permit for Channel 46 in Cidra and meet the requirements of § 73.685(b).[2] However, Mendez contends that the area would be better served by reserving Channel 60 for noncommercial educational use, since there is already a commercial assignment in Arecibo.

5. BGB and Nicolau support the assignment of Channel 60 to Arecibo for commercial use. Both state that they will apply for the channel, if it is assigned.

6. In reply comments, BGB opposes Mendez's proposal to reserve Channel 60 in Arecibo for noncommercial educational use. BGB argues that as an unreserved channel, the Commission retains the flexibility of accepting applications for commercial and noncommercial educational stations to compete for the construction permit. BGB further argues that no particular reason has been shown for preferring a noncommercial educational station over a commercial proposal. BGB contends that since Arecibo has only one commercial station, competitive commercial service remains an important unmet need in Arecibo.

7. Comments have discussed whether Channel 60 should be available for commercial or noncommercial educational use at Arecibo. Yet, we are not inclined to reserve Channel 60 since there have only been expressions of interest in applying for commerical use. While Mendez contends that Channel 60 should be reserved, it offers no reason for its argument other than the fact that there is already one commercial channel in Arecibo. Moreover, Mendez expresses no interest in applying for the channel. Inasmuch as Channel 60 is being substituted for a commercial channel and there is interest in applying for a second commercial channel in Arecibo, Channel 60 will be made available on an unreserved basis. The assignment can be made consistent with the minimum spacing requirements provided a mile west site restriction is imposed.

8. Accordingly, pursuant to the authority contained in sections 4(i), 5(d)(1), 303(g) and (r) and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is ordered, that effective March 11, 1985, the TV Table of Assignments, § 73.606(b) of the Commission's Rules, is amended as follows:

City	Channel No.
Arecibo, PR	54, 60.
Cayey, PR	
San Juan, PR	2+, 4–, *6+, 18, 24, 30.
Utuado, PR	

9. It is further ordered, that this proceeding is terminated.

10. For further information concerning the above, contact Arthur D. Scrutchins, Mass Media Bureau, (202) 634–6530.

(Secs. 4, 303, 48 stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85–720 Filed 1–9–85; 8:45 am]

BILLING CODE 6712-01-M

[1] AMST filed comments noting discrepancies in the site restrictions stated in the *Notice*.

[2] Section 73.685(b) requires providing an unobstructed signal to a principal community.

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47 CFR Part 73

[MM Docket No. 83–1142; RM–4503; RM–4674]

FM Broadcast Stations in Charlotte Amalie, VI and Isabel Segunda, PR; Correction

AGENCY: Federal Communications Commission.

ACTION: Final rule, correction.

SUMMARY: By this action, the Commission corrects the FM Table of Assignments to indicate that Channel 266 was previously deleted from Charlotte Amalie, Virgin Islands.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Leslie K. Shapiro, Mass Media Bureau (202) 634–6530.

SUPPLEMENTARY INFORMATION: Report and Order, MM Docket 83–1142, 49 FR 36379, published September 17, 1984.

List of subjects in 47 CFR Part 73

Radio broadcasting.

Erratum

In the matter of amendment of § 72.202(b), Table of Assignments, FM Broadcast Stations (Charlotte Amalie, Virgin Islands, and Isabel Segunda, Puerto Rico, MM Docket No. 83–1142, RM–4503, RM–4674.

Released: January 2, 1985.

By the Chief, Policy and Rules Division.

1. On August 31, 1984, the Commission adopted a *Report and Order*, 49 FR 36379, published September 17, 1984, assigning FM Channel 296A to Charlotte Amalie, Virgin Islands. Paragraph 5 of the *Report and Order* amended the FM Table of Assignments and specified that a fifth FM channel was being assigned to Charlotte Amalie. However, Channel 266 was previously deleted from that community. The correct entry for Charlotte Amalie in § 73.202(b) should read as follows:

City	Channel No.
Charlotte Amalie, Virgin Islands.	226, 250, 271, 296A

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

[FR Doc. 85-730 Filed 1-9-85; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 645

[Docket No. 41156-4156]

Spiny Lobster Fishery of Puerto Rico and the U.S. Virgin Islands

Correction

In FR Doc. 84-33527 beginning on page 50049 in the issue of Wednesday, December 26, 1984, make the following correction:

§ 645.8 [Corrected]

On page 50053, in § 645.8(d)(2), first line, the Morse Code for "Ry-Cy" should read as follows: (.–. –.– – –.–. –.– –)

BILLING CODE 1505-01-M

Proposed Rules

Federal Register
Vol. 50, No. 7
Thursday, January 10, 1985

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.

DEPARTMENT OF AGRICULTURE

Animal and Plant Health Inspection Service

9 CFR Parts 101 and 114

[Docket No. 84-088]

Viruses, Serums, Toxins, and Analogous Products; Amendment to Production Requirements for Biological Products; Expiration Date and Reprocessing

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: Proposed rule.

SUMMARY: These proposed revisions would amend the production requirements pertaining to establishing and extending expiration dates and reprocessing biological products. Currently, the earliest date of harvest and the date of a satisfactory potency test are used to establish and to extend the expiration date of a product. Current regulations only permit the reprocessing of product which is in liquid form. The proposed revision would: delete the use of the harvest date in computing the expiration date; relax the current restrictions on the movement of biological products between licensed establishments for the purpose of relabeling; and permit reprocessing of biological products in other than liquid form.

DATE: Comments must be received on or before March 11, 1985.

ADDRESS: Interested parties are invited to submit written data, views, or arguments regarding the proposed regulations to Thomas O. Gessel, Director, Regulatory Coordination Staff, APHIS, USDA, Room 728, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782. Written comments received may be inspected at Room 728 of the Federal Building, 8 a.m. to 4:30 p.m., Monday through Friday, except holidays.

FOR FURTHER INFORMATION CONTACT: Dr. Peter L. Joseph, Chief Staff Veterinarian, Veterinary Biologics Staff, VS, APHIS, USDA, Room 836, Federal Building, 6505 Belcrest Road, Hyattsville, MD 20782, 301-436-7760.

SUPPLEMENTARY INFORMATION:

Paperwork Reduction Act

This proposed rule contains no new or amended recordkeeping, reporting or application requirements or any type of information collection requirement subject to the Paperwork Reduction Act of 1980.

Executive Order 12291

This proposed action has been reviewed under USDA procedures established in Secretary's Memorandum No. 1512-1 to implement Executive Order 12291 and has been classified as "Nonmajor Rule."

The proposed rule would not have a significant effect on the economy and would not result in a major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of the United States-based enterprises to compete with foreign-based enterprises, in domestic or export markets.

Certification Under the Regulatory Flexibility Act

The Administrator of the Animal and Plant Health Inspection Services has determined that this action would not result in an adverse economic impact on a substantial number of small entities. Small entities are defined as independently owned firms not dominant in the field of veterinary biologics manufacturing.

Background

As presently written, the date of harvest for any component of a biological product and the date of satisfactory potency test are the major considerations in 9 CFR 114.13 for establishing the expiration date for a product in accordance with procedures contained in the Outline of Production. In the case of components which are stored prior to production of a biologic, the date such components are removed from storage may also be used as a starting point in determining the expiration date. In this case, the length of storage has always been a critical factor. At the time the regulations were written, the length of storage which relates back to the harvest data was thought to have a significant influence on expiration dating. Improvements in storage conditions have lessened the importance of this factor. When production materials are properly stored, it can be expected that a reasonable length of storage would not adversely affect the quality of the final product. Furthermore, since adverse effects caused by improper storage can be detected through potency tests which are required for each serial or subserial, it is not necessary to put so much emphasis on the date of harvest in establishing the expiration data. Therefore, it is proposed that the requirement to use the harvest data or storage time in computing the expiration date be deleted. Determination of the expiration date would, therefore, be based on potency testing. Accordingly, all references to harvest date would be deleted from 9 CFR 114.13. The definition of harvest date which appears in that section would be moved to 9 CFR 101.3.

Currently, the initial dating permitted in the Outline of Production of inactivated biological products is confirmed by potency testing samples of the prelicense serial on or after the stated expiration data. Subsequent changes in expiration date may be granted based on potency tests on five consecutive serials at least 6 months beyond the date requested. The most significant disadvantage of this procedure is its inadequate statistical validity depending on the number of serials produced. In addition, subtle differences may occur as licensees increase the size of serials during subsequent serial production. In order to provide for a more valid method of expiration date determination and testing, it is proposed that each serial be tested at release and at the approximate expiration date. A subsequent revision of expiration date would be based on statistically valid data supporting such revision.

Originally the five consecutive serial testing requirement was adopted because potency tests in use were thought to be inadequate to detect minor losses. Satisfactory testing 6 months

beyond the dating requested was considered necessary before an increase of the dating period specified in the Outline of Production could be authorized. Research and development have resulted in improved potency tests that can detect adverse changes. Therefore, satisfactory results of potency tests performed on samples stored through the dating requested would be sufficient to authorize an increase in the dating period. The proposed revision would relax the regulations by incorporating this change.

The current regulations in 9 CFR 114.14(a)(2) limit the movement of licensed products for relabeling between two licensed establishments to those owned or operated by the same person. The Agency published in the **Federal Register** on November 21, 1984, (49 FR 45845) a revision of 9 CFR 114.3 which will allow the movement of partially prepared or completed product between licensed establishments. The proposed revision of 9 CFR 114.14 makes this section consistent with the change in 9 CFR 114.3.

When the regulations in 9 CFR 114.18 were adopted, products amenable to reprocessing were limited to those in liquid form. New products and new or revised test standards have been developed which make reprocessing of products in other forms feasible. Examples include desiccated Brucella Abortus Vaccine and certain diagnostic test kits. In the case of Brucella Abortus Vaccine, a recent amendment of 9 CFR 113.65 requires that each serial of vaccine contain between 3 and 10 billion viable organisms per dose. Serials containing more than 10 billion organisms per dose when freshly prepared are declared unsatisfactory. Organism counts in these serials can be reduced by storage under specified conditions without adverse effects. This procedure is considered to be a reprocessing step and should be permitted to avoid rejection of a potentially satisfactory serial. Certain diagnostic test kits require that specific matching antigen and antibody lots be used in the preparation of a serial. In the event of an unsatisfactory potency test, a serial could feasibly be reprocessed by replacement of one of the components. This proposed revision of 9 CFR 114.18 would delete the words "in liquid form." The mixing and filling provisions of 9 CFR 114.18(b) would be deleted. Paragraph (c) would be amended by changing "required tests" to "appropriate tests" and would be redesignated as (b). Paragraphs (d) and (e) have been redesignated as (c) and (d).

List of Subjects

9 CFR Part 101

Animal biologics.

9 CFR Part 114

Animal biologics.

PART 101—DEFINITIONS

Section 101.3 would be revised by adding paragraph (l):

§ 101.3 Biological products and related terms.

* * * * *

(l) *Harvest date.* Unless otherwise specified in a filed Outline of Production, the harvest date shall be the date blood or tissues are collected for production or the date cultures of living microorganisms are removed from production incubators.

PART 114—PRODUCTION REQUIREMENTS FOR BIOLOGICAL PRODUCTS

Section 114.13 would be revised to read:

§ 114.13 Expiration date determination.

Unless otherwise provided for in a Standard Requirement or filed Outline of Production, the expiration date for each product shall be computed in accordance with the conditions provided in this section. Prior to licensure, potency test of each fraction shall be conducted to determine stability by methods acceptable to Veterinary Services. This will serve as the basis for establishing the appropriate dating of the product. Expiration dates based on this stability data and calculated from the initiation date of the potency test shall be confirmed as follows:

(a) *Products consisting of viable organisms.* Each serial shall be tested for potency at release and at the approximate expiration date until a statistically valid stability record has been established.

(b) *Inactivated biological products.* Each serial presented in support of licensure shall be tested for potency at release and at or after the dating requested.

(c) Subsequent changes in the dating period for a product may be granted, based on statistically valid data submitted to support a revision of the Outline of Production.

Section 114.14 would be revised to read:

§ 114.14 Extension of expiration date for a serial or subserial.

(a) Unless otherwise provided for in a filed Outline of Production for the product, the expiration date shall not be extended:

(1) If all fractions of the product are not evaluated for potency by tests designated in the filed Outline of Production for such product in accordance with § 113.4(b) of this subchapter.

(2) For any serial or portion of any serial which has left licensed premises: *Provided,* That product which has been shipped from one licensed premises to another licensed premises shall be exempt from this requirement.

(3) For a serial or portion of a serial if the expiration date has been extended previously, unless otherwise authorized in accordance with § 114.1.

(b) An extension of the expiration date may be granted by Veterinary Services if a request from the licensee is substantiated by valid test data which demonstrate the potency of the product meets or exceeds the requirements for release. The new expiration date shall be calculated from the date of the lastest satisfactory potency test was initiated. The extension of the expiration date shall not exceed the maximum dating allowed in the filed Outline of Production. Serials are approved for redating under the condition that Veterinary Services may require the firm to retest the redated serial for potency during the extended dating period and if found unsatisfactory require it be removed from the market by the licensee.

Section 114.18 would be revised to read:

§ 114.18 Reprocessing of biological products.

The Deputy Administrator may authorize a licensee to reprocess a serial of completed product subject to the conditions prescribed in this section.

(a) Reprocessing shall not include any method or procedure which would be deleterious to the product.

(b) All appropriate tests for purity, safety, potency, and efficacy for the product shall be conducted on the reprocessed product. A serial found unsatisfactory by a required test shall not be released.

(c) The reprocessed serial shall be identified by a new serial number and the records for the serial shall accurately reflect the action taken.

(d) Test samples of the reprocessed serial and test reports for all tests conducted shall be submitted to Veterinary Services. The licensee shall not release the serial until notified by Veterinary Services that the serial is eligible for release.

(37 Stat 832–833 (21 U.S.C. 151–158))

Done at Washington, D.C., this 4th day of January 1985.

K.R. Hook,

Acting Deputy Administrator, Veterinary Services.

[FR Doc. 85-762 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-34-M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 84-AGL-8]

Proposed Establishment of Additional Control Area-Badlands, SD, and V-491

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This notice proposes to establish an additional control area east of Rapid City, SD, and a VOR Federal Airway from Rapid City, SD, to Minot, ND. These actions are proposed to provide increased levels of efficient and economical service to airspace users through an increase of available controlled airspace and expansion of air traffic control services.

DATE: Comments must be received on or before February 18, 1985.

ADDRESSES: Send comments on the proposal in triplicate to: Director, FAA, Great Lakes Region, Attention: Manager, Air Traffic Division, Docket No. 84-AGL-8, Federal Aviation Administration, 2300 East Devon Avenue, Des Plaines, IL 60018.

The official docket may be examined in the Rules Docket, weekdays, except Federal holidays, between 8:30 a.m. and 5:00 p.m. The FAA Rules Docket is located in the Office of the Chief Counsel, Room 916, 800 Independence Avenue, SW., Washington, D.C.

An informal docket may also be examined during normal business hours at the office of the Regional Air Traffic Division.

FOR FURTHER INFORMATION CONTACT: Gene Falsetti, Airspace and Air Traffic Rules Branch (ATO-230), Airspace—Rules and Aeronautical Information Division, Air Traffic Operations Service, Federal Aviation Administration, 800 Independence Avenue, SW., Washington, D.C. 20591; telephone: (202) 426-8783.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, economic, environmental, and energy aspects of the proposal. Communications should identify the airspace docket and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: "Comments to Airspace Docket No. 84-AGL-8." The postcard will be date/time stamped and returned to the commenter. All communications received before the specified closing date for comments will be considered before taking action on the proposed rule. The proposal contained in this notice may be changed in the light of comments received. All comments submitted will be available for examination in the Rules Docket both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRM's

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Federal Aviation Administration, Office of Public Affairs, Attention: Public Information Center, APA-430, 800 Independence Avenue, SW., Washington, D.C. 20591, or by calling (202) 426-8058. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRM's should also request a copy of Advisory Circular No. 11-2 which describes the application procedure.

The Proposal

The FAA is considering an amendment to § 71.123 and § 71.163 of Part 71 of the Federal Aviation Regulations (14 CFR Part 71) to establish an Additional Control Area east of Rapid City, SD, between latitudes 43°40'00" N. and 44°45'00" N. and longitudes 99°30'00" W. and 102°28'00" W.; and a new VOR Federal Airway between Rapid City, SD, and Minot, ND. These actions are proposed following requests by airspace users for additional controlled airspace to reduce operating costs and fuel consumption through the availability of more direct routings. In addition, controlled airspace would be available for use in routing aircraft around extensive military activity along military training routes. The action would also provide for expanded radar vectoring services, off-course climbs, and more direct routings. Sections 71.123 and 71.163 of Part 71 of the Federal Aviation Regulations were republished in Handbook 7400.6 dated January 3, 1984.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore—(1) Is not a "major rule" under Executive Order 12291; (2) is not a "significant rule" under DOT Regulatory policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Control areas, VOR Federal airways, Aviation safety.

The Proposed Amendment

Accordingly, pursuant to the authority delegated to me, the Federal Aviation Administration proposes to amend § 71.123 and § 71.163 of Part 71 of the Federal Aviation Regulations (14 CFR Part 71) as follows:

§ 71.123

V-491—[New]

From Rapid City, SD; Dickinson, ND; to Minot, ND.

§ 71.163

Badlands, SD—[New]

That airspace extending upward from 1,200 feet AGL to but not including 14,500 feet MSL within the area bounded by a line beginning at lat. 44°45'00" N., long. 102°28'00" W.; to lat. 44°45'00" N., to long. 99°30'00" W.; to lat. 43°40'00" N., long. 99°30'00" W.; to lat. 43°40'00" N., long. 102°28'00" W.; to the point of beginning.

(Secs. 307(a) and 313(a), Federal Aviation Act of 1958 (49 U.S.C. 1348(a) and 1354(a)); (49 U.S.C. 106(g) (Revised, Pub. L. 97-449, January 12, 1983)); and 14 CFR 11.65)

Issued in Washington, D.C., on December 26, 1984.

Shelomo Wugalter,

Acting Manager Airspace—Rules and Aeronautical Information Division.

[FR Doc. 85-666 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-13-M

DEPARTMENT OF THE TREASURY

Customs Service

19 CFR Part 103

Access by Press to Information on Import Manifests

AGENCY: U.S. Customs Service, Department of the Treasury.

ACTION: Solicitation of comments.

SUMMARY: Members of the press have requested the Customs Service to permit access to manifests of merchandise imported into the U.S. by truck, rail, or aircraft on the same basis that the press has access to vessel manifests under § 103.14, Customs Regulations (19 CFR 103.14). Inasmuch as the commercial sensitivity, if any, of information contained on the manifests is best known by the parties to the involved commercial transactions, Customs requests written comments from any interested parties as to their views on access to, and releasibility of, information on the manifests to members of the press.

DATE: Comments must be received on or before March 4, 1985.

ADDRESS: Written comments should be addressed to and may be reviewed at the U.S. Customs Service, Attention: Regulations Control & Disclosure Law Division, 1301 Constitution Avenue NW., Room 2325, Washington, D.C. 20229.

FOR FURTHER INFORMATION CONTACT: Doris B. Robinson, Regulations Control and Disclosure Law Division, U.S. Customs Service, 1301 Constitution Avenue NW., Washington, D.C. 20229 (202-566-8681).

Dated: January 4, 1985.

B. James Fritz,

Director, Regulations Control, and Disclosure Law Division.

[FR Doc. 85-744 Filed 1-9-85; 8:45 am]

BILLING CODE 4820-02-M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of the Assistant Secretary for Housing—Federal Housing Commissioner

24 CFR Parts 200, 203, 220, 228

[Docket No. R-84-1189, FR-1927]

Mortgage Insurance; Claims Without Conveyance of Title

AGENCY: Office of the Assistant Secretary for Housing—Federal Housing Commissioner, HUD.

ACTION: Proposed rule.

SUMMARY: Section 426 of the Housing and Urban-Rural Recovery Act of 1983 (1983 Act) amended section 204(a) of the National Housing Act (Act) to authorize the Secretary of allow mortgagees to submit claims for the payment of mortgage insurance benefits on foreclosed single family properties without conveying title to the foreclosed properties to the Secretary. Existing regulations require mortgagees submitting a claim for insurance benefits to either assign the insured mortgage to the Secretary or tender the Secretary a good, marketable title to the property after foreclosing the insured mortgage or taking a deed in lieu of foreclosure. The purpose of this proposed rule is to implement the amendments to section 204(a) of the Act. By allowing claims without conveyance, the intended effect of the regulation will be to encourage parties other than the mortgagees to bid at foreclosure sales. The intended result is the reduction of HUD's single family acquired housing inventory, which will in turn reduce holding and resale costs to the Department.

DATE: Comments must be received by March 11, 1985.

ADDRESS: Interested persons are invited to submit written comments, suggestions, or data regarding the proposed rule to the Rules Docket Clerk, Office of General Counsel, Room 10276, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, D.C. 20410. Communications should refer to the above docket number and title. A copy of each communication submitted will be available for public inspection during regular business hours at the above address. The rule may be revised on the basis of comments received.

FOR FURTHER INFORMATION CONTACT: Richard B. Buchheit, Director, Single Family Servicing Division, Office of Single Family Housing, Department of Housing and Urban Develpment, Room 9180 451 Seventh Street, SW., Washington, DC 20410. Telephone (202) 755-6672. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: HUD now owns nearly 17,400 family houses throughout the country. Many of these houses are in the poorest areas of the nation's cities. Although the HUD single family houing inventory has significantly decreased from its high point of nearly 70,000 houses in July 1975, nevertheless, about 2,710 houses are added to HUD's inventory each month as the result of insurance claims. HUD holds these houses, usually vacant, for an average period of six months before they are sold. During this time, vandalism decreases their value, their poor condition blights neighborhoods, and HUD staff costs, contractor costs and other holding costs mount steadily. The proposed regulations will allow HUD to pay mortgage insurance benefits to mortgagees without receiving title to the foreclosed properties. Holding and sales cost which HUD would normally have to bear will be reduced as a result of these proposed regulations.

The proposed rule is to be applied to all mortgages insured pursuant to commitments issued on or after November 30, 1983, the effective date of the 1983 Act. It is the Department's position that the application of these regulations to mortgages insured pursuant to commitments issued between November 30, 1983 and the date of publication of the final rule will not adversely affect the interests of a mortgagee under an existing contract of mortgage insurance or commitment to insure (see 24 CFR 203.499).

The Department proposes the addition of two new sections in 24 CFR Part 203 regarding the implementation of Section 426 of the 1983 Act.

Under the proposed § 203.368, mortgagees must follow the procedures outlined under §§ 203.368 and 203.369 for those mortgages insured pursuant to a commitment issued on or after November 30, 1983. In addition, it is intended that mortgagees may elect, at their option, to utilize this claim without conveyance procedure for mortgages insured pursuant to a commitment issued prior to November 30, 1983.

The proposed § 203.368 authorizes the payment of a claim without conveyance of title where the mortgagee or a party other than the mortgagee is the successful bidder at a foreclosure sale. If the property is damaged as set out in 24 CFR 203.378, title must be conveyed to the Secretary in exchange for the insurance benefits. Section 203.368 also provides that the mortgagee is required

to bid a specific amount at the foreclosure sale, and sets out how this specified amount is to be determined. This amount is based on the fair market value of the property less adjustments for maintenance, management and other costs related to the holding and ultimate reselling of the property as determined by the Commissioner, but not more than the outstanding indebtedness under the insured mortgage, plus related foreclosure and acquisition expenses. If state law requires a bid in excess of the amount sepcified by the Department, the mortgagee is authorized to bid the outstanding indebtedness of the mortgage plus costs. If the amount of the outstanding indebtedness plus costs is less than the amount required under state law, the foreclosing mortgagee, in such a situation, could petition the court to have the property reappraised, or to allow the lower bid to be entered. Such circumstances should be rare. It should be emphasized that under the National Housing Act, the Secretary would not be authorized to pay an insurance claim in excess of the outstanding indebtedness plus costs. It should also be noted, as emphasized in paragraph (e) of § 203.368, that the requirements of HUD's mortgage assignment program are not negated by the claims without conveyance procedure.

The proposed § 203.369 states that the Department will determine the fair market value of a property, as well as the specified amount which the mortgagee is required to bid. Paragraph (b)(4) provides that the mortgagee may be required to advertise the upcoming sale in local newspapers and other publications, in addition to standard legal notices of foreclosure as required by state law. Such advertising may be necessary in order to generate additional interest in the foreclosure sale among potentially interested parties. Costs of advertising may be included in the claim for insurance benefits.

Paragraph (c) gives the mortgagee if it is the successful bidder, a choice of (1) retaining title to the property and making a claim for the insurance benefits, or (2) conveying title to the property and making a claim for the insurance benefits. Thus, the mortgagee will retain the option to decide whether or not to market the acquired property itself. Under paragraph (d), when a party other than the mortgagee is the successful bidder, the mortgagee files a claim for the insurance benefits, obviously without conveying title to the Secretary. Paragraph (e) provides that if the mortgagee is the successful bidder for an amount in excess of the specified bid amount, the mortgagee will have to retain title. Paragraph (f) provides that the mortgagee will use the existing procedures for filing a claim if the property is damaged.

Under paragraph (g), §§ 203.358 through 203.367 are not applicable when filing a claim without conveying title. These sections contain provisions which are utilized when title is conveyed, and for that reason are being excepted. The few provisions which would be applicable to the claims without conveyance procedure have been placed in paragraphs (h) through (k). They include a requirement that the mortgagee assign to HUD all claims resulting from the foreclosure, and also furnish HUD with all documents and fiscal data pertaining to the mortgage transaction. A requirement is also included that the mortgagee file its claim for insurance benefits within 30 days after the date of closing on the property.

Other conforming amendments to implement the claims without conveyance procedure would be made to §§ 200.155, 200.156, 203.283, 203.315, 203.320, 203.401 through 203.403, 203.423, and 228.290.

When implemented, the claims without conveyance procedure will be applicable to all mortgages on one-to-four family dwellings insured pursuant to a commitment issued on or after November 30, 1983, except for the following programs which have their own procedures for the filing of claims and the payment of the insurance benefits:

1. Rehabilitation loans insured under section 203(k) of the Act which are secured by a mortgage other than a first mortgage;

2. Home improvement loans insured under section 220(h) of the Act.

Accordingly, §§ 203.478 and 220.350 of the regulations would be revised to clarify that the claims without conveyance procedure will not be applicable to these programs.

Following are the major steps leading to the proposed bidding on foreclosed properties:

Mortgagor defaults;

Mortgagee or mortgagor requests assignment of mortgage;

HUD rejects assignment request;

HUD authorizes mortgagee to foreclose if it wishes;

Mortgagee initiates foreclosure (notifies mortgagor);

Mortgagee files complaint or first legal action under state law;

Mortgagee notifies HUD of foreclosure status and status of mortgage (unpaid principal balance, etc.) and estimated date of sale;

HUD selects appraiser from its list of fee appraisers;

HUD gives name of appraiser to mortgagee, which requests the appraiser to conduct an appraisal of property;

Appraiser conducts appraisal and sends report to HUD (with copy to mortgagee) and the bill to the mortgagee;

HUD receives appraisal report and reviews it for completeness and accuracy;

HUD determines the specified amount to be bid (the actual price to be bid by the mortgagee);

HUD may instruct the mortgagee to advertise the property and include the fair market value of the property in the advertisement;

HUD instructs mortgagee to bid the specified amount as a minimum bid (unless state law requires otherwise);

Foreclosure sale takes place with following possibilities:

a. If the mortgagee is successful bidder, it has the option either to retain the property or convey title to HUD.

(1) If it elects to retain title to the property, it submits a claim to HUD for the difference between the outstanding indebtedness (accrued interest, escrow advances, etc.) and the amount bid at the sale.

(2) If it conveys the property to HUD, it submits a claim under the current procedures.

b. If a party other than the mortgagee is the successful bidder, the mortgagee submits a claim to HUD for the difference between the outstanding indebtedness and the bid price.

HUD proposes to use one of two possible methods for determining the allowable costs which will be deducted from the fair market value (FMV) to calculate the specified amount. One method would be to deduct from the FMV specific line item costs such as broker's fee, tax liens (water and sewer), management fees, advertising costs, etc. Using this method, the specified amount would be calculated on an individual property basis. The other method would be to use a fixed percentage to be deducted from the FMV to determine the specific amount. Using this method, the percentage to be deducted from the FMV would be the average of the allowable cost items in a given region or the use of a fixed percentage on a nationwide basis.

The Department solicits comments on all elements of the proposed regulations, but particularly on the bidding strategy and the requirement for advertising.

Findings and Other Matters

A finding of No Significant Impact with respect to the environment has been made in accordance with HUD regulations in 24 CFR Part 50 which implement section 102(2)(C) of the National Environmental Policy Act of 1969. The Finding of No Significant Impact is available for public inspection during regular business hours at the Office of the Rules Docket Clerk, Office of the General Counsel, Room 10278, Department of Housing and Urban Development, 451 Seventh Street, SW., Washington, D.C. 20410.

This rule does not constitute a "major rule" as that term is defined in section 1(b) of the Executive Order on Federal Regulations issued by the President on February 17, 1981. Analysis of the rule indicates that it does not (1) have an annual effect on the economy of $100 million or more; (2) cause a major increase in costs or prices for consumers, individual industries, Federal, State or local government agencies, or geographic regions; or (3) 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.

Under 5 U.S.C. 605(b) (the Regulatory Flexibility Act), the Undersigned hereby certifies that this rule does not have a significant economic impact on a substantial number of small entities. The rule involves mortgagees from the mortgage banking industry, not small businesses.

The information collection requirements contained in this rule have been submitted to the Office of Management and Budget for review under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501–3520). The OMB control number, when assigned, will be announced by separate notice in the **Federal Register**. Please send any comments regarding the information collection requirements to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503, ATTENTION: Desk Officer for HUD.

This rule is listed at 49 FR 41703 as item number 51 in the Department's Semiannual Agenda of Regulations published on October 22, 1984 [49 FR 41684], pursuant to Executive Order 12291 and the Regulatory Flexibility Act.

The following numbers identify the programs, as listed in the Catalog of Federal Domestic Assistance, which will be affected by this regulation change:

14.105 Interest Reduction—Homes for Lower Income Families
14.108 Rehabilitation Mortgage Insurance
14.117 Mortgage Insurance—Homes
14.118 Mortgage Insurance—Homes for Certified Veterans
14.119 Mortgage Insurance—Homes for Disaster Victims
14.120 Mortgage Insurance—Homes for Low and Moderate Income Families
14.121 Mortgage Insurance—Homes in Outlying Areas
14.122 Mortgage Insurance—Homes in Urban Renewal Areas
14.123 Mortgage Insurance—Housing in Older, Declining Areas
14.132 Mortgage Insurance—Purchase of Sales-Type Cooperative Housing Units
14.133 Mortgage Insurance—Purchase of Units in Condominiums
14.152 Mortgage Insurance—Experimental Homes
14.165 Mortgage Insurance—Homes—Military Impacted Areas
14.166 Mortgage Insurance—Homes for Members of the Armed Forces

List of Subjects

24 CFR Part 200

Administrative practice and procedure, Claims, Equal employment opportunity, Fair housing, Housing standards, Loans programs: Housing and community development, Mortgage insurance, Organization and functions (Government agencies), Reporting and recordkeeping requirements, Minimum Property Standards, and Incorporation by reference.

24 CFR Part 203

Home improvement, Loan programs: housing and community development, Mortgage insurance, Solar energy.

24 CFR Part 220

Home improvement, Loan programs: housing and community development.

24 CFR Part 228

Mortgage insurance, Individual residences, National Defense Housing.

Accordingly, 24 CFR Parts 200, 203, 220, and 228 are proposed to be amended as follows:

PART 200—INTRODUCTION

1. By revising § 200.155 to read as follows:

§ 200.155 Claim requirements.

(a)(1) In the home mortgage programs, a mortgagee is required, in order to perfect its claim for the payment of the insurance benefits, to: (i) Assign the mortgage to the Commissioner; or (ii) obtain a deed in lieu of foreclosure and convey good, marketable title to the property covered by the insured mortgage to the Commissioner; or (iii) foreclose the insured mortgage.

(2) In connection with the foreclosure of an insured mortgage the mortgagee may either convey good, marketable title to the foreclosed property to the Commissioner, or file a claim for the insurance benefits without conveying title to the Commissioner in accordance with § 203.368.

(b) In project mortgage programs, in order to perfect a claim for payment, the mortgagee is required either to assign the project mortgage to the Commissioner, or to foreclose the property covered by the insured mortgage and tender to the Commissioner a good, marketable title. If the mortgagee elects to assign the project mortgage, the claim for insurance is reduced by one percent of the amount of the mortgage.

2. By revising § 200.156 to read as follows:

§ 200.156 Settlement of claims.

Upon approving the conveyance of title, and delivering possession of the property to the Commissioner, or upon approval of a claim to be paid without the conveyance of title in accordance with § 203.368, debentures and a certificate of claim are issued to the mortgagee in accordance with a computation provided by statute for the particular program. The debentures include an amount equal to the unpaid principal of the mortgage plus certain other items such as advances made for hazard insurance, payment of taxes, FHA mortgage insurance premium and a portion of foreclosure expenses. The terms of the statute strictly control the amounts which may be allowed in debentures. Certain expenditures made by the mortgagee, not allowed in the debentures, are included in the certificate of claim.

PART 203—MUTUAL MORTGAGE INSURANCE AND REHABILITATION LOANS

3. By revising paragraph (a) of § 203.283 to read as follows:

§ 203.283 Refund of one-time MIP.

(a) The Commissioner shall provide for the refund to the mortgagor of a portion of the unearned MIP paid pursuant to § 203.280 if the contract of insurance covering the mortgage is terminated by conveyance to one other than the Commissioner and a claim for the insurance benefits is not presented for payment (§ 203.315), by the

prepayment of the mortgage (§ 203.316), or by the voluntary agreement of the mortgagor and mortgagee, with the approval of the Commissioner (§ 203.317).

* * * * *

4. By revising § 203.315 to read as follows:

§ 203.315 Termination by conveyance to other than Commissioner.

The contract of insurance shall be terminated if:

(a) The mortgagee acquires the mortgaged property and notifies the Commissioner that it will not file a claim for the insurance benefits.

(b) The property is acquired at foreclosure by a party other than the mortgagee, and the mortgagee gives notice to the Commissioner that it will not file a claim for the insurance benefits;

(c) After foreclosure, the property is redeemed; or

(d) After foreclosure and during the redemption period, the mortgagee gives notice to the Commissioner that it will not convey the property to the Commissioner and also will not file a claim for the insurance benefits.

5. By revising paragraph (a) of § 203.320 to read as follows:

§ 203.320 Notice and date of termination by Commissioner.

* * * * *

(a) The date foreclosure proceedings were instituted by the mortgagee, or the property was otherwise acquired by the mortgagee or a party other than the mortgagee, if the mortgagee notifies the Commissioner that title will not be conveyed to the Commissioner and a claim for the insurance benefits will not be presented for payment.

* * * * *

6. By adding immediately after § 203.367 a new center heading and new § 203.368 to read as follows.

Claim Procedure—Without Conveyance to the Commissioner

§ 203.368 Claims without conveyance option.

With respect to a mortgage which was insured, or for which a commitment to insure was issued, on or after November 30, 1983, the mortgagee must use the provisions of this section and § 203.369 in filing a claim for insurance benefits. For those mortgages which were insured or where a commitment for insurance was issued prior to November 30, 1983, the mortgagee may elect to follow the claim procedure without conveyance option.

(a) The benefits of mortgage insurance may be paid without conveying title to the Commissioner where (1) the mortgagee is the successful bidder at the foreclosure sale, or (2) a party other than the mortgagee is the successful bidder at the foreclosure sale. In both instances, all of the requirements regarding claims without conveyance must be followed as set out in this subpart.

(b) If the mortgaged property has been damaged as set out in § 203.378, title must be conveyed to the Commissioner in order for a claim to be paid.

(c) The mortgagee must enter a bid at the foreclosure sale for a specified amount based on the fair market value of the property, less any adjustments for maintenance, management, and other costs related to the holding and ultimate reselling of the property as determined by the Commissioner. Fair market value is the price at which a property would be expected to be sold in "as is" condition, as determined by the Commissioner. If the fair market value, less such costs, exceeds the outstanding indebtedness under the mortgage, the mortgagee must enter the outstanding indebtedness under the mortgage, plus the mortgagee's acquisition and foreclosure costs, as its foreclosure sale bid.

(d) If a minimum bid is required under applicable state law, and this minimum bid exceeds the specified amount, the mortgagee may bid an amount not to exceed the outstanding indebtedness plus the mortgagee's acquisition and foreclosure costs. If the minimum bid required under state law is less than the specified amount, the mortgagee shall bid the specified amount. Where the mortgagee is the successful bidder, and has bid the outstanding indebtedness plus the mortgagee's acquisition and foreclosure costs, which is greater than the specified amount, the amount of the outstanding indebtedness plus such costs shall govern for the purpose of this subpart and for the purpose of computing the ultimate loss under the mortgage insurance contract under this subpart.

(e) The requirements of the assignment program are not negated by the claim procedure with nonconveyance option.

7. By adding a new § 203.369 to read as follows:

§ 203.369 Claim without conveyance option—procedure.

(a) After the mortgage institutes proceedings to foreclose an insured mortgage by judicial, statutory, or other means, the mortgagee shall promptly deliver a copy of the notice of sale to the Commissioner on or before the date of first publication, posting or other notice.

(b) Upon receipt of notice of a judiciary or statutory sale, or a sale by other means as contained in the mortgage instrument, the Commissioner shall specify the amount which the mortgagee is to bid at the sale.

(1) The Commissioner will cause an appraisal of the property to be performed, in order to determine the property's fair market value.

(2) The Commissioner will determine the specified amount which the mortgagee will be required to bid at the foreclosure sale.

(3) The fair market value of the property and the specified amount to be bid will be given to the mortgagee prior to the sale.

(4) Upon the timely receipt of the fair market value and specified amount to be bid, the mortgagee may be required to advertise the upcoming sale in addition to the standard legal notices which may be required by state law. Advertising costs may be included in the claim for the insurance benefits.

(c) Where the mortgagee is the successful bidder for an amount not in excess of the bid amount specified by the Commissioner or as set out in § 203.368(d), the mortgagee may retain title to the property, or elect to convey title to the property to the Commissioner.

(1) If the mortgagee elects to convey title to the Commissioner, the amount of the claim is computed as set out in § 203.401(a).

(2) If the mortgagee elects to retain title, the amount of the claim is computed as set out in § 203.401(b).

(d) Where a party other than the mortgagee is the successful bidder, the amount of the claim is computed as set out in § 203.401(b).

(e) Where the mortgagee is the successful bidder for an amount in excess of the bid amount specified by the Commissioner, the mortgagee shall not have the option to convey title to the Commissioner. The amount of the claim is computed as set out under § 203.401(b).

(f) If the property is damaged, the mortgagee shall follow the claim procedure for the payment of the mortgage insurance benefits as if the commitment for the insured mortgage was issued prior to November 30, 1983.

(g) Sections 203.358 through 203.367 shall not be applicable to filing a claim for the insurance benefits when title to the property is not conveyed to the Commissioner.

(h) In filing a claim for insurance benefits when title is not conveyed to the Commissioner, the mortgagee shall assign to the Commissioner, without

recourse or warranty, any or all claims which the mortgagee has acquired in connection with the mortgage transaction and as a result of the foreclosure proceedings or other means by which the mortgagee or party other than the mortgagee acquired such property, except such claims as may have been released with the approval of the Commissioner.

(i) In filing a claim for the insurance benefits when title is not to be conveyed to the Commissioner, the mortgagee shall forward to the Commissioner:

(1) Fiscal data pertaining to the mortgage transaction;

(2) The original credit and security instruments, if available, or a deficiency judgment, if any, the latter being duly assigned or endorsed by the mortgagee, without recourse, to the Commissioner; and

(3) Any additional information or data which the Commissioner may require.

(j) The mortgagee shall retain all cash amounts held or deposited for the account of the mortgagor or to which it is entitled under the mortgage transaction that have not been applied in reduction of the principal mortgage indebtedness. Cash amounts shall be itemized and deducted from the claim balance. Receipts for disbursements are to be retained by the mortgagee and are to be made available upon request by the Commissioner.

(k) The mortgagee shall file its claim within 30 days after the date of the closing on the property.

8. By revising the heading of § 203.401, designating the present text of § 203.401 as paragraph (a), and adding a new paragraph (b) to read as follows:

§ 203.401 Amount of payment—conveyed and non-conveyed properties.

* * * * *

(b) In conjunction with paragraph (a), the amount of the insurance benefits shall be computed as follows:

(1) In cases where the mortgagee is the successful bidder as set out in § 203.369(c):

(i) If the mortgagee elects to retain title, the amount bid at the sale shall be deducted from the outstanding indebtedness under the mortgage, and the difference shall be added to the items set forth in § 203.402, less all items set out in § 203.403.

(ii) If the mortgagee elects to convey title to the Commissioner, the computation of the insurance benefits shall be made in accordance with paragraph (a) of this section.

(2) In cases where a party other than the mortgagee acquires title for an amount equal to or greater than the specified amount as established by the Commissioner, the proceeds of the sale shall be deducted from the outstanding indebtedness under the mortgage, and the difference shall be added to the items allowable under § 203.402, less all items set out in § 203.403.

(3) In cases where a party other than the mortgagee acquires title for an amount that is less than the specified amount as established by the Commissioner, the mortgage insurance payment is computed by subtracting the specified amount which is required to be bid at the sale from the outstanding indebtedness under the mortgage, and adding the difference to the items allowable under § 203.402, less all items set forth in § 203.403.

(4) In cases where the mortgagee is the sucessful bidder at the sale for an amount in excess of the specified amount as established by the Commissioner, the payment of the insurance benefits is computed by subtracting the amount bid at the sale from the outstanding indebtedness of the mortgage, and adding the difference to the items allowable under § 203.402, less all items set forth in § 203.403.

9. By revising the heading and introductory text of § 203.402 and by adding new paragraphs (l), (m), and (n) to read as follows:

§ 203.402 Items included in payment—conveyed and non-conveyed properties.

The insurance benefits paid in connection with foreclosed properties, whether or not conveyed to the Commissioner, and those properties conveyed to the Commissioner as the result of a deed in lieu of foreclosure, shall include the following items:

* * * * *

(l) Costs of appraisal under 203.369(b)(1).

(m) Costs of advertising under 203.369(b)(4).

(n) Costs of foreclosure as set out in paragraph (f) of this section where the acquiring party is a party other than the mortgagee, as provided in § 203.368(a)(2).

10. By revising the heading of § 203.403 to read as follows:

§ 203.403 Items deducted from payment—conveyed and non-conveyed properties.

* * * * *

11. By revising paragraph (a) of § 203.423 to read as follows:

§ 203.423 Distribution of distributive shares.

(a) The Commissioner may provide for the distribution to the mortgagor of a share of the participating reserve account:

(1) If the contract of insurance is terminated by conveyance to one other than the Commissioner and a claim for the insurance benefits is not presented by the mortgagee (§ 203.315);

(2) By the prepayment of the mortgage (§ 203.316); or

(3) By the voluntary agreement of the mortgagor and mortgagee, with the approval of the Commissioner (§ 203.317).

* * * * *

12. By adding a new paragraph (e) to § 203.478 to read as follows:

§ 203.478 Payment of insurance benefits.

* * * * *

(e) In cases involving a loan secured by a first mortgage that was insured pursuant to a commitment to insure on or after November 30, 1983, the lender shall follow the procedures as set out in §§ 203.350 through 203.369. The Commissioner shall pay the lender the insurance benefits as set out in §§ 203.400 through 203.404.

PART 220—URBAN RENEWAL MORTGAGE INSURANCE AND INSURED IMPROVEMENT LOANS

13. By revising § 220.350 to read as follows:

§ 220.350 Cross-reference.

(a) All of the provisions of §§ 203.440 through 203.495 of this chapter covering insured home improvement loans under section 203(k) of the Act shall apply to home improvement loans on one-to-four family dwellings under section 220(h) of the Act, except as set out in paragraph (b) of this section.

(b) The provisions of §§ 203.473(a) and 203.478(e) shall not be applicable to home improvement loans on one-to-four family dwellings under section 220(h) of the Act.

PART 228—INDIVIDUAL RESIDENCES: NATIONAL DEFENSE HOUSING MORTGAGE INSURANCE [Sec. 903]

14. By amending the heading and introductory test to § 228.290 to read as follows:

§ 228.290 Insurance benefits—conveyed and non-conveyed properties—foreclosure costs.

All of the provisions of § 203.402 of this chapter shall govern the computation of the items included in insurance benefits for conveyed and non-conveyed properties, except that in lieu of the allowance for foreclosure costs or for the costs of acquiring the property otherwise in paragraph (f) of § 203.402 for conveyed properties or in paragraph (f) and (n) of § 203.402 for

non-conveyed properties, there shall be included on account of such costs, in those cases involving mortgages on which the unpaid principal obligation at the time of the institution of foreclosure exceeds 80 percent of the appraised value of the property as the date the mortgage was accepted for insurance, an amount not in excess of the greater of the following:

* * * * *

(Sec. 7(d), Department of HUD Act (42 U.S.C. 3535(d)), Sec. 211, National Housing Act (12 U.S.C. 1715(b)), Sec. 204(a), National Housing Act (12 U.S.C. 1710(a))

Dated: November 30, 1984.

Maurice L. Barksdale,

Assistant Secretary for Housing—Federal Housing Commissioner.

[FR Doc. 85-617 Filed 1-9-85; 8:45 am]

BILLING CODE 4210-27-M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 264

[OSWER-FRL-2754-5]

Hazardous Waste Treatment, Storage, and Disposal Facilities; Availability of Information

AGENCY: Environmental Protection Agency.

ACTION: Notice of availability of information and request for comments.

SUMMARY: The Environmental Protection Agency today announces the availability of two draft Permit Guidance Manuals for public comment. These manuals are (1) *Permit Guidance Manual on Unsaturated Zone Monitoring for Hazardous Waste Land Treatment Units* (EPA/530-SW-84-016), and (2) *Permit Guidance Manual on Hazardous Waste Land Treatment Demonstrations* (EPA/530-SW-84-015). The first manual provides guidance on unsaturated zone monitoring for hazardous waste land treatment units. It can be used by permit applicants and permit writers to develop effective monitoring systems that comply with the Part 264, Subpart M regulations. The second manual provides guidance on treatment demonstrations that are required under § 264.272 for all owners and operators of hazardous waste land treatment units.

These manuals may be used for information and guidance by owners and operators of facilities that treat or dispose of hazardous waste in land treatment units. These manuals will assist in the implementation of the 40 CFR Part 264 hazardous waste management regulations by helping owners/operators and permit officials to design and carry out comprehensive treatment demonstrations and to develop effective unsaturated zone monitoring programs.

DATE: Comments on these draft permit guidance documents must be submitted on or before March 11, 1985.

ADDRESS: Comments should be addressed to Docket Clerk, Office of Solid Waste (WH-562), U.S. Environmental Protection Agency, 401 M Street, SW., Washington, D.C. 20460. All communications should identify the document title and publication number (e.g., *Permit Guidance Manual on Hazardous Waste Land Treatment Demonstrations* (EPA/530-SW-84-015)).

Copies of these draft guidance manuals are available for reading at the EPA Library Public Information Reference Unit (Room 2904) and the Subtitle C Docket Room (Room S212), both located at 401 M St. SW, Washington, D.C., 20460, as well as at all Regional Office Libraries, Monday through Friday during the hours of 9:00 a.m. to 4:30 p.m. A limited number of personal copies of the draft manuals may be obtained by calling the RCRA Hotline at (800) 424-9346 (toll free) or at (202) 382-3000.

FOR FURTHER INFORMATION CONTACT: RCRA Hotline, at (800) 424-9346 (toll free) or at (202) 382-3000. For technical information, contact Michael Flynn, Office of Solid Waste (WH-565E), U.S. Environmental Protection Agency, 401 M Street, SW., Washington, D.C. 20460, at (202) 382-4489.

SUPPLEMENTARY INFORMATION: Subtitle C of the Resource Conservation and Recovery Act (RCRA), Section 3004, required the Environmental Protection Agency (EPA) to promulgate regulations setting performance standards for owners and operators of facilities that treat, store, or dispose of hazardous waste. 40 CFR Part 265 contains the standards applicable to owners and operators of interim status facilities, while 40 CFR Part 264 contains permitting standards for new and existing facilities.

To help implement these standards, the EPA has developed a series of guidance documents. There are three types of documents: RCRA Technical Guidance Documents, Permit Guidance Manuals, and Technical Resource Documents. The Permit Guidance Manuals are directed to permit applicants and EPA/State permit writers. They describe the permitting process, present the regulatory requirements, and provide recommendations for the preparation of a permit application and the development of the resulting permit. Certain Permit Guidance Manuals also provide detailed technical and policy guidance on specific regulatory requirements that must be addressed in the facility's permit. The detailed policy guidance in these documents is an elaboration of the Agency's policy guidance already described in the preamble to the regulations.

Today's notice announces the availability of two draft Permit Guidance Manuals. These manuals are *Permit Guidance Manual on Hdzardous Waste Land Treatment Demonstrations* and *Permit Guidance Manual on Unsaturated Zone Monitoring for Hazardous Waste Land Treatment Units.*

Permit Guidance Manual on Hazardous Waste Land Treatment Demonstrations provides permit applicants and writers with guidance on land treatment demonstrations required under § 264.272. The manual identifies specific laboratory and field test methods that may be used to complete the demonstration, and describes the applicability of alternative treatment demonstration approaches and permitting procedures (e.g., short-term permit, two-phase permit, etc.) to various situations. The manual addresses numerous technical and policy questions regarding the overall approach to the demostration, the extensiveness of the demostration, and the permitting of land treatment units to accommodate the treatment demonstration.

Permit Guidance Manual on Unsaturated Zone Monitoring for Hazardous Waste Land Treatment Units is directed toward permit applicants and permit writers who are developing unsaturated zone monitoring programs for hazardous waste land treatment units required under § 264.278. This manual covers both soil core and soil pore-liquid monitoring. Equipment selection, installation, and operation, sampling procedures, chain of custody considerations, and data evaluation are all addressed. The installation and sampling procedures are presented in a step-by-step format so that the manual may be easily used by field personnel.

The Agency requests comments on the accuracy and completness of the information presented in these draft documents. EPA encourages commenters to suggest remedies and alternatives should inaccuracies or incompleteness be identified.

List of Subjects in 40 CFR Part 264

Hazardous materials Packaging and containers, Reporting and recordkeeping

requirements, Security measures, Surety bonds, Waste treatment and disposal.

Authority: Secs. 1006, 2002(a), 3004 and 3005 of the Solid Waste Disposal Act as amended by the Resource Conservation and Recovery Act of 1976, as amended (42 U.S.C. 6905, 6912(a), 6924, and 6925).

Dated: December 26, 1984.

Jack McGraw,

Acting Assistant Administrator for Solid Waste and Emergency Response.

[FR Doc. 85-704 Filed 1-9-85; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 73

[Gen. Docket No. 82-797; FCC 84-647]

Commission Policy Regarding the Advancement of Minority Ownership in Broadcasting

AGENCY: Federal Communications Commission.

ACTION: *Report and Order;* Denial of Proposed Rule.

SUMMARY: This *Report and Order* declines to adopt the change in Commission Rule § 73.1150 proposed in the *Notice of Proposed Rule Making* in Gen. Docket 82-797. Specifically, the Commission determined that allowing a seller-creditor to retain a reversionary interest in the license in a seller-financed sale of a broadcast property to a minority buyer is prohibited by the Communications Act of 1934, as amended. The Commission further concluded that permitting a seller-creditor to contractually guarantee a contingent right to reassignment of a broadcast license would be inadvisable as a matter of policy. The Commission found that such action would pose a serious threat to the ability of a minority buyer to freely and independently operate a broadcast station in the public interest.

FOR FURTHER INFORMATION CONTACT: Marcia C Alterman, Mass Media Bureau, (202) 632-7792.

SUPPLEMENTARY INFORMATION:

Report and Order (Proceeding Terminated)

In the Matter of Commission Policy Regarding the Advancement of Minority Ownership in Broadcasting; General Docket No. 82-797.

Adopted: December 21, 1984.

Released: January 8, 1985.

By the Commission.

1. Before the Commission for consideration are comments filed in response to the *Notice of Proposed Rule Making* ("*Notice*") in the above-captioned proceeding.[1] The *Notice* solicited comments with respect to permitting alternative security arrangements in seller-financed sales of broadcast properties to minorities.

Background

2. The Commission has long supported increased minority participation and ownership in the broadcast industry. Such participation benefits not only minorities, but the general public as well, by diversifying control of the media and thus the selection of available programming. Accordingly, the Commission is firmly committed to the goal of encouraging minority participation in the broadcast industry. In 1981, we created the Advisory Committee on Alternative Financing for Minority Opportunities in Telecommunications (Advisory Committee) in furtherance of this goal.[2] The Advisory Committee examined regulatory and economic conditions thought to hinder minority acquisition of telecommunication properties and its *Report*[3] offered a number of proposals designed to enhance minority ownership. Several of these proposals, such as the expanded use of distress sales and the broader availability of tax certificates, have already been adopted.[4] This *Report and Order* deals with the Advisory Committee's proposal concerning the possible expansion of seller-creditors' rights in seller-financed transactions.

3. The Advisory Committee found that obtaining "financing [particularly] has remained the greatest obstacle" to minorities' entrance and establishment in the telecommunications industry. In this regard, the Advisory Committee observed:

> many minority broadcasters do not know how to obtain financing and financial institutions have misconceptions about potential minority broadcasters. * * * [Also] the small or minority entrepreneur * * * does not have access to fixed rate long-term funds. As a result, that entrepreneur is subject to the vicissitudes of short-term rates.[5]

The Advisory Committee recommended that seller-financing, already prevalent in broadcast-sale transactions, be further encouraged "particularly since it is obviously one of the ways that minorities can obtain broadcasting properties."[6] Specifically, the Advisory Committee proposed the Commission expand the options accorded seller-creditors to include the right to retain a reversionary interest in the license of the station being sold.

4. The Commission's current Rule, found at 47 CFR 73.1150, prohibits agreements, express or implied, which permit a broadcast licensee to: (1) Retain an interest in the license; (2) claim a right to future assignment of the license; or (3) reserve a privilege to use the broadcast facilities, upon the sale or transfer of its interest in a station. In addition, as we observed in the *Notice*, the Communications Act of 1934, as amended, and longstanding Commission precedent, as affirmed by the United States Supreme Court, appear to support this prohibition.[7] However, the *Notice* also stated that:

> we believe it appropriate to inquire as to whether certain limitations could be removed, consistent with the provisions of the Communications Act, so as to further encourage the use of this financing tool, particularly where the transaction would enhance minority ownership of the mass media communications.

The *Notice* solicited comments from the public on this proposal, specifically inviting interested parties to address the following:

> the type of security interest that may be retained by a seller-creditor; whether that interest can or should include a reversionary interest in the license itself and the legal process, if any, that should be required before the creditor could exercise its reversionary interest.

Comments

5. Parties supporting the expansion of seller-creditors' rights argued that the proposed rule was necessary to stimulate minority acquisition of broadcast properties.[8] These commenters asserted that because the physical assets of a station rarely represent more than a small portion of the purchase price, reliance on a security interest in only those physical assets forces a seller-creditor to place his own capital at significantly greater risk. To minimize the risk associated

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[1] *Notice of Proposed Rule Making* in Gen. Docket 82-797, 48 FR 5976 (February 9, 1983).

[2] The Advisory Committee was comprised of leaders in both the private and public sectors of the financial and telecommunications communities.

[3] *Strategies for Advancing Minority Ownership Opportunities in Telecommunications:* The Final Report of the Advisory Committee on Alternative Financing for Minority Opportunities in Telecommunications to the Federal Communications Commission (May 1982) (hereafter "*Report*").

[4] *Commission Policy Regarding the Advancement of Minority Ownership in Broadcasting,* 48 FR 5943 (February 9, 1983) (hereafter "*Policy Statement*").

[5] *Report* at 25-26.

[6] *Notice* at 5976.

[7] For a detailed discussion, *see Notice* at 5977.

[8] Comments supporting the proposed rule were submitted by: Bone and Woods, Columbia Broadcasting Systems, Inc., and National Radio Broadcasters Association.

with severe under-collateralization, supporters of the proposed rule favored allowing a seller-creditor to retain a reversionary interest in the license. By allowing collateralization of the *actual* value of the station, *i.e.*, the physical assets plus the goodwill/going concern value, the Commission could provide an added inducement for the sale of broadcast properties to minority purchasers.

6. Columbia Broadcasting Systems, Inc. (CBS) contended that permitting a reversionary interest in a station in furtherance of important public policy goals would not confer a property right in the seller, but would merely create a priority of interests as between the seller and purchaser before the Commission. In the event of a default, CBS acknowledged that the transfer and return of the station to the seller would still require Commission approval.[9] Thus, CBS claimed, the proposed rule would not be in violation of the prohibition against a property right in the license itself. CBS also noted that the Commission could waive the multiple ownership rules if the seller had subsequently purchased another station, subject to the condition that the station be resold within a fixed time period.

7. National Radio Broadcasters Association (NRBA) urged easing current restrictions on seller-financed broadcast property transactions for all potential buyers, noting that the Commission has recognized the free transferability of broadcast stations to be in the public interest. Bone and Woods added that the scope of the rule making should be expanded to include third party financing in addition to seller-financing, to better enable minority broadcasters to obtain bank loans.

8. Parties opposing the expansion of seller-creditor's rights relied upon the Communications Act and long established Commission and judicial precedent which, they argued, conclusively negated the possibility of a reversionary interest in a broadcast license.[10] They noted that since there can be no property right in a broadcast license, it cannot be the subject of a reversionary interest. Furthermore, parties opposing the rule argued that no such reversion could occur absent formal application for transfer and an affirmative public interest finding by the Commission. To do otherwise, they warned, would permit a mortgage holder to circumvent the public interest standard by obtaining a license simply because a licensee defaulted on a mortgage.

9. Both the National Association of Black Owned Broadcasters (NABOB) and Citizens Communications Center (Citizens) also asserted that the rule would fail to achieve its intended purpose, and would, in fact, actually undermine the independence of minority owners. Specifically, Citizens warned that "[s]ince the benefits to the public of the minority ownership flow from the minority owner's control of the broadcast facility, these benefits would be reduced by allowing reversionary interests."[11] Citizens also noted that the operation of the seller's reversionary interest would foreclose the possibility of a new minority owner purchasing the broadcast property.

10. In addition to the above-noted objections, NABOB questioned whether the Commission can or should attempt to define its own standards for permitting foreclosure of a broadcast license, when creditors' rights upon foreclosure are generally governed by state law and the enforcement of creditors' remedies has traditionally been handled by the courts.

Discussion

11. As we recognized in the *Notice*, there is a longstanding and firmly established principle followed by the Commission,[12] and affirmed by the United States Supreme Court,[13] that a broadcast license does not confer a property right. Rather, it is a valuable, though limited, privilege to utilize the airwaves.

12. Since a broadcast license is not subject to ownership, it has not been subject to a reversionary interest, mortgage, lien, pledge, or any other form of security interest.[14] Section 301 provides, in pertinent part, that it is the purpose of the Act "to provide for the use of [radio transmission] channels, *but not the ownership thereof*, by persons for limited periods of time, under licenses granted by Federal authority, and no such license shall be construed to create any right, beyond the terms, conditions and period of the licensee [sic] * * *." (Emphasis added). Furthermore, section 304 of the Act requires applicants for licenses to "waive any claims to the use of any particular frequency * * * because of the previous use of the same, whether by license or otherwise." Section 309(h) requires station licenses to contain the following statement: "The station license shall not vest in the licensee any right to operate the station nor any right in the use of the frequencies designated by the license beyond the term thereof. * * *" Finally, section 310(d) of the Act requires Commission approval prior to the transfer, assignment or disposal of rights in a construction permit or station license. While we recognize that seller financing can facilitate minority entrance into the broadcast industry, the express language of the Communications Act, and the overwhelming precedent cited herein, leads us to conclude that any automatic reversionary interest in a license is prohibited.[15] We have been cited no precedent to the contrary, and we are aware of none. Moreover, although the *Notice* sought proposals on alternative security interests short of an automatic reverter, no specific proposals were made by the commenting parties in this regard. Thus, the record herein is insufficient to warrant authorization of any such alternative security arrangements.

13. Finally, as we recognized in the *Notice* herein, seller-creditors are not without protection. The Commission already recognizes and approves of

[9] NRBA also suggested that the reversionary interest could only be conveyed with Commission approval. Bone and Woods recommended, however, that the Commission approve the terms of the reversionary interest at the time of the initial transfer.

[10] Comments opposing the proposed rule were submitted by: National Association of Black Owned Broadcasters, National Association of Broadcasters, and Citizens Communications Center on behalf of Black Citizens for a Fair Media and National Association for Better Broadcasting.

[11] *See* Citizens Comments at p. 5.

[12] *Churchill Tabernacle v. FCC*, 160 F.2d 244 (D.C. Cir. 1947); *Radio KDAN, Inc.*, 11 F.C.C. 2d 934 (1968); *Bonanza Broadcasting Corp.*, 11 RR 2d 1072 (1967); *Yankee Network, Inc.*, 13 F.C.C. 1014 (1949); *Alabama Polytechnic Institute*, 7 F.C.C. 225 (1939); *Associated Broadcasters, Inc.*, 6 F.C.C. 387 (1938).

[13] *Ashbacker Radio Corp. v. FCC*, 326 U.S. 327, 331–332 (1945); *FCC v. Sanders Bros. Radio Station*, 309 U.S. 470, 475 (1940).

[14] In *Radio KDAN, Inc., supra* n.12, a contractual provision purporting to mortgage and create a reversionary interest in a license was declared void *ab initio*. The Commission recognized that "[t]he extraordinary notion that a station license issued by this Commission is a mortgageable chattel in the ordinary commercial sense is untenable." The Commission further noted that the sale or transfer of a bare license is prohibited. *See also Bonanza Broadcasting Corp., supra* n.12, and *Donald L. Horton*, 11 RR 2d 417, 420 (1967).

[15] As used herein, the term "automatic reversionary interest" is intended to connote an interest which passes solely by operation of law, and thus affords no opportunity for Commission review, upon the happening of some specified event such as default.

contractual arrangements whereby fifty percent or more of the stock of a corporate licensee may be pledged, if: (1) The licensee-borrower retains the voting rights in the stock and thus control of the station, and (2) in the event of default, the pledged stock is disposed of in a manner which would not restrict the sale to the seller-creditor, *e.g.*, at public auction. Moreover, 49.9 percent of the stock (representing the absence of positive or negative control) currently may be foreclosed without prior Commission approval, although it would not be legal for such a foreclosure to result in a change of actual control. Such arrangements provide additional financial security for lenders, without jeopardizing the independence of the licensee. To the extent that potential seller-creditors can fashion analogously protective yet beneficial mechanisms, we would welcome the opportunity to consider them.

14. In conclusion, the Commission is acutely aware of the lack of financing available to capitalize minority broadcast ventures. We have already undertaken various measures to enhance minority ownership, including expansion of the use of distress sales and the availability of tax certificates. We are committed to continuing our efforts in this area. However, for the reasons noted herein, we have decided to continue to rely on the alternatives currently available to minority buyers, rather than adopting the proposals contained in the *Notice*.

15. Pursuant to section 604 of the Regulatory Flexibility Act, 5 U.S.C. 604 *et seq.*, the Commission has prepared a Final Regulatory Flexibility Analysis in connection with this action and it is attached hereto as an Appendix.

16. Accordingly, it is ordered that, the above-captioned proceeding is terminated.

17. It is further ordered that, the Secretary shall cause a copy of this *Report and Order* to be printed in the FCC Reports.

Federal Communications Commission.

William J. Tricarico,

Secretary.

Appendix—Final Regulatory Flexibility Analysis

I. Reason for Action

In order to comply with the requirements of sections 301, 304, 309 and 310 of the Communications Act of 1934, as amended, we are retaining 47 CFR 73.1150 of the Commission's Rules without modification.

II. Summary of Issuance Raised by Public Comment in Response to the Initial Regulatory Flexibility Analysis, Commission Assessment, and Change Made as a Result

A. Issues Raised

Parties supporting expansion of seller-creditors' protections argued that allowing a seller-creditor to retain a reversionary interest in a broadcast license in seller-financed transactions would lead to increased minority ownership of broadcast properties. Those opposing the change in Commission Rule § 73.1150 argued that not only is the proposed modification barred by statute, but in fact, poses a substantial risk to the independent operation of minority-owned stations.

B. Assessment

The Commission has been persuaded by the arguments advanced by parties opposing the proposed change. While we recognize that seller-financed transactions may enable minority and other small business entrepreneurs to acquire broadcast properties, we are constrained by the Communications Act of 1934, as amended, from authorizing an automatic reversionary interest in a broadcast license. Futhermore, no alternative security arrangements short of an actual reverter were offered.

III. Significant Alternatives Considered and Rejected

No other alternatives were proposed.

[FR Doc. 85-732 Filed 1-9-85; 8:45 am]

BILLING CODE 6712-01-M

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47 CFR Part 73

[MM Docket No. 84-1314; RM-4804]

FM Broadcast Station in Sanibel, FL

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: Action taken herein proposes the substitution of Channel 253A for Channel 285A in Sanibel, Florida, in response to a petition filed by Harte-Hanks Radio, Inc. This substitution is requested to enable Station WRBQ, Tampa, Florida to relocate its transmitter.

DATES: Comments must be filed on or before March 11, 1985, and reply comments must be filed on or before March 26, 1985.

ADDRESS: Federal Communications Commission, Washington, D.C. 20554.

FOR FURTHER INFORMATION CONTACT: Arthur D. Scrutchins, Mass Media Bureau (202) 634-6530.

SUPPLEMENTARY INFORMATION:

List of Subjects in 47 CFR Part 73

Television broadcasting, Radio.

Proposed Rulemaking

In the matter of Amendment of § 73.202(b), Table of Assignments, FM Broadcast Stations (Sanibel, Florida) MM Docket No. 84-1314, RM-4804.

Adopted: December 19, 1984.

Released: January 3, 1985.

By the Chief, Policy and Rules Division.

1. The Commission has before it a petition for rule making filed by Harte-Hanks Radio, Inc. ("Harte-Hanks"), licensee of FM Station WRBQ, Channel 284, in Tampa, Florida, proposing to substitute Channel 253A for Channel 285A in Sanibel, Florida.[1]

Background

2. Harte-Hanks presently operates WRBQ from downtown Tampa. According to Harte-Hanks there has been and continues to be tremendous growth in the area adjacent to and surrounding its present antenna site. As a result of this rapid development, Harte-Hanks is concerned about the construction's cumulative obstruction to WRBQ's signal, possibly causing substantial shadowing problems and adversely affecting the quality of service provided within Tampa.

3. On July 14, 1983, Harte-Hanks filed a major change application to relocate WRBQ's transmitter and antenna to a predominately rural area, to increase the antenna height and to make related changes in the station's transmitting equipment. In its application, Harte-Hanks also requested a waiver of the Commission's spacing requirements since the proposed new site was 7.4 miles short spaced to the Sanibel allotment.[2] By letter dated October 28,

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[1] Presently there are 12 applicants for Channel 285A in Sanibel, Florida: Sanibel Broadcasting Co. BPH-830204AH; Hillebrand Broadcasting, Inc. BPH-830217AI; Island Sounds BPH-830714AQ; Buenos Aires Radio BPH-830531AK; High Tech Industries, Inc. BPH-830714AP; Gumbo Limbo Broadcasting, Co. BPH-830610AC; Sanibel Radio, Ltd. BPH-830622AF; Island Broadcasting, Inc. BPH-830713AA; Sanibel-Captiva FM Associates BPH-830714AL; Punta Ybel Communications BPH-830714AM; Sanibel Communications Company BPH-830714AN; Riviera Communications-Sanibel, Inc. BPH-830714AO.

[2] Due to limits imposed by the FAA, it is not possible for Harte-Hanks to increase WRBQ's antenna elevation at its present site in downtown Tampa.

1983, the Commission returned Harte-Hanks' application due to the short spacing stating that the waiver justification submitted was inadequate. Harte-Hanks, subsequently filed a petition for reconsideration, which is being treated as mutually exclusive with the Sanibel applicants and is still pending.

4. In the instant petition, Harte-Hanks seeks to substitute Channel 253A for Channel 285A at Sanibel, Florida. Harte-Hanks contends that favorable consideration of the instant petition will alleviate the problems presented by the construction of high rise buildings near WRBQ's facilities and render moot the complicated application, waiver request and petition for reconsideration presently before the Commission. Therefore, Harte-Hanks argues that the Commission should make a limited exception to its stated policy of not entertaining proposals to amend the FM Table of Assignments outside the context of Docket 84–231, due to the unique circumstances involved.

5. Harte-Hanks claims that the accelerated development of downtown Tampa, causes two major concerns: obstruction to the station's signal and the potential risk to persons working in nearby buildings. Harte-Hanks points out that the construction of numerous multi-story buildings will cause substantial shadowing problems, by obstructing the station's signal. Morever, the people occupying these new buildings may be subjected to prolonged exposure to relatively high levels of non-ionizing electromagnetic radiation.

6. Harte-Hanks concludes that grant of its petition would enable Station WRBQ to improve its facilities to provide maximum service to Tampa and would not adversely affect the interests of the pending applications for Channel 285A at Sanibel. If necessary, in order to facilitate the proposed changes, Harte-Hanks, will commit itself to reimburse the reasonable costs incurred by any or all of the Sanibel applicants in amending their applications to specify operation on Channel 253A instead of Channel 285A. On March 1, 1984, the Commission also adopted the *Notice of Proposed Rule Making* in Docket 84–231 which proposed the allotment of 684 new FM channels and deferred acceptance of petitions for rule makings which did not conflict with one or more of the proposed 684 communities, until after the proceeding was concluded. Harte-Hanks requests waiver of the present policy of not accepting petitions and consideration of its proposal to substitute Channel 253A for Channel 285A in Sanibel, Florida.

7. Under the circumstances presented, we agree that a waiver is warranted and the change in the FM Table of Assignments should be proposed for the following reasons. First, the proposed substitution would alleviate the need for further consideration of Harte-Hanks petition for reconsideration as a mutually exclusive proposal to the hearing concerning Sanibel, Florida, and facilitate the implementation of a first local broadcast service there. Second, all spacing requirements can be met to the site specified in the applications if Channel 253A is substituted for Channel 285A and there does not appear to be any adverse impact on the proposals under consideration in MM Docket 84–231. As for the allegation that continued operation from the present location could present a potential human safety risk that could be avoided by the relocation of the transmitter and antenna to a less populated site, further evaluation of that impact must await the development of objective standards.

8. By virture of this action accepting for consideration a petition filed after December 16, 1983, we do not intend to impair the effectiveness of the *Public Notice* of December 9, 1983. However we are convinced that it would be in the public interest to expedite processing of this particular proposal for the reasons stated.

9. Comments are invited on the proposals to amend the FM Table of Assignments, § 73.202(b) of the Commission's Rules, with regard to the following community:

	Present	Proposed
Sanibel, Florida	285A	253A

10. It is further ordered that the Secretary shall send copies of this *Notice of Proposed Rule Making* to the following:

1. Sanibel Broadcasting Co. c/o Terri Susan Pollack, P.O. Box 88864, Atlanta, GA 30338.

2. Hillebrand Broadcasting, Inc. c/o William A. Hillebrand, 4665 W. Bancroft St., Toledo, Ohio 43615.

3. Buenos Aires Radio c/o Rita C. Halley, 115 San Salvador St., Naples, FL 33942.

4. Gumbo Limbo Broadcasting, Inc. c/o Nancy Arthur, 5553 South Chester Ct., Englewood, CO 80111.

5. Pearlyn Ionie Miller, Esther H. Kays, Glen R. Thiessen d/b/a Sanibel Radio Ltd. c/o A.G. Thiessen, Suite 418, Uptain Building, Chattanooga, TN 37411.

6. Island Broadcasting, Inc. c/o Albert A. Jiles, 1810 NW 23rd Blvd. #196, Gainesville, FL 32605.

7. Sanibel-Captiva FM Associates c/o James Oyster, Esq., 1544 N. Edgewood St., Arlington, VA 22201.

8. Punta Ybel Communications c/o Mrs. Candice R. Colter, P.O. Box 542, Sanible, FL 33957.

9. Sanibel Communications Co. c/o Harold M. Kneller, Jr., 47 Wood Pond Road, West Hartford, CT 06107.

10. Communications-Sanibel, Inc. c/o Ann C. Farhat, Esq., 1000 Potomac St., NW., Suite 402, Washington, D.C. 20007.

11. High Tech Industries, Inc. c/o Theodore S. Oleck, 181 E. 87th St., Suite 201B, New York, NY 10028.

12. Island Sounds c/o Sophie G. Dirks, 62 Forest Avenue, Glen Ellyn, IL 60137.

Counsel: Robert G. Allen, Esq., Daly, Joyce, & Borsari, 1830 Jefferson Pl., N.W., Washington, DC. 20036.

13. Harte-Hanks Radio, Inc. c/o John G. Johnson, 1229 19th St., NW., Washington, DC 20036.

11. The Commission's authority to institute rule making proceedings, showings required, cut-off procedures, and filings requirements are contained in the attached Appendix and are incorporated by reference herein. NOTE: A showing of continuing interest is required by paragraph 2 of the Appendix before a channel will be assigned.

12. Interested parties may file comments on or before March 11, 1985, and reply comments on or before March 26, 1985, and are advised to read the Appendix for the proper procedures.

13. The Commission has determined that the relevant provisions of the Regulatory Flexibility Act of 1980 do not apply to rule making proceedings to amend the FM Table of Assignments, § 73.202(b) of the Commission's Rules. See, *Certification that sections 603 and 604 of the Regulatory Flexibility Act Do Not Apply to Rule Making to Amend §§ 73.202(b), 73.504 and 73.606(b) of the Commission's Rules*, 46 FR 11549, published February 9, 1981.

14. For further information concerning this proceeding, contact Arthur D. Scrutchins, Mass Media Bureau, (202) 634–6530. However, members of the public should note that from the time a Notice of Proposed Rule Making is issued until the matter is no longer subject to Commission consideration or court review, all *ex parte* contacts are prohibited in Commission proceedings, such as this one, which involve channel assignments. An *ex parte* contact is a message (spoken or written) concerning the merits of a pending rule making, other than comments officially filed at the Commission, or oral presentation required by the Commission. Any comment which has not been served on the petitioner constitutes an *ex parte*

presentation and shall not be considered in the proceeding. Any reply comment which has not been served on the person(s) who filed the comment, to which the reply is directed, constitutes an *ex parte* presentation and shall not be considered in the proceeding.

(Secs. 4, 303, 48 Stat., as amended, 1066, 1082; 47 U.S.C. 154, 303)

Federal Communications Commission.

Charles Schott,

Chief, Policy and Rules Division, Mass Media Bureau.

Appendix

1. Pursuant to authority found in section 4(i), 5(c)(1), 303 (g) and (r), and 307(b) of the Communications Act of 1934, as amended, and §§ 0.61, 0.204(b) and 0.283 of the Commission's Rules, it is proposed to amend the FM Table of Assignments, § 73.202(b) of the Commission's Rules and Regulations, as set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached.

2. *Showings Required.* Comments are invited on the proposal(s) discussed in the *Notice of Proposed Rule Making* to which this Appendix is attached. Proponent(s) will be expected to answer whatever questions are presented in initial comments. The proponent of a proposed assignment is also expected to file comments even if it only resubmits or incorporates by reference its former pleadings. It should also restate its present intention to apply for the channel if it is assigned, and, if authorized, to build a station promptly. Failure to file may lead to denial of the request.

3. *Cut-off Procedures.* The following procedures will govern the consideration of filings in this proceeding.

(a) Counterproposals advanced in this proceeding itself will be considered, if advanced in initial comments, so that parties may comment on them in reply comments. They will not be considered if advanced in reply comments. (See § 1.420(d) of the Commission's Rules.)

(b) With respect to petitions for rule making which conflict with the proposal(s) in this *Notice*, they will be considered as comments in the proceeding, and Public Notice to this effect will be given as long as they are filed before the date for filing initial comments herein. If they are filed later than that, they will not be considered in connection with the decision in this docket.

(c) The filing of a counterproposal may lead the Commission to assign a different channel than was requested for any of the communities involved.

4. *Comments and Reply Comments; Service.* Pursuant to applicable procedures set out in §§ 1.415 and 1.420 of the Commission's Rules and Regulations, interested parties may file comments and reply comments on or before the dates set forth in the *Notice of Proposed Rule Making* to which this Appendix is attached. All submissions by parties to this proceeding or persons acting on behalf of such parties must be made in written comments, reply comments, or other appropriate pleadings. Comments shall be served on the petitioner by the person filing the comments. Reply comments shall be served on the person(s) who filed comments to which the reply is directed. Such comments and reply comments shall be accompanied by a certificate of service. (See § 1.420 (a), (b) and (c) of the Commission's Rules.)

5. *Number of Copies.* In accordance with the provisions of § 1.420 of the Commission's Rules and Regulations, an original and four copies of all comments, reply comments, pleadings, briefs, or other documents shall be furnished the Commission.

6. *Public Inspection of Filings.* All filings made in this proceeding will be available for examination by interested parties during regular business hours in the Commission's Public Reference Room at its headquarters, 1919 M Street, NW., Washington, D.C.

[FR Doc. 85-729 Filed 1-9-85; 8:45 am]

BILLING CODE 6712-01-M

DEPARTMENT OF TRANSPORTATION

Federal Highway Administration

49 CFR Parts 390, 391, 392, 393, 394, 395, 396, 397, 398, and 399

[BMCS Notice No. 84-7]

Motor Carrier Safety Act of 1984; Submission of State Safety Regulations for Review: Initial Guidelines

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Public notice of guidelines to States.

SUMMARY: This notice provides the initial guidelines required by section 207(c) of the Motor Carrier Safety Act of 1984. Section 207(c) requires the Secretary of Transportation to issue initial guidelines, by December 30, 1984, to assist the States in compiling, analyzing, and submitting their commercial motor vehicle State safety laws and regulations and other information to the Secretary. Such information must be submitted to the Secretary by April 30, 1985.

EFFECTIVE DATE: January 10, 1985.

FOR FURTHER INFORMATION CONTACT: Mr. J.J. Fulnecky, Bureau of Motor Carrier Safety, (202) 426-0033; or Mr. Thomas P. Holian, Office of the Chief Counsel, (202) 426-0346, Federal Highway Administration, Department of Transportation, 400 Seventh Street SW., Washington, D.C. 20590. Office hours are from 7:45 a.m. to 4:15 p.m. ET, Monday through Friday.

SUPPLEMENTARY INFORMATION: This notice set forth the requirements of section 207 of the Motor Carrier Safety Act of 1984 (Pub. L. 98-554, 98 Stat. 2829) (the Act) that States submit to the Secretary and the Commercial Motor Vehicle Safety Review Panel (Safety Panel) all State laws and regulations pertaining to the safe operation of commercial motor vehicles in interstate or foreign commerce (not safety laws or regulations pertaining exclusively to intrastate operations).

Sections 207-209 of the Act call for the submission of all State rules and regulations pertaining to commercial motor vehicle safety to the Secretary and the Safety Panel. The Safety Panel will review those State laws and regulations and make certain recommendations to the Secretary. Pursuant to notice and comment rulemaking, the Secretary will further review those State laws and regulations and will determine which of them may remain in effect. Section 207 specifically directs the States, including the District of Columbia, to submit to the Secretary and the State Panel a copy of any State law or regulation, rule, standard, or order, including any law or regulation enacted or issued by any political subdivision of a State, pertaining to commercial motor vehicle safety.

For purposes of this review, *"commercial motor vehicle"* means any self-propelled or towed vehicle used on highways in interstate commerce to transport passengers or property (1) if such vehicle has a gross vehicle weight rating of 10,001 or more pounds; (2) if such vehicle is designed to transport more than 15 passengers, regardless of its gross vehicle weight rating and including school buses; or (3) if such vehicle, regardless of its gross vehicle weight rating, is used to transport hazardous materials in quantities requiring placarding under the Department's Hazardous Materials Regulations. *"Interstate commerce"* means trade, traffic, or transportation in the United States which is between a place in a State and a place outside of

such State (including a place outside the United States) or is between two places in a State through another State or a place outside of the United States. State laws or regulations strictly applicable to intrastate commerce are not included in this review.

Notice regarding the establishment of the Safety Panel by the Secretary pursuant to section 209 of the Act will be published separately in the **Federal Register**. The Secretary, or the Secretary's delegate, will serve as the Chairperson of the Safety Panel. Thus, submission of the information required by section 207 of the Secretary will constitute adequate submission to the Safety Panel. The information requested in this notice should be sent to the docket indicated above. Failure to submit copies of State laws or regulations, or other information requested in this notice, will result in separate reviews and analyses of such laws by the Safety Panel without the benefit of the State's views.

The ultimate objective of the reviews and analyses by the Safety Panel and the Secretary is to determine which State laws and regulations pertaining to commercial motor vehicle safety may remain in force and effect after October 30, 1989, and which must be preempted. In order to facilitate these reviews and analyses, States are requested, in addition to identifying and submitting copies of relevant States laws and regulations, to indicate, in writing, whether each State law or regulation identified has (1) the same effect; (2) is less stringent than; or (3) is additional to or more stringent than a regulation issued by the Secretary pertaining to commercial motor vehicle safety. These regulations issued by the Secretary are the Federal Motor Carrier Safety Regulations, 49 CFR Parts 390–399.

The States are requested to identify their laws and regulations, to analyze then for comparable stringency as outlined above, and to submit copies of the laws and regulations along with the results of their analyses to the docket indicated above. States are further asked to advise the Secretary of any factors, such as controlling precedents, administrative interpretation, etc., which the State believes should be considered in analyzing the State law or regulation. States are also encouraged to provide any other information a State may believe would be helpful to the Secretary or the Safety Panel in determining whether a State law or regulation should be permitted to remain in force and effect after October 30, 1989. The Secretary may supplement the guidance published in this notice or ask States for further information to assist the Secretary or the Safety Panel in their review and analyses.

This notice will also be transmitted by letter to the Governors of all 50 States and to the District of Columbia.

Guidelines

Guideline A. The compilation should include all State safety laws, regulations, rules, standards, or orders related to the subject matter of each of the Federal Motor Carrier Safety Regulations (FMCSR) (49 CFR Parts 390 through 399), be they identical (including those incorporated by reference) similar, different or inconsistent. A list of the Parts and Subparts of the FMCSR appears in Guideline E.

Guideline B. The compilation submitted to the Secretary and the Commercial Motor Vehicle Safety Regulatory Review Panel for evaluation *should not* contain: (1) Vehicle size and weight laws; (2) vehicle traffic laws unless they are unique in their applicability to commercial motor vehicles; nor (3) licensing or permit laws.

Guideline C. The compilation should include all State laws, rules, regulations, standards, or orders related to the safe operation of commercial motor vehicles in interstate commerce whether addressed by the FMCSR or not. This guideline applies to those laws, rules, regulations, standards, or orders in effect and also those about to be enacted, adopted, or issued.

Guideline D. To further assist the Secretary and the Commercial Motor Vehicle Safety Regulatory Review Panel in its evaluation process, each State law, regulation, rule, standard, or order must be analyzed from two standpoints, *stringency* and *applicability*.

"Stringency", as required by section 207(d)(1) of the Act, requires the State to indicate if the State requirement: (a) Has the same effect as; (b) is less stringent than; or (c) is additional to or more stringent than any requirement of the FMCSR. (As a convenience, the matrix chart shown at end of this guideline may be used).

When reviewing the State submission, it is vital that the Panel know to what extent the State requirement is applicable to both for-hire carriers (FH) and private carriers (P) or both.

It is suggested that the following chart (or a similar information matrix) be used to submit the comparative information required by the Act.

Date _____

Page ____ of ____ Pages

INTERSTATE COMMERCIAL MOTOR VEHICLE

(Name of State) State Safety Law Matrix Sheet

FMCSR Citation	State Citation	A	B	C	D	FH	P	Remarks
393.24 Req. for headlamps and aux. road lighting lamps.	12.32 Headlamps		x			x	x	(Example).

KEY—FMCSR (49 CFR 393.24); (State Revised Code); A (Same); B (Less stringent); C (More stringent); D (No Law); FH (For-hire Carriers); P (Private Carriers).

Guideline E. List of Parts and Subparts comprising the FMCSR (Title 49, Code of Federal Regulations, Parts 390 through 399):

Part 390—Federal Motor Carrier Safety Regulations:
General
- Subpart A—Definitions
- Subpart B—General/Applicability

Part 391—Qualifications of Drivers
- Subpart A—General/Applicability
- Subpart B—Qualifications and Disqualification of Drivers
- Subpart C—Background and Character
- Subpart D—Examinations and Tests
- Subpart E—Physical Qualifications and Examinations
- Subpart F—Files and Records
- Subpart G—Limited Exemptions

Part 392—Driving of Motor Vehicles
- Subpart A—General/Applicability
- Subpart B—Driving of Vehicles
- Subpart C—Stopped Vehicles
- Subpart D—Use of Lighted Lamps and Reflectors
- Subpart E—Accidents and License Revocation; Duties of Driver
- Subpart F—Fueling Precautions
- Subpart G—Prohibited Practices

Part 393—Parts and Accessories Necessary for Safe Operations
- Subpart A—General/Applicability
- Subpart B—Lighting Devices, Reflectors, and Electrical Equipment
- Subpart C—Brakes
- Subpart D—Glazing and Window Construction
- Subpart E—Fuel Systems
- Subpart F—Coupling Devices and Towing Methods
- Subpart G—Miscellaneous Parts and Accessories
- Subpart H—Emergency Equipment
- Subpart I—Protection Against Shifting or Falling Cargo

Part 394—Notification and Reporting of Accidents
Part 395—Hours of Service of Drivers
Part 396—Inspection, Repair, and Maintenance
Part 397—Transportation of Hazardous Materials; Driving and Parking Rules
Part 398—Transportation of Migrant Workers
Part 399—Employee Safety and Health Standards
Subpart A—K [Reserved]
Subpart L—Step, Handholds, and Deck Requirements for Commercial Motor Vehicles

These Parts and Subparts contain over 200 Sections which set forth each of the individual regulations to be used in the comparison of the State laws, regulations, rules, standards, or orders. A current copy of the FMCSR, with amendments, will accompany these guidelines to the Governor of each State.

Guideline F. Because the Motor Carrier Safety Act of 1984 provides time constraints for the Secretary's Commercial Motor Vehicle Safety Regulatory Review Panel to evaluate the requested compilation of State requirements, it is requested that the initial compilation and analysis be submitted as soon as possible. States are requested to submit immediately upon enactment, adoption, or issuance by the State, any State law or regulation that becomes effective after April 30, 1985.

(The Motor Carrier Safety Act of 1984, Pub. L. 98-554, 98 Stat. 2829, October 30, 1984, Title II, section 207)

Issued on: December 31, 1984.

Kenneth L. Pierson,

Director, Bureau of Motor Carrier Safety.

[FR Doc. 85-747 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-22-M

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49 CFR Parts 393 and 396

[BMCS Docket No. MC-113; Notice No. 84-9]

Parts and Accessories Necessary for Safe Operation and Inspection, Repair, and Maintenance

AGENCY: Federal Highway Administration (FHWA), DOT.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: The FHWA is seeking public comment concerning the development of Federal commercial motor vehicle inspection standards which would be applicable to motor carriers engaged in interstate or foreign commerce. This rulemaking action is required by section 210 of the Motor Carrier Safety Act of 1984. Section 210 of the Act also requires the Secretary to open Part 393 of the Federal Motor Carrier Safety Regulations (FMCSR), which concerns the parts and accessories necessary for the safe operation of commercial motor vehicles, for public comment and review.

DATE: Comments must be received on or before February 25, 1985.

ADDRESS: All comments should refer to the docket number that appears at the top of this document and must be submitted (preferably in triplicate) to Room 3404, Bureau of Motor Carrier Safety, 400 Seventh Street, SW., Washington, D.C. 20590. All comments received will be available for examination at the above address from 7:45 a.m. to 4:15 p.m., ET, Monday through Friday, except legal holidays.

FOR FURTHER INFORMATION CONTACT: Mr. J.J. Fulnecky, Bureau of Motor Carrier Safety (202) 426-0033; or Mrs. Kathleen S. Markman, Office of the Chief Counsel (202) 426-0346, Federal Highway Administration, Department of Transportation, 400 Seventh Street, SW., Washington, D.C. 20590. Office hours are from 7:45 a.m. to 4:15 p.m. ET, Monday through Friday.

SUPPLEMENTARY INFORMATION: On October 11, 1984, Congress passed the Motor Carrier Safety Act of 1984 (Pub. L. 98-554, 98 Stat. 2829) (the Act). The Act was signed into law by the President on October 30, 1984.

Background

This rulemaking action addresses section 210 of the Act, which requires the Secretary of Transportation to establish standards for the annual or more frequent inspection of all commercial motor vehicles engaged in interstate or foreign commerce which: (1) Have a gross vehicle weight rating of 10,001 pounds or more; (2) are designed to transport more than 15 passengers, including the driver; or (3) are used to transport hazardous materials in a quantity which requires the vehicle to be placarded. The current intent is that any inspection standards developed during the course of this rulemaking will be placed in Part 396 of the FMCSR, which provides for the adequate inspection, repair, and maintenance of commercial motor vehicles.

Section 210 of the Act also requires the Secretary to "initiate a rulemaking to afford interested parties an opportunity to comment on" Part 393 of the FMCSR. We are, therefore, addressing aspects of Part 393 of this rulemaking action.

The purpose for this document is to obtain guidance regarding Section 210. The successful completion of this rulemaking effort depends upon a diverse flow of viewpoints and supporting data to this public docket. The FHWA seeks detailed answers to the following requests for information. Failure to provide complete data may not permit the FHWA to adequately consider the merits of an interested party's position. Information which provides a rationale for a particular position on a question is very important, as is data which estimates the cost impacts and benefits of the action under consideration.

Section 210

By the passage of section 210, the Congress appears to have expressed its intent that there be general improvements in the commercial vehicle inspection programs currently in effect. Congress provided a number of guidelines and points of consideration which are discussed in the following paragraphs.

Section 210(b) requires the Secretary to establish Federal standards for both the systematic inspection of commercial motor vehicles and evidence that the inspections have been performed. The inspections are to be on at least an annual basis unless the Secretary finds that another inspection system is as effective. Public comment is requested regarding other inspection systems which would be as effective as an annual or more frequent inspection system.

Many motor carriers are currently permitted by State agencies to inspect their own fleet of motor vehicles. Would such a self-inspection program be as effective as another type of annual or more frequent inspection program? On what basis should a motor carrier be granted or denied the privilege of conducting a self-inspection program? Guidance is requested as the the level of training or qualification the individuals performing the inspection should have.

Many States presently require the periodic inspection of vehicles registered in that State. As evidence of successful completion of the inspection, a sticker is frequently placed on the vehicle. Since both units of a combination vehicle such as a tractor semi-trailer are required to be inspected, evidence that the semi-trailer has been inspected would be necessary. Comments are requested regarding this issue of evidence of inspection.

Currently, the FHWA field staff conducts an "essential element examination" (EEE) of vehicles selected for inspection during unannounced roadside checks. The EEE emphasizes

the inspection of certain vehicle components, the failure of which would likely cause an accident. In general, the inspection is restricted to an evaluation of the vehicle's brake system, suspension system, steering system, tires, wheels and rims. In the past, the field staff performed comprehensive inspections of motor vehicles, during which the entire motor vehicle was evaluated in terms of the vehicle requirements contained in Parts 393 and 396 of the FMCSR. These inspections generally required between 45 minutes to 1 hour to complete. It was for this reason that the FHWA modified its inspection procedures. With the EEE, which requires approximately 30 minutes to complete, the FHWA's limited field staff is able to inspect more vehicles.

At the present time, member States of the Commercial Vehicle Safety Alliance (CVSA) conduct roadside inspections of commercial motor vehicles operating in their respective States. The inspection is similar to the FHWA's EEE inspection program in that CVSA member States emphasize the inspection of a limited number of vehicle components which have been shown to contribute to accidents. Following a vehicle's successful completion of an inspection, a sticker is placed on the windshield of the power unit. This sticker is generally valid for 3 months. After the 3-month period expires, the vehicle may once again be selected by State personnel for inspection.

According to the provisions of section 210(d)(1)(D) of the Act, States participating in and enforcing the provisions of the CVSA requirements, may not be required by the provisions of section 402 of the Surface Transportation Assistance Act of 1982 (Pub. L. 97–424, 96 Stat. 2155; 49 U.S.C. 2302) (STAA) or the provisions of section 208 of this Act, to enforce the inspection standards developed during this rulemaking procedure. We invite public comment as to whether the Secretary should interpret this to mean that the Congress considered the CVSA/EEE (roadside) type of inspection to meet the "as effective as an annual or more frequent inspection system" requirement of section 210(b) of the Act, even though all components required by Part 393 of the FMCSR are not inspected.

Commenters should note that section 210(f) prohibits the DOT from requiring enforcement of the inspection standards developed during this rulemaking procedure in those States implementing the provisions of the CVSA program "if the Secretary determines that such Federal standards not having effect and being enforced with respect to such inspection is in the public interest and consistent with public safety". However, should the Secretary determine that the Federal standards not having effect and being enforced with respect to such CVSA inspection is *not* in the public interest and consistent with public safety, the options available to the Secretary are unclear. This is due to the fact that section 210(d)(1)(D) prohibits the use of the authority provided by section 402 of the STAA and section 208 of this Act, to require use of the Federal inspection standards developed in this rulemaking procedure by States implementing the CVSA inspection system. Comment with respect to this issue is requested.

Section 208 of the Act provides for the review and possible preemption of State regulations. According to the provisions of this section, if a State has a law or regulation which is less stringent than one issued under section 206 of the Act, the Secretary may preempt that State requirement. Consequently, a situation may arise where a State which is not part of the 402 funding program (known as the Motor Carrier Safety Assistance Program) will not have an inspection program or has a program that will likely be preempted in sixty months, as delineated in section 208(c)(3). What incentives can be offered to States to adopt either the inspection standards developed as a result of this rulemaking or an alternative program?

An alternative approach which would eliminate problems such as those described in the paragraph above would be to apply all regulatory requirements solely to the motor carrier industry. In essence then, it would be sole responsibility of the motor carrier to insure that they have complied with the inspection requirements developed in this rulemaking action. How this is accomplished would be the responsibility of the motor carrier. Where available, State inspection systems could be acceptable, along with the use of self-inspection programs. Public comment is requested concerning the merits of this proposal. Comment is also requested regarding the possible use of commercial garages, fleet leasing companies, major truckstops, and original equipment manufacturers by motor carriers to meet the Federal inspection standards and regarding the safeguards which should be imposed to insure the competency of the individual or organization performing the inspection.

Section 210(c) requires the Secretary to afford interested parties an opportunity to comment on Part 393 of the FMCSR, which concerns the parts and accessories necessary for safe operation. In essence, Part 393 is the basis for the vehicle inspection currently performed on vehicles operated by motor carriers subject to the jurisdiction of the DOT. We invite public comment regarding whether a need for revision of Part 393 exists. In the event a commenter recommends a revision of a section(s) now found in Part 393, it is important that detailed justification for the revision be submitted along with recommended language for the revision.

As an adjunct to the comments requested on Part 393, it is important to note that certain vehicle components presently evaluated during roadside vehicle inspections are not discussed in Part 393. In Part 396 of the FMCSR, which deals with inspection, repair, and maintenance issues, section 396.3(a)(1) requires motor carriers subject to the Regulations to ensure that all parts and equipment required by Part 393 are "in safe and proper operating condition at all times." This section goes on to require that the vehicle's other parts and accessories which may affect safety of operating, including the vehicle's (1) frame and frame assemblies, (2) suspension systems, (3) axles and attaching parts, (4) wheels and rims, and (5) steering systems, also be in safe and proper operating condition. Public comment is requested on the issue of expanding the present scope of Part 393 to include these 5 items.

According to the language of section 210(d)(1)(A) of the Act, a State is not to be prohibited "from imposing more stringent standards for use in their own periodic roadside inspection programs of commercial motor vehicles." Although section 210(d)(1) specifically prohibits the imposition of the authority contained in section 208, it should be noted that section 208(c)(4) permits the Secretary to prohibit continued enforcement of a more stringent law or regulation if:

(A) There is no safety benefit associated with such State law or regulation;

(B) Such State law or regulation is incompatible with the regulation issued under section 206; or

(C) Enforcement of such State law or regulation would be an undue burden on

interstate commerce. We invite public comment on this issue, including what action should be taken if a more stringent State inspection standard is found to clearly violate (A), (B), or (C) above.

Within the context of this rulemaking action, the FHWA is considering a petition filed by Prisoner Transport Service, Inc. of Titusville, Florida, which requested an exemption from the emergency egress requirements when a motor vehicle is transporting prisoners. The petitioner requested a waiver of § 393.61(b), bus windows; § 393.61(c), push-out window requirements; § 393.62, window obstructions; and § 393.63, window markings.

Prisoner Transport Service, Inc. provides transportation of local, State and Federal prisoners on a nationwide basis. Many of the prisoners are of maximum security classification and the remainder are all medium security. It is the petitioner's position that the matter of public safety far outweighs the remote possibility of injury to a prisoner, as a result of the inability to take advantage of the emergency egress provisions. Public comment is requested regarding the merits of this petition.

The FHWA has determined that this document contains neither a major rule under Executive Order 12291 nor a significant regulation under the regulatory policies and procedures of the Department of Transportation. A draft regulatory evaluation will be prepared based upon the data received in response to this notice.

Based on the information available to the FHWA at this time, the action taken in this rulemaking will not have a significant economic impact on a substantial number of small entities.

List of Subjects in 49 CFR Parts 393 and 396

Highways and roads, Highway safety, Motor carriers, Motor vehicle safety, Parts and accessories, Inspection, repair, maintenance.

(Catalog of Federal Domestic Assistance Program Number 20.217, Motor Carrier Safety)

(49 U.S.C. 3102; The Motor Carrier Safety Act of 1984, Pub. L. 98-554, 98 Stat. 2829 (October 30, 1984), Title II, section 210, 49 CFR 1.48 and 301.60)

Issued on: January 3, 1985.

Kenneth L. Pierson,

Director, Bureau of Motor Carrier Safety.

[FR Doc. 85-717 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-22-M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 17

Endangered and Threatened Wildlife and Plants; Proposal To Determine Cycladenia humilis var. jonesii To Be and Endangered Species

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule.

SUMMARY: The Service proposes to determine *Cycladenia humilis* var. *jonesii* (Jones cycladenia) to be an endangered species under the authority of the Endangered Species Act, as amended. There are three general areas where this taxon occurs in the Canyon Lands section of southeastern Utah, in Emery, Garfield, and Grand Counties. The four populations total less than 2,900 individuals; over half are on public land managed by the Bureau of Land Management (BLM). One major site is on State of Utah land, about 300 plants are on public land in the Glen Canyon National Recreation Area of the National Park Service (NPS), and one small population is possibly on private land. A fifth population may still occur in southern Utah or in Mohave County, Arizona, but is known only from an indefinite collection in 1882.

The taxon grows on low hills and outwash plains below mesas. The two larger populations are crisscrossed with vehicle tracks associated with mineral and/or oil and gas exploration. There is motorcycle disturbance to one of the smaller populations, and the risk of loss of the smallest population from erosion. This proposal, if made final, would implement protection provided by the Endangered Species Act of 1973, as amended. The Service is requesting comments on this action.

DATES: Comments from all interested parties must be received by March 11, 1985. Public hearing requests must be received by February 25, 1985.

ADDRESSES: Comments and materials concerning this proposal should be sent to the Regional Director, U.S. Fish and Wildlife Service, P.O. Box 25486, Denver Federal Center, Denver, Colorado 80225. Comments and materials received will be available for public inspection, by appointment, during normal business hours at the Service's Regional Endangered Species Division at 134 Union Boulevard, 4th floor, Lakewood, Colorado.

FOR FURTHER INFORMATION CONTACT: Dr. James L. Miller, Regional Botanist, Regional Endangered Species Staff, at either address above, 303-234-2496; FTS 234-2496.

SUPPLEMENTARY INFORMATION:

Background

Cycladenia humilis var. *jonesii* (Jones cycladenia) is a herbaceous perennial 10-15 centimeters tall, with clumps of bright green leaves and ". . . rosy flowers (that) somewhat resemble small morning-glories and have a charm that thrills the beholder" (Eastwood, 1942). Alice Eastwood described the plant in 1942 as *Cycladenia jonesii* based on a collection from the San Rafael Swell by Marcus E. Jones in 1914. Except for two other San Rafael Swell (Emery County) collections in the 1930's, this taxon was not seen again until a single plant was discovered by Dr. Stanley Welsh in 1968 in Castle Valley northeast of Moab (Grand County), about 65 miles east of the San Rafael Swell (Welsh, 1970). Land ownership of this site is unclear: it could be BLM, State or private. He and Dr. Duane Atwood later changed Jones cycladenia to varietal status (Welsh, Atwood and Reveal, 1975). During subsequent inventories in this new area, about 12-20 individuals were located in a third population on BLM land about 5 miles to the northeast of the second, along Onion Creek. These plants are growing in the lower edge of the pinyon-juniper community (5000-5500 feet) on sparsely vegetated siltstone hills of the Cutler Formation.

In 1979, James Harris, then a graduate student with Dr. Welsh (who was studying the flora of the San Rafael Swell), rediscovered Jones cycladenia in the area of the 1914 collection. There are at least 30 total acres of habitat in 2 sites 2 miles apart. The larger site with some 2,000 plants is on public land managed by the BLM, the other has some 500 plants on State of Utah land. This San Rafael Desert population, which is east of the San Rafael Reef and south of Interstate 70, consists of mostly mature plants, many of which are connected by underground stems. Therefore, the number of separate individual plants is hard to determine but is certainly lower than the number of "separate" above-ground stems. These plants are growing on sparsely vegetated gypsiferous clay hills, a habitat similar to the one in Grand County, but of a different formation (Summerville) at a different elevation (4600 feet) and hence in a different plant community: Mixed desert shrub with Mormon tea *(Ephedra torreyana)*, shrubby wild-buckwheat *(Eriogonum corymbosum)*, and other herbaceous perennials. A fourth population was found during the 1983 field season on

the Chinle Formation on and near the Purple Hills, west of Waterpocket Fold in the Glen Canyon National Recreation Area, Garfield County. This population is about 90 miles south of the first and consists of approximately 300 individuals on approximately two acres (Welsh, 1983, 1984a). A fifth population from further south in Utah or from northern Arizona (possibly the Pipe Spring area, Mohave County) may remain; it is known only from an 1882 collection by Siler, but the locality information is indefinite and the site has never been relocated (Holmgren, 1984; Welsh, 1984b).

Cycladenia humilis var. *jonesii* is the only member of its genus in the Intermountain West; the genus consists of only the one species with two or three additional varieties restricted to California. While the known occurrence of this taxon in three general areas over 60 miles apart with different geologic formations and elevations indicates some ecological amplitude, the populations are still quite localized and limited in number of individual plants.

The Canyon Land section of Utah has more plant endemics than any other portion of the State, about 70 taxa (Reveal, 1979). In addition to the *Cycladenia*, about 13 of these taxa are candidates for possible listing under the Endangered Species Act (48 FR 53639). The Canyon Lands are considered relatively ancient floristically, having "been less affected by the special conditions of recent changing [geological] epochs" (Holmgren, 1972, p. 103; cf. Reveal, 1979).

Threats to Jones cycladenia include oil and gas exploration at all populations, mineral explorations to the San Rafael Swell and Waterpocket Fold populations, motorcycle activity on the Onion Creek population, and erosion at Castle Valley. The San Rafael Swell and Waterpocket Fold populations are staked with mining claims and crisscrossed with vehicle tracks; the former is pockmarked from exploration, while the latter is near the major access road into the Moody Canyon oil lease area. Motorcycle use at the Onion Creek locale has caused denuded strips through the population. The single plant clump at Castle Valley is on the bank of a deep gully subject to erosion, and the area has been subject to bulldozer activity in the past.

Section 12 of the Endangered Species Act of 1973 directed the Secretary of the Smithosonian Institution to prepare a report on those plants considered to be endangered, threatened, or extinct. This report, designated as House Document No. 94–51, was presented to Congress on January 9, 1975. On July 1, 1975, the Director published a notice in the **Federal Register** (40 FR 27823) of his acceptance of this report as a petition within the context of section 4(c)(2) of the 1973 Act, and of his intention thereby to review the status of the plant taxa named within. On June 16, 1976, the Service published a proposed rule in the **Federal Register** (41 FR 24523) to determine approximately 1,700 vascular plant taxa to be endangered species pursuant to section 4 of the Act. This list was assembled on the basis of comments and data received by the Smithsonian Institution and the Service in response to House Document No. 94–51 and the July 1975 **Federal Register** notice. *Cycladenia humilis* var. *jonesii* was included [as *Cycladenia jonesii)* in the July 1975 notice (40 FR 27880) and the June 1976 proposal (41 FR 24527). General comments received in relation to the 1976 proposal are summarized in the April 26, 1978, **Federal Register** publication (43 FR 17909). Comments on this taxon that are received during the comment period for this new proposal will be summarized in the final rule.

The Endangered Species Act Amendments of 1978 required that all proposals over 2 years old be withdrawn. On December 10, 1979, the Service published a notice of the withdrawal of the still applicable portions of the June 1976 proposal along with other proposals that had expired (44 FR 70796). The July 1975 notice was replaced on December 15, 1980, by the Service's publication in the **Federal Register** (45 FR 82479) of a new notice of review for plants, which included *Cycladenia humilis* var. *jonesii* (45 FR 82501). No comments on this taxon have been received in response to the 1980 notice. On February 15, 1983, the Service published a notice in the **Federal Register** (48 FR 6752) of its prior finding that the petitioned action on this taxon may be warranted, in accord with section 4(b)(3)(A) of the Act as amended in 1982.

In the spring of 1981, new field work was carried out at the large San Rafael Swell population by Service botanists and Utah Native Plant Society members. This investigation showed that the population remains limited in known occurrence, and the impacts of mineral exploration continue. The Waterpocket Fold population and threats to it were discovered in 1983 during a survey for rare plants funded by the National Park Service. The Onion Creek population was checked in 1984.

On October 13, 1983, the petition finding was made that listing Jones cycladenia was warranted but precluded by other listing actions, in accordance with section 4(b)(3)(B)(iii) of the Act; notification of the finding was published in the January 20, 1984, **Federal Register** (49 FR 2485). Such a finding requires a recycling of the petition, pursuant to section 4(b)(3)(C)(i) of the Act. Therefore a new finding must be made; we find that the petitioned action is warranted and hereby publish the proposed rule to implement the action, in accord with section 4(b)(3)(B)(ii) of the Act.

Summary of Factors Affecting the Species

Section 4(a)(1) of the Endangered Species Act (16 U.S.C. 1531 *et seq.*) and regulations promulgated to implement the listing provisions of the Act to be codified at 50 CFR Part 424; see 49 FR 38900, October 1, 1984, set forth the procedures for adding species to the Federal lists. A species may be determined to be an endangered or a threatened species due to one or more of the five factors described in section 4(a)(1). These factors and their application to *Cycladenia humilis* Bentham var. *jonesii* (Eastwood) Welsh *et* Atwood, Jones cycladenia, are as follows:

A. *The present or threatened destruction, modification, or curtailment of its habitat or range.* Off-road vehicle use associated with mineral and oil and gas explorations and with recreation is impacting the habitat of *Cyclandenia himilis* var. *jonesii*. The tracks of bulldozers, trucks, and motorcycles have been observed in the area of the largest population [Anderson, 1981; Hreha and Geenwood, 1980). This San Rafael Swell habitat has been staked with mining claims. Although none of the claims have been developed and most may be simply speculative, the danger of future mining for uranium remains a possibility. Also, annual assessment work is required to maintain a valid claim. This assessment work is a continual disturbance to the habitat. Vehicle tracks and mining claims are also in evidence at the Waterpocket Fold population (Welsh, 1983). Motorcycle activity is particularly heavy in the midst of the small Onion Creek population.

Oil and gas leases have been issued either on or immediately adjacent to all population sites. Vehicle tracks in the San Rafael Swell and Onion Creek habitats may relate to the oil and gas leases, as well as mining exploration in the former habitat and recreation at the latter locale. Leases issued and pending adjacent to the population west of Waterpacket Fold indicate interest in tar sand development. Bulldozers were active in 1977 in the Castle Valley area

in connection with oil and gas exploration (Holmgren *et al.*, 1977; Welsh, 1978).

B. *Overutilization for commercial, recreational, scientific, or educational purposes.* Not known.

C. *Diseas or predation.* The solitary *Cycladenia* plant clump found in Castle Valley in 1968 was extant in 1984. It had been partially damaged by trampling from cattle when observed in 1980. Trampling also is a potential threat to the San Rafael Swell population because it is accessible to livestock, but the probability of serious damage is low.

D. *The inadequacy of existing regulatory mechanisms.* No Federal or State laws directly protect *Cyclandenia humilis* var. *jonesii* or its habitat. Although the BLM is aware of this taxon, it is not currently obligated to regulate activities so as to provide for the conservation of the *Cyclandenia*. the National Recreation Area is under management guidelines for multiple use, which could minimize surface disturbance but provide for mineral extraction. The Endangered Species Act offers possibilities for additional protection of this taxon through section 7 (interagency cooperation) requirements and through section 9, which prohibits removing and reducing to possession a plant from an area under Federal jurisdiction.

E. *Other natural or manmade factors affecting its continued existence.* The arid climate and harsh soils of the habitat of Jones cycladenia make its ecosystem a fragile one, easily degraded by surface disturbances and slow to recover its natural condition. The two populations at Onion Creek and Castle Valley may be reproducing only by vegetative propagation, and they are very small. They may have little genetic adaptability over time. The Castle Valley plant is on the bank of a gully subject to continuing erosion.

The Service has carefully assessed the best scientific and commercial information available regarding the past, present, and future threats faced by this taxon in detemining to propose this rule. Based on this evaluation, the preferred action is to list *Cycladenia himilis* var. *jonesii* as an endangered species. With less than 2,900 individuals known in four populations and the risk of damage to the *Cycladenia* and its habitat, endangered status seems an accurate assessment of the taxon's condition. It is not prudent to propose critical habitat because doing so would increase risk for the taxon, as detailed below.

Critical Habitat

Section 4(a)(3) of the Act, as amended, requires that to the maximum extent prudent and determinable, the Secretary designate any habitat of a species that is considered to be critical habitat concurrent with the determination that a species is endangered or threatened. The designation of critical habitat is not considered to be prudent when such designation would not be of benefit to the taxon involved (50 CFR 424.12). The Service finds that designation of critical habitat is not prudent for *Cycladenia humilis* var. *jonesii* at this time.

Critical habitat is not being proposed due to the possible threats to the taxon from vandalism and collecting. The potential for vandalism exists from the accessibility of the *Cycladenia* habitats to vehicles and the nature of the threats. In addition, the plant is attractive and conspicuous, and could be taken despite the Federal collecting prohibition discussed below because of the difficulty of enforcing it. For example, if critical habitat were designated, the population on State land would be part of it but the Federal collecting prohibition could not apply. Publication of critical habitat localities and maps would therefore increase the risk of vandalism and taking for all populations, and thus would be detrimental to the survival of the taxon and not a beneficial and prudent course of action. Federal and State agencies are aware of the taxon's locations.

Available Conservation Measures

Conservation measures provided to species listed as endangered or threatened under the Endangered Species Act include recognition, recovery actions, requirements for Federal protection, and prohibitions against certain practices. Recognition through listing encourages and can result in conservation actions by Federal, State, and private agencies, groups, and individuals. The Endangered Species Act provides for possible land acquisition and cooperation with the States, and requires that recovery actions be carried out for all listed species. Such actions are initiated by the Service as appropriate following listing. The protection required by Federal agencies and the prohibitions against taking and trade are discussed, in part, below.

Section 7(a) of the Act, as amended, requires Federal agencies to evaluate their actions with respect to any species that is proposed or listed as endangered or threatened. Regulations implementing this interagency cooperation provision of the Act are codified at 50 CFR Part 402, and are now under revision (see proposal at 48 FR 29990; June 29, 1983). Section 7(a)(4) requires Federal agencies to confer informally with the Service on any action that is likely to jeopardize the continued existence of a proposed species. If a species is listed subsequently, section 7(a)(2) requires Federal agencies to ensure that activities they authorize, fund or carry out are not likely to jeopardize the continued existence of such a species. If a Federal action may affect a listed species, the responsible Federal agency must enter into formal consultation with the Service. Possible effects from BLM and NPS activities are expected to be quite limited. Their management would be affected, but not to any great extent. The two agencies funded some of the field surveys on this taxon, and are aware of it for planning purposes. Restricting traffic to some existing roads and some fencing might be required, as well as special care in administering mining claims and oil and gas leases so that the taxon is accommodated in exploration or any development activity.

The Act and its implementing regulations found at 50 CFR 17.61, 17.62, and 17.63 set forth a series of general trade prohibitions and exceptions that apply to all endangered plant species. With respect to *Cycladenia humilis* var. *jonesii*, all trade prohibitions of section 9(a)(2) of the Act, implemented by 50 CFR 17.61, would apply. These prohibitions, in part, would make it illegal for any person subject to the jurisdiction of the United States to import or export, transport in interstate or foreign commerce in the course of a commercial activity, or sell or offer for sale this taxon in interstate or foreign commerce. Certain exceptions can apply to agents of the Service and State conservation agencies. The Act and 50 CFR 17.62 also provide for the issuance of permits to carry out otherwise prohibited activities involving endangered species under certain circumstances. No such trade in *Cycladenia humilis* var. *jonesii* is known. It is not anticipated that many trade permits would be sought or issued since this plant is not common in the wild or known in cultivation.

Section 2(a)(2)(B) of the Act, as amended in 1982, prohibits the removal and reduction to possession of endangered plant species from areas under Federal jurisdiction. This new prohibition would apply to Jones cycladenia. Permits for exceptions to this prohibition are available through section 10(a) of the Act, until revised regulations are promulgated to incorporate the 1982 amendments. Proposed regulations implementing this new prohibition were published on July 8, 1983 (48 FR 31417), and it anticipated that these will be made final following

public comment. The taxon occurs in large part on land managed by the BLM and NPS. It is likely that few collecting permits for the *Cycladenia* will be requested because it has only been of scientific interest. Requests for copies of the regulations on plants and inquiries regarding them may be addressed to the Federal Wildlife Permit Office, U.S. Fish and Wildlife Service, Washington, D.C. 20240 (703/235-1903).

If this taxon is listed under the Act, the Service will review it to determine whether it should be placed upon the Annex of the Convention on Nature Protection and Wildlife Preservation in the Western Hemisphere, which is implemented through section 8A(e) of the Act, and whether it should be considered for other appropriate international agreements.

Public Comments Solicited

The Service intends that any final rule adopted will be accurate and as effective as possible in the conservation of each endangered or threatened species. Therefore, any comments or suggestions from the public, other concerned governmental agencies, the scientific community, industry, or any other interested party concerning any aspect of these proposed rules are hereby solicited. Comments particularly are sought concerning:

(1) Biological, commercial trade, or other relevant data concerning any threat (or lack thereof) to *Cycladenia humilis* var. *jonesii*;

(2) The location of any additional populations of *Cycladenia humilis* var. *jonesii* and the reasons why any habitat of this taxon should or should not be designated critical habitat as provided by Section 4 of the Act;

(3) Additional information concerning the range and distribution of this taxon; and

(4) Current or planned activities in the subject areas and their possible impacts on *Cycladenia humilis* var. *jonesii*.

Final promulgation of the regulation on *Cycladenia humilis* var. *jonesii* will take into consideration the comments and any additional information received by the Service, and such communications may lead to adoption of a final regulation that differs from this proposal.

The Endangered Species Act provides for a public hearing on this proposal, if requested. Requests must be filed within 45 days of the date of the proposal. Such requests must be made in writing and addressed to the Regional Director, U.S. Fish and Wildlife Service (see **ADDRESSES** section above).

National Environmental Policy Act

The Fish and Wildlife Service has determined that an Environmental Assessment, as defined by the National Environmental Policy Act of 1969, need not be prepared in connection with regulations adopted pursuant to section 4(a) of the Endangered Species Act of 1973, as amended. A notice outlining the Service's reasons for this determination was published in the **Federal Register** on October 25, 1983 (48 FR 49244).

References Cited

Anderson, J. 1981. Trip Report—Field Trip with Larry England, Staff Botanist, Salt Lake City Area Office, U.S. Fish and Wildlife Service, Denver, Colorado.

Eastwood, A. 1942. New Western Plants IV. Leaflets of Western Botany 3:157-160.

Holmgren, A.H., L.M. Shultz, and J.S. Shultz. 1977. Report on Rare Plant Species for the BLM Moab, Utah District (Grand Resource Area). Utah State University, Logan, Utah.

Holmgren, N.H. 1972. Plant Geography of the Intermountain Region, pp. 77-161. *In* A. Cronquist, A.H. Holmgren, N.H. Holmgren, and J.L. Reveal. Intermountain Flora, Vol. 1. Hafner Publishing Co., New York.

Holmgren, N.H. 1984. *Cycladenia*, pp. 30-31. *In* A. Cronquist, A.H. Holmgren, N.H. Holmgren, J.L. Reveal, and P.K. Holmgren. Intermountain Flora, Vol. 4. New York Botanical Garden, Bronx.

Hreha, A.M., and L.R. Greenwood. 1980. Field Report of *Cycladenia* on the San Rafael Swell. Meiji Resource Consultants, Layton, Utah.

Reveal, J.L. 1979. Biogeography of the Intermountain Region. Mentzelia No. 4.

Welsh, S.L. 1970. New and Unusual Plants from Utah. Great Basin Naturalist 30:16-32.

Welsh, S.L. 1978. Status Report—*Cycladenia humilis* var. *jonesii*. U.S. Fish and Wildlife Service, Denver, Colorado.

Welsh, S.L. 1983. Personal communications to J.L. Miller, U.S. Fish and Wildlife Service, Denver, Colorado.

Welsh, S.L. 1984a. Flora of the Glen Canyon National Recreation Area, pp. 19-20. Glen Canyon National Recreation Area Research Management Team, Page, Arizona.

Welsh, S.L. 1984b. Personal communication to B. MacBryde, U.S. Fish and Wildlife Service, Washington, D.C.

Welsh, S.L., N.D. Atwood, and J.L. Reveal. 1975. Endangered, Threatened, Extinct, Endemic, and Rare or Restricted Utah Vascular Plants. Great Britain Naturalist 35:327-378.

Authors

The primary authors of this proposed rule are John Anderson, Endangered Species Staff Botanist, U.S. Fish and Wildlife Service, Grand Junction Field Office, Grand Junction, Colorado (303/243-2779) and Dr. Bruce MacBryde, then of the Service's Washington Office of Endangered Species. Dr. James L. Miller of the Service's Denver Endangered Species Staff served as editor.

List of Subjects in 50 CFR Part 17

Endangered and threatened plants, Endangered and threatened wildlife, Fish, Marine mammals, Plants (agriculture).

Proposed Regulation Promulgation

PART 17—[AMENDED]

Accordingly, it is hereby proposed to amend Part 17, Subchapter B of Chapter I, Title 50 of the Code of Federal Regulations as set forth below:

1. The authority citation for Part 17 reads as follows:

Authority: Pub. L. 93-205, 87 Stat. 884; Pub. L. 94-359, 90 Stat. 911; Pub. L. 95-632, 92 Stat. 3751; Pub. L. 96-159, 93 Stat. 1225; Pub. L. 97-304, 96 Stat. 1411 (16 U.S.C. 1531 *et seq.*).

2. It is proposed to amend § 17.12(h) by adding the following, in alphabetical order in the family Apocynaceae, to the List of Endangered and Threatened Plants:

§ 17.12 Endangered and threatened plants.

* * * * *

(h) * * *

Species		Historic range	Status	When listed	Critical habitat	Special rules
Scientific name	Common name					
* * *	*	*	*	*		*
Apocynaceae—Dogbane family:						
Cycladenia humilis var. *jonesii*	Jones cycladenia	U.S.A. (AZ, UT).	E		NA	NA
* * *	*	*	*	*		*

Dated: December 12, 1984.

G. Ray Arnett,

Assistant Secretary for Fish and Wildlife and Parks.

[FR Doc. 85-693 Filed 1-9-85; 8:45 am]

BILLING CODE 4310-55-M

Notices

Federal Register
Vol. 50, No. 7
Thursday, January 10, 1985

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

Agricultural Marketing Service

National Advisory Committee on Instrument Standards for Cotton; Renewal

Pursuant to the Federal Advisory Committee Act (Pub. L. 92–463), notice is hereby given that the Secretary of Agriculture has renewed the National Advisory Committee on Instrument Standards for Cotton. The purpose of the committee is to provide advice to the Secretary on the technical and scientific aspects of measuring cotton fiber quality with instruments, and to make recommendations with respect to the development and application of appropriate standards, callibration and measurement procedures. The committee will provide the Secretary with assistance in communicating between the Department and those who are directly affected by the ongoing transition from manual to instrument classing of cotton.

The Secretary has determined that the work of the committee is in the public interest and is in connection with the duties of the Department of Agriculture. No other advisory committee in existence is capable of advising and assisting the Department on the task assigned, nor does the Department have alternative means to obtain the technical and practical expertise needed from private industry.

For further information, contact: Dr. H.H. Ramey, Jr., Chief, Standards and Testing Branch, Cotton Division, Agricultural Marketing Service, U.S. Department of Agriculture, Washington, DC 20250, (202) 477–2167.

Dated: December 26, 1984.

Ernie Mathias,

Acting Assistant Secretary for Administration.

[FR Doc. 85–758 Filed 1–9–85; 8:45 am]

BILLING CODE 3410–02–M

Farmers Home Administration

Natural Resource Management Guide Meeting; Athens, GA

AGENCY: Farmers Home Administration, USDA.

ACTION: Notice of meeting.

SUMMARY: The Farmers Home Administration (FmHA) State office located in Athens, Georgia, is announcing a public information meeting to discuss its draft Natural Resource Management Guide.

DATES: Meeting on January 16, 1985, 1:00 p.m. to 3:00 p.m.

Comments must be received no later than February 15, 1985.

ADDRESSES: Meeting location at ASCS Conference Room, 355 East Hancock Avenue, Athens, Georgia

Written comments and further information will be addressed to: State Director, FmHA, 355 East Hancock Avenue, Athens, Georgia 30601 (404–546–2162).

All written comments will be available for public inspection during regular work hours at the above address.

SUPPLEMENTARY INFORMATION: FmHA's Georgia State Office State Office has prepared a draft Natural Resource Management Guide. The Guide is a brief document describing the major environmental standards and review requirements that have been promulgated at the Federal and State levels and that affect the financing of FmHA activities in Georgia. The purpose of the meeting is to discuss the Guide as well as to consider comments and questions from interested parties. Copies of the Guide can be obtained by writing or telephoning the above contact.

Any person or organization desiring to present formal comments or remarks during the meeting should contact FmHA in advance, it possible. It will also be possible at the start of the meeting to informally present brief, general remarks or pose questions. Additionally, a 30-day period for the submission of written comments will follow the meeting.

Dated: January 4, 1985.

David J. Howe,

Director, Program Support Staff.

[FR Doc. 85–760 Filed 1–9–85; 8:45 am]

BILLING CODE 3410–07–M

Natural Resource Management Guide Meeting; Mt. Holly, New Jersey

AGENCY: Farmers Home Administration, USDA.

ACTION: Notice of meeting.

SUMMARY: The Farmers Home Administration (FmHA) State Office located in Mt. Holly, New Jersey, is announcing a public information meeting to discuss its draft Natural Resource Management Guide.

DATES: Meeting on January 24, 1985, 2:00 p.m. to 4:00 p.m.

Comments must be received no later than February 23, 1985.

ADDRESSES: Meeting location at Conference Room, 100 High Street, Mt. Holly, New Jersey.

Written comments and further information will be addressed to: State Director, FmHA, Suite 100, 100 High Street, Mt. Holly, New Jersey 08060 (609–267–3090).

All written comments will be available for public inspection during regular work hours at the above address.

SUPPLEMENTARY INFORMATION: FmHA's New Jersey State Office has prepared a draft Natural Resource Management Guide. The Guide is a brief document describing the major environmental standards and review requirements that have been promulgated at the Federal and State levels and that affect the financing of FmHA activities in New Jersey. The purpose of the meeting is to discuss the Guide as well as to consider comments and questions from interested parties. Copies of the Guide can be obtained by writing or telephoning the above contact.

Any person or organization desiring to present formal comments or remarks during the meeting should contact FmHA in advance, it possible. It will also be possible at the start of the

meeting to make arrangements to speak. Time will be available during the meeting to informally present brief, general remarks or pose questions. Additionally, a 30-day period for the submission of written comments will follow the meeting.

Dated: January 4, 1985.

David J. Howe,

Director, Program Support Staff.

[FR Doc. 85-761 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-07-M

Federal Crop Insurance Corporation

[Doc. No. 1847S]

Offer To Provide Nursery Crops Reinsurance for Writers of Multiple-Peril Crop Insurance Policies

AGENCY: Federal Crop Insurance Corporation, USDA.

ACTION: Notice of offer to provide reinsurance for writers of multiple-peril crop insurance policies.

SUMMARY: The Federal Crop Insurance Corporation (FCIC) hereby gives notice to writers to multiple-peril crop insurance policies of an offer to provide reinsurance coverage on nursery crop insurance policies. The intended effect of this notice is to publish the Nursery Crops Reinsurance Agreement presently in effect for the information of all interested parties.

EFFECTIVE DATE: January 10, 1985.

ADDRESS: Written comments on this notice should be sent to the Office of the Manager, Federal Crop Insurance Corporation, Room 4096, South Building, U.S. Department of Agriculture, Washington, D.C., 20250.

FOR FURTHER INFORMATION CONTACT: Peter F. Cole, Secretary, Federal Crop Insurance Corporation, U.S. Department of Agriculture, Washington, D.C., 20250, telephone (202) 447-3325.

SUPPLEMENTARY INFORMATION: Section 508(e) of the Federal Crop Insurance Act (7 U.S.C. 1501 *et seq.*), as amended by Pub. L. 96-365 (September 26, 1980), authorizes and directs FCIC to offer reinsurance, to the maximum extent practicable, to writers of multiple-peril crop insurance.

Nursery Crops Reinsurance Treaty

Nursery Crops Reinsurance Agreement between the *Federal Crop Insurance Corporation* and the:

(company name)
of
(city, state).

The Federal Crop Insurance Corporation (FCIC) and the insurance company named above (Company) hereby agree as follows:

Section I. Business Reinsured

A. FCIC will reinsure, during the period of this Agreement, nursery crop insurance policies written or reinsured by the Company, which comply with the terms of this Agreement and the Federal Crop Insurance Act, as amended. The Company agrees to cede to FCIC all such policies.

B. Only policies issued on forms and at rates approved by FCIC will be reinsured under this Agreement.

C. Only policies issued in accordance with FCIC approved Plan of Operations for each reinsurance year will be reinsured under this Agreement. The Company must submit on FCIC's forms a proposed Plan of Operations to FCIC for approval before sales begin each reinsurance year. This Plan of Operations will provide information pertaining to the Company's proposed operations as may be requested by FCIC, including but not limited to the maximum premium volume to be reinsured, state and/or county lines of surplus reinsurance requested, and the identities of companies that will be reinsuring through the Company.

D. The Company may use other reinsurance for its net risk retention under this Agreement. If such other reinsurance is obtained by the Company, recoveries thereunder shall inure solely to the benefit of the Company.

Section II. Commencement and Termination

A. This Agreement shall become effective when signed by an authorized representative of each party. The liability of FCIC for any loss under this Agreement shall commence simultaneously with that of the Company. FCIC will accept reinsurance liability for otherwise complying policies written before the effective date of this Agreement but after October 1, 1984.

B. This Agreement shall continue in effect until terminated. It may be terminated by either party by providing written notice to the other before March 1 of any year. Termination will be effective at one minute past midnight Eastern Daylight Time on the following first day of July. FCIC's liability under this Agreement for policies whose period of coverage extends beyond the effective date shall remain in force until the termination of the coverage for that crop year as provided by those policies.

C. At any time, FCIC may suspend its obligation to continue acceptance of additional liability from the Company by providing written notice to the Company. However, the reinsurance liability of FCIC for polices reinsured hereunder that were issued by the Company before the suspension shall remain in force until the termination of the coverage for that crop year as provided by those policies.

Section III. Reinsurance Cessions and Premiums

A. FCIC's reinsurance liability shall be a percentage of the Company's ultimate net losses in accordance with the following Reinsurance Schedule, and determined according to the combined loss ratio for all of the Company's policies reinsured hereunder that have sales closing dates in the reinsurance year.

REINSURANCE SCHEDULE

Loss Ratio		Portion of ultimate net losses payable by FCIC (percent)
From—	To—	
0.00	25.00	100.00
25.01	120.00	80.00
120.01	160.00	90.00
160.01	200.00	95.00
200.01	500.00	98.33
500.01 and above		100.00

Example: If the net book premium for the reinsurance year was $200, and ultimate net losses were $260, the loss ratio would be 130. FCIC's reinsurance liability would then be calculated as follows:

Step 1: Calculation of loss in each loss ratio range.

(25.00 − 0.00) × $200 = $50
(120.00 − 25.01) × $200 = $190
(160.00 − 120.01) × $200 = $20*
(200.00 − 160.01 × $200 = $0
(500.00 − 200.01) × = $0
Above 500.00 = $0

*Total losses paid were $260, therefore only $20 can be shown in this loss ratio range and zero in the subsequent ranges.

Step 2: Calculation of FCIC liability.

$50 × 100.00% = $50
$190 × 80.00% = $152
$20 × 90.00% = $18
FCIC's liability is $220

B. The Company shall pay FCIC eighty-five (85) percent of net book premium as reinsurance premium.

C. Loss ratios will be computed to the nearest hundredth of a percent; with the numbers five (5) and above rounded upward and the numbers four (4) and below rounded downward.

Section IV. Expense Reimbursement and Premium Subsidy

A. FCIC shall provide the Company and administrative expense reimbursement equal to thirty (30) percent of net book premium on policies reinsured under this Agreement for the Company's administrative expenses.

B. It is expressly agreed that FCIC shall not be liable for any dividends; commissions; taxes; board, exchange, or bureau assessments; nor any other expenses of whatever nature by the Company, except as provided in this Agreement.

C. FCIC shall pay a portion of each producer's premium on the policies reinsured by this Agreement as authorized by the Federal Crop Insurance Act, as amended.

Section V. Remittances

A. The Company shall pay to FCIC, at the time of submission of each monthly or annual report or amendment thereto, eighty-five (85) percent of the net book premium due from sales of all policies during the preceding period, whether collected or not, plus or minus the following amounts:

1. Minus an amount equal to thirty (30) percent of net book premium, as a reimbursement for its administrative expenses; and

2. Minus FCIC's reinsurance liability for losses actually paid; and

3. Plus any interest charges or other amounts due to FCIC; and

4. Minus the subsidy for each producer's premium, as provided in this Agreement; and

5. Plus or minus adjustments to previous reports.

B. FCIC's share of losses shall be calculated on the basis of the known loss ratio as of the report date and shall be adjusted in each subsequent report as necessary.

C. When a report or amendment thereto shows a net balance due from FCIC to the Company, FCIC shall pay the amount due within fifteen (15) days after receipt of a complete and correct monthly or annual report or amendment thereto.

D. If the monthly or annual report or any amendment thereto shows a balance due FCIC the amount shown shall be remitted with the report. If a payment is delinquent, a simple interest charge of eighteen (18) percent per annum on said balance will be assessed. This interest will be calculated on a daily basis, using a 365-day year.

Section VI. Reports

A. Within thirty (30) days after the end of each month, the Company shall submit a monthly report to FCIC, on forms approved by FCIC, containing the following information on the reinsured policies for the reporting period:

1. The number of nursery crop insurance policies sold, with the report specifying the crop program insured, the total amount of coverage, and the net book premium for each; and

2. Producer's subsidy paid or payable by FCIC; and

3. The reimbursement for administrative expense paid or payable by FCIC; and

4. Ultimate net losses paid to and premiums collected from each insured; and

5. The name and address of each applicant refused coverage and the name and address of each insured whose coverage is cancelled by the Company; the reasons for each refusal or cancellation; and the crop programs, the total amount of coverage, and the net book premium for each.

B. Not later than November 1 of each year, the Company shall submit to FCIC an annual report containing the information required for the final settlement of the preceding reinsurance year's account.

C. All reports to FCIC shall be sent to the Director, Reinsurance Division, Federal Crop Insurance Corporation, USDA, P.O. Box 293, Kansas City, MO 64141.

Section VII. Loss Adjustment

A. The Company shall have the power, consistent with sound insurance practices, to settle, compromise, or contest by legal proceeding any claim; to engage in reasonable efforts to mitigate losses; and to employ any person, firm, or company in connection with any claim.

B. No person acting for the Company whose compensation is based on a percentage of sales will adjust losses; settle claims; or manage, supervise, or coordinate such adjustment or settlement.

C. If the Company recovers any amount against any claim and having included said claim payment in the Company's monthly or annual report to FCIC, the Company will include such recovery in the next monthly or annual report to FCIC; or, if the annual report has been filed, the Company will immediately amend that report.

D. At its own option and expense, FCIC, may cooperate with the Company in the adjustment of any claim or participate in any action brought against the Company or any of its agents with respect to any policy reinsured hereunder.

Section VIII. Field Underwriting

A. The Company is authorized to establish yield guarantees on each policy reinsured herein. The Company warrants that it will employ for this purpose field underwriting procedures approved by FCIC.

Section IX. Miscellaneous Clauses

A. No member of or Delegate to Congress and no Resident Commissioner shall be admitted to any share or part of this Agreement or to any benefit that may arise therefrom, except that this provision shall not be construed to apply to benefits from this agreement that accrue to a corporation for its general benefit. Nor shall this provision be construed to prohibit the solicitation of any application for crop insurance from a Member of or Delegate to Congress or from a Resident Commissioner.

B. The Company shall not discriminate against any employee, applicant for employment, insured, or applicant for insurance because of race, color, religion, sex, age, handicap, marital status or national origin.

C. The Company will hold FCIC harmless for any loss FCIC may incur as a result of the Company's conduct in the investigation, negotiation, defense, or handling of any claim or suit or in the servicing of any reinsured policyholder.

D. FCIC and the Comptroller General of the United States, or their duly authorized representatives, shall have access for the purpose of investigation, audit, and examination to any books, documents, papers, and records of the Company that are pertinent to this Agreement. The Company shall keep records that fully disclose all matters pertinents to this Agreement, including premiums and claims paid or payable under this Agreement. Records relating to premiums shall be retained and available for three (3) years after final adjustment of such premiums, and records relating to reinsurance claims shall be retained and available for three (3) years after adjustment of such claims.

E. Whenever any Company reinsured hereunder is unable to fulfill its obligations to its policyholders reinsured herein by reason of a directive duly issued by the Department of Insurance, Commissioner of Insurance, or similar authority of any jurisdiction to which the Company is subject, FCIC shall accept as direct insurance all policies affected by such directive, in force and subject to this agreement as of the date of such inability or failure to perform. In such event, FCIC will

assume all obligations for unpaid losses, whether occurring before or after the date of transfer. The Company shall immediately pay to FCIC all funds in its possession with respect to all such policies transferred, including but not limited to premiums collected, loss reserves, and twenty-five (25) percent of the administrative expense reimbursement specified in this agreement. The Company shall also immediately cede to FCIC the right to all producer's premiums then uncollected and the right to twenty-five (25) percent of the administrative expense reimbursement then unpaid by FCIC.

Section X. Definitions

A. "Incurred" as applied to losses or ultimate net losses shall mean losses to crops covered by reinsured policies during the period such policies are in force.

B. "Insured" means any person issued a policy of insurance reinsured under this Agreement.

C. "Loss Ratio" means the percentage computed by dividing the amount of ultimate net losses for the reinsured policies that have sales closing date occurring during the reinsurance year by the net book premium for the same period, and multiplying the result by one hundred (100).

D. "Net Book Premium" means premium payable by policyholders plus the associated premium subsidy payable by FCIC in accordance with the Federal Crop Insurance Act as amended, less cancellations and adjustments.

E. "Reinsurance year" means the period from July 1 of any year through June 30 of the following year.

F. "Sales closing date" means the date(s) approved by FCIC as the last date on which a producer may apply for multi-peril crop insurance on specific crops and in specific areas.

FCIC herewith publishes the terms and conditions of the Nursery Crops Reinsurance Agreement presently in effect advising all interested parties of an offer to provide nursery crops reinsurance for writers of multiple-peril crop insurance policies.

The purpose of this notice is to set forth the terms and conditions of the Nursery Crops Reinsurance Treaty as follows:

G. "Ultimate net loss" means the sum or sums paid by the Company (excluding all litigation and loss adjustment expenses) on policies reinsured under this Agreement in settlement of claims and in satisfaction of judgments rendered on account of such claims, after deduction of all recoveries by the Company. Liability of FCIC for any damages assessed against the Company arising out of its conduct in the handling of any claims or suits or in servicing its policyholders is specifically excluded from this Agreement. Nothing herein shall be construed to mean that losses incurred in accordance with this Agreement are not recoverable until the Company's ultimate net loss has been ascertained.

Approved and Accepted for

FCIC

(Signature)

(Name)

(Title)

(Date)

Company

(Signature)

(Name)

(Title)

(Date).

Done in Washington, D.C., on December 13, 1984.

Peter F. Cole,

Secretary, Federal Crop Insurance Corporation.

Dated: January 3, 1985.

Approved by:

Merritt W. Sprague,

Manager.

[FR Doc. 85-710 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-08-M

Soil Conservation Service

Kanawha Twomile Creek Watershed, WV; Deauthorization of Federal Funding

AGENCY: Soil Conservation Service, USDA.

ACTION: Notice.

SUMMARY: Pursuant to the Watershed Protection and Flood Prevention Act, Pub. L. 83-566, and the Soil Conservation Service Guidelines (7 CFR Part 622); the Soil Conservation Service Gives notice of the deauthorization of Federal Funding for the Kanawha Twomile Creek Watershed project, Kanawha County, West Virginia, Effective on November 29, 1984.

FOR FURTHER INFORMATION CONTACT: Rollin N. Swank, State Conservationist, Soil Conservation Service, 75 High Street, Room 301, Morgantown, WV, 26505, telephone: 304-291-4151.

(Catalog of Federal Domestic Assistance Program No. 10.904, Watershed Protection and Flood Prevention. State and local review procedures for Federal and federally assisted programs and projects are applicable)

Dated: January 2, 1985.

Rolin N. Swank,

State Conservationist.

[FR Doc. 85-709 Filed 1-9-85; 8:45 am]

BILLING CODE 3410-16-M

DEPARTMENT OF COMMERCE

International Trade Administration

[C-588-040]

Certain Fasteners From Japan; Preliminary Results of Administrative Review of Countervailing Duty Order

AGENCY: International Trade Administration/Import Administration, Commerce.

ACTION: Notice of Preliminary Results of Administrative Review of Countervailing Duty Order.

SUMMARY: The Department of Commerce has conducted an administrative review of the countervailing duty order on certain fasteners from Japan. The review covers the period January 1, 1983 through December 31, 1983.

As a result of the review, the Department has preliminarily determined the aggregate net subsidy to be 0.05 percent *ad valorem*, a rate the Department considers to be *de minimis*. Interested parties are invited to comment on these preliminary results.

EFFECTIVE DATE: January 10, 1983.

FOR FURTHER INFORMATION CONTACT: Al Jemmott or Lorenza Olivas, Office of Compliance, International Trade Administration, U.S. Department of Commerce, Washington, D.C. 20230; telephone (202) 377-2786.

SUPPLEMENTARY INFORMATION:

Background

On May 11, 1984, the Department of Commerce ("the Department") published in the **Federal Register** (49 FR 20041) the final results of its last administrative review of the countervailing duty order on certain fasteners from Japan (42 FR 23147, May 16, 1977; amended by 44 FR 31972, June 4, 1979) and announced its intent to conduct the next administrative review. As required by section 751(a)(1) of the Tariff Act of 1930 ("the Tariff Act"), the Department has now conducted that administrative review.

Scope of the Review

Imports covered by the review are shipments of all Japanese fasteners currently classifiable under items 646.5400 and 646.5600, and non-metric Japanese fasteners currently classifiable under items 646.1700, 646.4000, 646.4100, 646.4920, 646.4940, 646.5100, 646.5300, 646.5800, 646.6020, 646.6040, 646.6320, 646.6340, 646.6500, 646.7200, 646.7400, 646.7500, 646.7600, and 646.7800, of the Tariff Schedules of the United States Annotated. The review covers the period January 1, 1983 through December 31, 1983, and the following programs: (1) Benefits received under the "Temporary Measures Act for Small and Midsized Businesss with regard to the High Yen Exchange Market" ("High Yen Law"); (2) the deferral of income taxes on export earnings under the Overseas Market Development Reserve ("OMDR"); and (3) other loans given at preferential rates by the People's Finance Corporation, the Bank of Commerce and Industrial Cooperatives, the Small Business Finance Corporation, and the Japan Development Bank.

Analysis of Programs

(1) High Yen Law

The two methods of assistance available under the High Yen Law and previously used by the fasteners industry, loans at preferential rates and deferral of payment of interest on these loans, were terminated prior to the period of this review. Loans were for a period of six years and their benefits continued during 1983. The third method of assistance, special government credit guarantees, was not used by the fasteners industry. We have calculated the aggregate benefit from this program to be 0.002 percent *ad valorem*.

(2) OMDR

The Japanese government offers the OMDR program to firms with a total capitalization of 500 million yen or less. The program allows a firm the opportunity to set aside a portion of income earned on overseas operations. The amount set aside escapes taxation for up to 5 years. Twenty percent of the amount set aside must be returned to taxable income each year, and the total amount must be returned by the end of the fifth year. We have considered the taxes owed on these amounts set aside to be zero interest loans made by the government. We used as the benchmark the average short-term interest rate charged to small and medium sized enterprises as reported by the Japanese government. We have calculated the benefit under the OMDR program to be 0.50 percent *ad valorem*.

(3) Other Preferential Loan Programs

From information received from the Government of Japan, we conclude that the fasteners industry did not receive preferential loans during the period of review from the People's Finance Corporation, the Small Business Finance Corporation, the Bank of Commerce and Industrial Cooperatives, or the Japan Development Bank.

Preliminary Results of the Review

As a result of the review, we preliminarily determine the aggregate net subsidy to be 0.05 percent *ad valorem* for the period of review. The Department considers any rate less than 0.50 percent *ad valorem* to be *de minimis*. Therefore, the Department intends to instruct the Customs Service not to assess countervailing duties on any shipments of this merchandise exported on or after January 1, 1983 and on or before December 31, 1983.

Further, the Department intends to instruct the Customs Service to continue to waive the collection of a cash deposit of estimated countervailing duties, as provided for by section 751(a)(1) of the Tariff Act, on all shipments of this merchandise entered, or withdrawn from warehouse, for consumption on or after the date of publication of the final results of this administrative review. This deposit waiver shall remain in effect until publication of the final results of the next administrative review.

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 5 days after the date of publication. The Department will publish the final results of this administrative review including the results of its analysis of issues raised in any such written comments or at a hearing.

This administrative review and notice are in accordance with section 751(a)(1) of the Tariff Act (19 U.S.C. 1675(a)(1)) and § 355.41 of the Commerce Regulations (19 CFR 355.41).

Dated: January 3, 1985.

Alan F. Holmer,

Deputy Assistant Secretary, Import Administration.

[FR Doc. 85-736 Filed 1-9-85; 8:45 am]

BILLING CODE 3510-DS-M

[A-428-037]

Drycleaning Machinery From West Germany; Final Results of Administrative Review of Dumping Finding

AGENCY: International Trade Administration/Import Administration, Commerce.

ACTION: Notice of Final Results of Administrative Review of Dumping Finding.

SUMMARY: On December 14, 1981, the Department of Commerce published the preliminary results of its administrative review of the dumping finding on drycleaning machinery from the Federal Republic of Germany. The review covers the two known manufacturers and/or exporters of this merchandise to the United States and separate time periods for each firm through June 30, 1980.

We gave interested parties an opportunity to submit oral or written comments on the preliminary results. At the request of the exporters, we held a public hearing on February 8, 1982. Based on our analysis of the comments received, we have made adjustments to the dumping margins for both firms. The Department is deferring until the next review assessment of certain machines sold by one company as part of fully or partially equipped drycleaning establishments.

EFFECTIVE DATE: January 10, 1985.

FOR FURTHER INFORMATION CONTACT: Arthur N. DuBois, Office of Compliance, International Trade Administration, U.S. Department of Commerce, Washington, D.C. 20230; telephone: (202) 377-2209.

SUPPLEMENTARY INFORMATION:

Background

On November 8, 1972, the Treasury Department published in the Federal Register (37 FR 23715) a dumping finding with respect to drycleaning machinery from the Federal Republic of Germany. On December 14, 1981, the Department of Commerce ("the Department") published in the Federal Register (46 FR 60866-60869) the preliminary results of its administrative review of the finding. The Department has now completed that administrative review.

Scope of the Review

Imports covered by the review are shipments of drycleaning machinery, currently classifiable under item 670.4100 of the Tariff Schedules of the United States Annotated. The review covers the two known manufacturers and/or exporters of West German drycleaning machinery to the United

States, Seco Maschinenbau GmbH & Co. and Boewe Maschinenfabrik GmbH.

This review covers Seco for all time periods up through June 30, 1980, for which assessments instructions ("master lists") were not issued by the Treasury Department. The review for Boewe covers the one-year period from July 1, 1979, through June 30, 1980. We will analyze Boewe's sales of drycleaning machinery during previous unreviewed periods, and certain machines sold during the current review period as part of fully or partially equipped drycleaning establishment packages, in a subsequent administrative review.

Anaylsis of Comments Received

Interested parties were invited to comment on our preliminary results. At the request of the respondents, we held a hearing on February 8, 1982.

We received the following comments from the petitioner, Vic Manufacturing Company.

(1) *Comment.* The notice of preliminary results presented the Department's factual determinations. No submissions up to the time of publication of the preliminary results challenged the Department's findings. Since no submissions were made, the respondents cannot now argue against the Department's decision and the Department must not modify its decision.

Department's Position. The comment period after publication of the preliminary results of administrative review is the time the Department allows for interested parties to challenge its findings. The respondent firms correctly adhered to our procedures in requesting a hearing to comment on the Department's preliminary results.

(2) *Comment.* Both Seco and Boewe failed to provide timely submissions in response to the Department's questionnaire.

Department's Position. We generally do not accept data after publication of the preliminary results except when mitigating circumstances exist. In this case, we accepted data submitted by Boewe and its U.S. subsidiary, American Permac, Inc., after publication of the preliminary results only when it clarified previously submitted data. We did not accept Seco's additional data submitted after publication of our preliminary results. Seco failed to respond at all to our repeated requests for additional information during the review.

(3) *Comment.* Boewe's sales through independent agents to end-users in Germany are made at a comparable level of trade to the sales of Permac to distributors in the U.S.

Department's Position. We agree. See our position under Comment 28.

(4) *Comment.* The Department should verify that Permac engages in a practice of accepting trade-ins. No American manufacturer of drycleaning machinery deals with trade-ins or secondhand units. The U.S. manufacturer may allow a small discount, but no profit is made by the manufacturer or trade-ins.

Department's Position. See our position under Comment 15.

(5) *Comment.* The fact that the respondents have had to allocate their expenses on home market sales supports a finding that the expenses are indirect in nature.

Department's Position. If we determine that expenses are not directly related to sales, we do not allow them as circumstance-of-sale adjustments. In this case the circumstance-of-sale adjustments were based, when necessary, on reasonable allocations of selling costs shown in the product sales records of the narrowest corporate accounting unit. The Department maintains that allocated expenses may be considered direct selling expenses. *See Smith-Corona Group* v. *United States*, 713 F.2d 1568 (Fed. Cir. 1983).

We received the following comments from Seco and its related U.S. subsidiary, Multimatic Corporation.

(6) *Comment.* The Department should make adjustments for differences in the physical characteristics between U.S. and West German merchandise sold by Seco.

Department's Position. Wherever possible, based on the Seco submission, the Department compared merchandise sold in the U.S. with identical merchandise sold in the home market. Where there were no sales or offers for sale of identical mechandise in the home market, the Department chose for comparison the home market models most similar to the relevant U.S. models.

Seco did not provide cost data to support claimed adjustments for differences in the merchandise. Therefore, the Department made no such adjustments.

(7) *Comment.* The Department should not reduce the exporter's sales price ("ESP") by the amount provided in Multimatic's submission for "additional charges in Germany" related to those sales because such charges did not exist. The inclusion of such charges in the company's submission was pure clerical error.

Department's Position. Section 772(d)(2)(A) of the Tariff Act of 1930 ("the Tariff Act") requires that the Department reduce the U.S. price by charges incident to bringing the merchandise to the United States. In doing so, we included the amount for "additional charges in Germany" given in Multimatic's response to our questionnaire.

Six months prior to publication of our preliminary results, we asked Multimatic to provide additional information with regard to these expenses in Germany. We received no response to our request. Therefore, we have not accepted Multimatic's assertion.

(8) *Comment.* The Department's reduction of exporter's sales price for "technical, sales, administrative and warranty expenses" was too high. The amounts for these expenses are much lower than the amounts deducted by the Department.

Department's Position. The respondent provided no explanation of its claim that the expenses the Department used were too high. Therefore, the Department used the best information available; *i.e.*, the company's response, and deducted all selling expenses as direct selling expenses in calculating exporter's sales price.

(9) *Comment.* In calculating foreign market value, the Department should allow adjustments for differences in circumstances of sale.

Department's Position. Seco failed to provide adequate quantification for its claimed circumstance of sale adjustments. Therefore, we made no changes our calculations.

(10) *Comment.* Section 353.15(c) of the Commerce Regulations regarding ESP offsets is inapplicable since Seco incurs absolutely no selling expenses in the U.S.

Department's Position. While Seco may not directly incur selling expenses in the U.S., its related party, Multimatic, does incur such expenses. In an exporter's sales price comparison, the Department considers a related U.S. firm to be a selling arm of the foreign manufacturer and bases its comparisons on the (resale prices of the subsidiary.

(11) *Comment.* Seco and Multimatic relied on past Treasury practice in submitting their responses to the Department. The companies could not have known that their responses were inadequate.

Department's Position. In addition to the Department's original questionnaires (which differ from prior Treasury Department questionnaires), the Department in writing requested additional information from the two firms and clarification of their original responses. We received no reply. The Department notified the firms of inadequacies in their responses long

before publication of the preliminary results. Therefore, we disagree that the firms could reasonably rely on past Treasury practice or were unaware of inadequacies in their responses.

We received the following comments from Boewe and Permac.

(12) *Comment.* The Department should use average prices to calculate foreign market value rather than individual sales prices. This is consistent with past Treasury practice and the status permits such averaging. Further, the use of individual home market sales prices within a limited 135-day window is distortive.

Department's Position. The Department has decided to use weighted-average home market prices for the period of review. We have calculated these averages on a model-by-model basis for the two periods in which the price lists were in effect.

(13) *Comment.* The Department improperly used confirmation dates, rather than the dates of invoice and delivery, in establishing dates of sale for its foreign market value calculations.

Department's Position. It is long-standing Treasury Department and Commerce Department policy to use the date on which all the terms of sale, including price, are fixed. In this case the price was fixed on the confirmation date.

(14) *Comment.* The Department should uniformly allow Boewe's cash discounts as deductions from foreign market value since they are freely offered and generally granted.

Department's Position. The Department grants allowances for expenses actually incurred. Therefore, the Department allowed only those discounts that actually were given.

(15) *Comment.* The Department should accept as direct selling expenses on sales of new machines Boewe's losses on resales of trade-in machines. Boewe supported its claim with documentation in its pre-hearing brief.

Alternatively, if the Department continues to use individual, rather than weighted-average, home market prices, then the amount credited by Boewe for trade-ins should be treated as discounts in the home market. Similarly, the Department should accept Permac's profit on its trade-in business in the U.S. as a "negative selling expense" and increase United States price accordingly.

Department's Position. We do not consider profits and losses on the sales of any machines to be selling expenses, whether direct or indirect. Therefore, no adjustment is warranted.

Whether or not the Department uses individual sales as the basis for foreign market value, we do not consider the amount deducted from the price of a new machine for a trade-in to be a discount. The amount of that credit is a measure of the value to Boewe of the used machine.

(16) *Comment.* Boewe maintains that, in calculating foreign market value, the Department should accept its claims for bad debt expenses and credit insurance as direct selling expenses. Boewe supplied supporting documentation in its pre-hearing brief to show that these expenses were incurred for specific customers.

Department's Position. The Department maintains that the bad debt expenses are not direct selling expenses because they do not directly relate to the sales under consideration. Similarly, payment of premiums for credit insurance is not a direct selling expense.

(17) *Comment.* The Department should not treat advertising as a direct selling expense in its ESP calculation of United States price since the prior established practice in this case was to treat such advertising as an indirect selling expense.

Department's Position. Permac provided adequate clarification of the amounts claimed. Therefore, we have decided to accept advertising as an indirect selling expense.

(18) *Comment.* The Department should allow Boewe's warranty/guarantee expenses as direct circumstance-of-sale adjustments. The Department now has all documentation necessary to support Boewe's claim.

Department's Position. Boewe provided clarification of the amounts claimed for direct selling expenses. Therefore we have decided to allow the warranty/guarantee expense adjustment.

(19) *Comment.* The Department should accept product maintenance (product recall) expenses as a direct circumstance-of-sale adjustment. Boewe supported its claim with copies of representative service reports which show that product maintenance is not research and development, but rather the repair of defects discovered in machines already sold.

Department's Position. We agree that, since such repair expense is similar to a warranty expense, it should be allowed as a circumstance-of-sale adjustment.

(20) *Comment.* The Department should accept Boewe's claim that the expenses it incurs in maintaining the service department are direct selling expenses. Boewe submitted source documentation to support its claim.

Department's Position. We do not consider the expenses incurred in maintaining Boewe's service department to be direct selling expenses. Boewe's customers pay for the claimed service. The Department considers the costs of maintaining the service department to be overhead and, therefore, indirect expenses, and has included them in its calculation of the ESP offset.

(21) *Comment.* In calculating foreign market value, the Department should allow Boewe's warehousing expenses as direct selling expenses. These expenses relate to machines covered by specific confirmations, *i.e.*, expenses which the Department should consider to be after-sale direct selling expenses. However, if the Department agrees with Boewe that a confirmation does not constitute a sale, then warehousing expenses should continue to be treated as indirect selling expenses.

Department's Position. Boewe has not established that its warehousing expenses directly relate to the sales under consideration. Thus, the Department does not consider these warehousing expenses to be direct selling expenses. Further, the Department does not consider these specific warehousing expenses in Germany to be selling expenses at all and has not included them in its calculation of the ESP offset. See Comment 13 for our position on confirmations and the date of sale.

(22) *Comment.* In calculating the ESP offset the Department should allow Boewe's claimed "traffic" expenses as indirect selling expenses. The traffic department, which is responsible for arranging for freight, insurance, transportation and the like, provides an essential service which is integrally related to the sale of these machines in the home market.

Department's Position. Boewe incurs traffic expenses in the home market on its sales to all markets. Since Boewe was unable to properly quantify the portion of traffic expenses incurred on home market sales, we did not include this expense as an indirect selling expense.

(23) *Comment.* The Department should allow Boewe's "management" expenses as indirect selling expenses. The expenses reported for management do not differ from expenses reported for sales personnel under the category of sales office expenses, except that the management expenses are limited to the sales-related work of company officers.

Department's Position. The Department considers expenses incurred for corporate officers not directly involved in the company's sales function to be corporate overhead expenses, not selling expenses. Therefore, the Department has not included an

adjustment for "management" expenses in its calculations.

(24) *Comment.* Congress intended that all selling expenses be deducted in calculating foreign market value. The division of selling expenses into direct and indirect expenses is not authorized by statute, nor is the ESP offset cap.

Department's Position. The Court of International Trade recently found support for our practices regarding the division of selling expenses into direct and indirect expenses.

The Department is aware that the Court of International Trade has held that the offset cap is arbitrary and beyond the Department's authority. See *Silver Reed Americ, Inc.* v. *United States*, 581 F. Supp. 1290, 1294–95 (CIT 1984); however, we are appealing the decision by the Court of International Trade and will continue to use the ESP offset cap unless we lose our appeal.

(25) *Comment.* For certain transactions, the Department should make adjustments for differences in physical characteristics, preferably based on price differentials, but at least based on cost differences supplied since publication of the preliminary results.

Department's Position. We determined that, for comparisons with U.S. sales, sales of identical merchandise took place in the home market. Therefore, no adjustments for differences in the merchandise are necessary.

(26) *Comment.* Commissions should be allowed as direct selling expenses. Commissions are paid in both markets. Therefore, the special rule regarding commission offsets under § 353.15(c) of the Commerce Regulations, does not apply.

Department's Position. We agree that commissions paid in both markets are direct selling expenses. Because commissions were paid in both markets during the period of review we will not apply the "special rule" under § 353.15(c), but instead will adjust for differences in commissions in accordance with § 353.15(b).

(27) *Comment.* The Department should accept Boewe's "special account" as a direct circumstance-of-sale adjustment, or as a discount, rather than as a commission. The "special account" is an account under a selling agent's control used primarily to grant discount to customs. Amounts not used in this manner eventually revert to the agent as a bonus.

Department's Position. We now agree that the "special account" is not a commission. However, the Department maintains that only the discount portion of the "special account" is an allowable expense. We have recalculated the results accordingly.

(28) *Comment.* Boewe argues that the Department is required to make a level of trade adjustment for comparisons with its U.S. sales to distributors. The company only sells to end-users in the home market. The Department should base its adjustments on: (1) Boewe's sales to distributors in Austria, or on (2) Boewe's sales in West Germany through agents to end-users.

Department's Position. In terms of function in the marketplace, Permac's distributor customers and Boewe's agents are at a comparable level of trade. The Department has compared Permac's sales to distributors with Boewe's sales in West Germany through agents to end-users, in accordance with § 353.19 of the Commerce Regulations. When there were no contemporaneous home market sales through agents, we compared sales to distributors in the U.S. with direct sales to end-users in the home market, with no adjustment for level of trade differences in the absence of adequate quantification of such differences.

(29) *Comment.* The Department should accept Boewe's claim for research and development ("R & D") as an indirect selling expense. Boewe also maintains that one-third of the R & D amount claimed is allowable as a difference in circumstances of sale. According to Boewe, at least one-third of the R & D relates specifically to compliance with German and European health, safety, and environmental requirements.

Department's Position. The Department maintains that Boewe's general R & D is an overhead expense related to production of drycleaning machines, not a selling expense. Further, Boewe has not established that differences in the circumstances of sale between the U.S. and home markets exist as a result of research and development incurred to comply with health, safety, or environmental requirements, nor has Boewe adequately quantified the amount attributable to such requirements. Therefore, the Department has disallowed these claimed adjustments.

(30) *Comment.* Boewe claims that the amount of general and administrative expenses ("G & A") claimed as selling expenses was too low in that it only included the direct cost for three cost centers: sales manager, assistant sales manager, and sales planning. Boewe initially failed to include any provision for bookkeeping, accounting, computer support, product design, security, or any other G & A expenses.

Department's Position. Boewe did not adequately demonstrate the specific relationship of these additional claims to the sales function; therefore, we disallowed these claims.

Final Results of the Review

After analysis of the comments received and correction of certain clerical errors, we have changed the margins for the two firms:

Manufacturer and/or exporter	Time period	Margin (percent)
Boewe Maschinenfabrick GmbH.	7/1/79–6/30/80.	30.05
Seco Maschinenbau GmbH & Co.	1/1/78–6/30/80.	3.94

The Department shall determine, and the U.S. Customs Service shall assess, antidumping duties on all appropriate entries. Individual differences between United States price and foreign market value may vary from the percentages stated above. The Department will issue appraisement instructions on each exporter to the Customs Service.

Further, as provided by § 353.48(b) of the Commerce Regulations, a cash deposit of estimated antidumping duties based on the above margins shall be required for these firms. For future entries from a new exporter not covered in this or prior reviews, whose first shipments occurred after June 30, 1980, and who is unrelated to any reviewed firm, a cash deposit of 30.05 percent shall be required. These deposit requirements are effective for all shipments of the Federal Republic of Germany drycleaning machinery entered, or withdrawn from warehouse, for consumption, on or after the date of publication of this notice and shall remain in effect until publication of the final results of the next administrative review.

The Department encourages interested parties to review the public record and submit applications for protective orders as early as possible after the Department's receipt of the requested information.

This administrative review and notice are in accordance with section 751(a)(1) of the Tariff Act (19 U.S.C. 1675(a)(1)) and § 353.53 of the Commerce Regulations (19 CFR 353.53).

Alan F. Holmer,

Deputy Assistant Secretary for Import Administration.

January 3, 1985.

[FR Doc. 85–698 Filed 1–9–85; 8:45 am]

BILLING CODE 3510–25–M

[A-588-005]

High Power Microwave Amplifiers and Components Thereof From Japan; Final Results of Administrative Review of Antidumping Duty Order

AGENCY: International Trade Administration/Import Administration, Commerce.

ACTION: Notice of Final Results of Administrative Review of Antidumping Duty Order.

SUMMARY: On June 19, 1984, the Department of Commerce published the preliminary results of its administrative review of the antidumping duty order on high power microwave amplifiers and components thereof from Japan. The review covers the one known exporter of this merchandise to the United States and the period July 1, 1982, through June 30, 1983.

During disclosure of our methodology to the exporter, we discovered an error in our calculation of constructed value. We corrected the error and, based on our revised analysis, found no dumping margins for the period. We gave interested parties an opportunity to submit oral or written comments on the preliminary and revised results. We received comments from the petitioner regarding the results. After review of the comments, and as a result of our correction, we determined that no dumping margins exist for the period.

EFFECTIVE DATE: January 10, 1985.

FOR FURTHER INFORMATION CONTACT: Laurie A. Lucksinger or Robert J. Marenick, Office of Compliance, International Trade Administration, U.S. Department of Commerce, Washington, D.C. 20230; telephone: (202) 377-1130/5255.

SUPPLEMENTARY INFORMATION:

Background

On June 19, 1984, the Department of Commerce ("the Department") published in the **Federal Register** (49 FR 25020) the preliminary results of its administrative review of the antidumping duty order on high power microwave amplifiers and components thereof from Japan (47 FR 31413-31414, July 20, 1982). The Department has now completed that administrative review in accordance with section 751 of the Tariff Act of 1930 ("the Tariff Act").

Scope of the Review

Imports covered by the review are shipments of high power microwave amplifiers and components thereof. High power microwave amplifiers are radio-frequency power amplifiers assemblies and components thereof, specifically designed for uplink transmission in C, X, and Ku bands from fixed earth stations to communications satellites and having a power output of one kilowatt or more. High power microwave amplifiers may be imported in subassembly form, as complete amplifiers, or as a component of higher level assemblies (generally earth stations). This merchandise is currently classifiable under item 685.29 of the Tariff Schedules of the United States.

The review covers the one known exporter of Japanese high power microwave amplifiers and components thereof to the United States, NEC Corporation, and the period July 1, 1982 through June 30, 1983. During the period NEC Corporation shipped only components.

Analysis of Comments Received

We invited interested parties to comment on the preliminary results. We received no comments or requests for a hearing. However, during disclosure to the respondent we discovered an error in our calculation of constructed value. We corrected that error and, based on our revised analysis, we found no dumping margins for the period. We gave the parties (specifically the petitioner) and additional opportunity to comment on the corrected profit calculation on which the revised results were based. We received three comments from the petitioner. One comment addressed the adjusted profit figure, to which we respond below. The second comment discussed the general selling and administrative expenses of NEC's U.S. subsidiary, NEC America, and a third comment suggested additional deductions to the United States price. We have not considered the latter two comments, since comments on such issues should have been submitted within the original 30-day comment period set forth in the preliminary results of review.

Comment. Petitioner argues that the Department in its constructed value calculations should not accept a home market profit figure which reflects profit on sales of merchandise other than the same general class or kind covered by the order. More specifically, the sale of high power amplifiers and components is a low volume, high-risk operation, and we should not accept a profit figure that includes sales of high volume, low-risk merchandise, such as pagers and radios, which are produced at the same production facilities. Petitioner argues that we should estimate a reasonable profit for home market sales, and as best evidence, the actual profit on the U.S. sales would not be unreasonable.

Department's Position. While we agree that some of the merchandise on which NEC's provided home market profit figure is based is not of the same general class or kind as required by § 353.6(a)(2) of the Commerce Regulations, we cannot use U.S. profit as best evidence in our constructed value calculation (*see* Certain Electric Motors from Japan, Final Results of Administrative Review of Antidumping Duty Order, 48 FR 14719, April 5, 1983) as we erroneously did in our preliminary results. After disclosure we tried to gather additional profit information for home market sales of such amplifiers, as prescribed in the final determination of sales at less than fair value with regard to strontium nitrate from Italy (46 FR 25496, May 7, 1981). In so doing, we only found information representing company-wide profit on all electronic products, which is far less specific than the factory-wide profit provided by NEC. NEC's factory profit is higher than the company profit but lower than the statutory minimum of 8 percent; therefore, we have used 8 percent profit in our constructed value calculation.

Final Results of the Review

After review of the comment timely received, and as a result of our correction, the final results of our review changed from the preliminary results, and we determine that no dumping margins exist for the period.

The Department shall instruct the Customs Service not to assess antidumping duties on appropriate entries. Further, the Department shall not require a cash deposit of estimated antidumping duties, as provided for in § 353.48(b) of the Commerce Regulations, on any shipments of Japanese high power microwave amplifiers and components thereof entered, or withdrawn from warehouse, for consumption on or after the date of publication of this notice. This requirement shall remain in effect until publication of the final results of the next administrative reivew.

The Department encourages interested parties to review the public record and submit applications for protective orders as early as possible after the Department's receipt of the requested information in the next review.

This administrative review and notice are in accordance with section 751(a)(1) of the Tariff Act (19 U.S.C. 1675(a)(1))

and section 353.53 of the Commerce Regulations (19 CFR 353.53).

Alan F. Holmer,

Deputy Assistant Secretary for Import Administration.

[FR Doc. 85-697 Filed 1-9-85; 8:45 am]

BILLING CODE 3510-DS-M

Importers and Retailers' Textile Advisory Committee; Partially Closed Meeting

A meeting of the Importers and Retailers' Textile Advisory Committee will be held on January 24, 1985, 10:30 a.m., Herbert C. Hoover Building, Room 4830, 14th Street and Constitution Avenue, NW., Washington, D.C. 20230. (The Committee was established by the Secretary of Commerce on August 13, 1963 to advise Department officials of the effects on import markets of cotton, wool, and man-made fiber textile and apparel agreements).

General Session: 10:30 a.m. Review of import trends, international activities, report on conditions in the market, and other business.

Executive Session: 11:00 a.m. Discussion of matters properly classified under Executive Order 12356 (3 CFR Part 166 (1982)) and listed in 5 U.S.C. 552b(c) (1) and (9).

The general session will be open to the public with a limited number of seats available. A notice of Determination to close meetings or portions of meetings to the public on the basis of 5 U.S.C. 552b (c)(1) and (c)(9) has been approved in accordance with the Federal Advisory Committee Act. A copy of the notice is available for public inspection and copying in the Central Reference and Records Inspection Facility Room 6628, U.S. Department of Commerce, (202) 377-3031.

For further information or copies of the minutes contact Helen L. LeGrande (202) 377-4217.

Dated: January 7, 1985.

Ronald I. Levin,

Acting Deputy Assistant Secretary for Textiles and Apparel.

[FR Doc. 85-727 Filed 1-9-85; 8:45 am]

BILLING CODE 3510-DR-M

Management-Labor Textile Advisory Committee; Partially Closed Meeting

A meeting of the Management-Labor Textile Advisory Committee will be held on January 24, 1985, 1:30 p.m., Herbert C. Hoover Building, Room 4830, 14th Street and Constitution Avenue, NW., Washington, D.C. 20230. (The Committee was established by the Secretary of Commerce on October 18, 1961 to advise Department officials of the effects on import markets of cotton, wool, and man-made fiber textile and apparel agreements).

General Session: 1:30 p.m. Review of import trends, international activities, report on conditions in the market, and other business.

Executive Session: 2:00 p.m. Discussion of matters properly classified under Executive Order 12356 (3 CFR Part 166 (1982)) and listed in 5 U.S.C. 552b(c) (1) and (9).

The general session will be open to the public with a limited number of seats available. A notice of Determination to close meetings or portions of meetings to the public on the basis of 5 U.S.C. 552b (c)(1) and (c)(9) has been approved in accordance with the Federal Advisory Committee Act. A copy of the notice is available for public inspection and copying in the Central Reference and Records Inspection Facility Room 6628, U.S. Department of Commerce (202) 377-3031.

For further information or copies of the minutes contact Helen L. LeGrande (202) 377-4217.

Dated: January 7, 1985.

Ronald I. Levin,

Acting Deputy Assistant Secretary for Textiles and Apparel.

[FR Doc. 85-728 Filed 1-9-85; 8:45 am]

BILLING CODE 3510-DR-M

Applications for Duty-Free Entry of Scientific Instruments; Iowa State University

Pursuant to section 6(c) of the Educational, Scientific and Cultural Materials Importation Act of 1966 (Pub. L. 89-651; 80 Stat. 897; 15 CFR Part 301), we invite comments on the question of whether instruments of equivalent scientific value, for the purposes for which the instruments shown below are intended to be used, are being manufactured in the United States.

Comments must comply with § 301.5(a) (3) and (4) of the regulations and be filed within 20 days with the Statutory Import Programs Staff, U.S. Department of Commerce, Washington, D.C. 20230. Applications may be examined between 8:30 a.m. and 5:00 p.m. in Room 1523, U.S. Department of Commerce, 14th and Constitution Avenue, NW., Washington, D.C.

Docket No. 84-93R. Applicant: Iowa State University, Purchasing Department, 2nd Floor Physical Plant Building, Ames, IA 55011. Instrument: Mass Spectrometer System, Model MS50/DS55. Original notice of this resubmitted application was published in the Federal Register of March 19, 1984.

Docket No. 84-111R. Applicant: Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226. Instrument: Mass Spectrometer System, Model MS-80. Original notice of this resubmitted application was published in the Federal Register of April 6, 1984.

Docket No. 84-181R. Applicant: Brown University, Department of Chemistry, 324 Brook Street, Providence, RI 02912. Instrument: Gas Chromatograph Mass Spectrometer System, Model MS 80. Original notice of this resubmitted application was published in the Federal Register of May 18, 1984.

Docket No. 85-051. Applicant: California Institute of Technology, Pasadena, CA 91125. Instrument: Electron Microprobe Analyzer System, Model Superprobe 733. Manufacturer: JEOL Inc., Japan. Intended use: The instrument will be used for research in geology, mineralogy, petrology, and geochemistry. Typical problems involve analysis of rocks, minerals, and meteoritic materials in connection with studies aimed at determining the origin and age of the earth, moon, and solar system. Some of the sample to be analyzed will be synthetic materials created in an effort to duplicate some of the rock forming processes. The instrument will also be used for teaching purposes in the courses Ge 114—Optical and X-ray Mineralogy; Ge 115—Petrology and Petrography; Ge 214—Advanced Mineralogy; Ge 215—Topics in Advanced Petrology. Application received by Commissioner of Customs: December 17, 1984.

Docket No. 85-055. Applicant: University of Kansas, Lawrence, KS 66045. Instrument: Mass Spectrometer System with Gas Chromatograph and Data System, Model ZAB-HS. Manufacturer: VG Analytical Ltd., United Kingdom. Intended use: Studies of organic compounds or compounds with an organic portion, or mixtures or solutions of such compounds. The structure of the compounds, relative quantities of compounds in a mixture or relative amounts of isotopic species in an isotopic mixture will be investigated. Experiments will be conducted to determine the structure, the quantities present and the isotopic composition of the compounds. The ultimate purpose being generally to find what compound of compounds are formed in a chemical reaction, or to obtain information about mechanisms of chemical reactions, including measurement of kinetic isotope effects. Application received by

Commissioner of Customs: December 13, 1984.

Docket No. 85–056. Applicant: Texas A & M University, 6th Floor, Sterling C. Evans Library, College Station, TX 77843. Instrument: Computerized, Electronic, Equine Lameness Diagnostic Machine. Manufacturer: Mr. Bruno Kägi, Switzerland. Intended Use: Studies of equine lameness, specifically equine gait and locomotion. The objectives to be pursued include not only evaluation of The Kägi System but also development of profiles of sound horses and lame horses with specific syndromes. In addition, training students in veterinary medicine as well as practicing veterinarians in lameness evaluations is also an important objective. Application received by Commissioner of Customs: December 13, 1984.

Docket No. 85–058. Applicant: Rensselaer Polytechnic Institute, 110 Eight Street, Troy, NY 12180. Instrument: Focused Ion Beam Implanter. Manufacturer: VG Semicon, United Kingdom. Intended use: Studies of silicon and GaAs, specifically the study of breakdown voltage, I–V characteristics, depletion width, and resistivity properties of devices on Si substrate. In addition the instrument will be used to train students at the M.S. and Ph.D. levels in the science and technology of microelectronics. Application received by Commissioner of Customs: December 13, 1984.

Docket No. 85–062. Applicant: Yale University School of Medicine, Department of Pathology, 310 Cedar Street, Rm. L112, New Haven, CT 06510. Instrument: Electron Microscope, Model EM 10CA with Accessories. Manufacturer: Carl Zeiss, West Germany. Intended use: Examination of the ultrastructure of a variety of human and animal tissues. The human tissues to be studied will be obtained from either autopsy or surgical sources. The ultrastructural alterations associated with various disease entities will be correlated with the clinical syndromes and functional aberrations with which they are associated. In addition, animal tissues obtained from experimental models which parallel human disease will be studied at various stages in order to gain an understanding of the pathogenesis of these disease processes. The instrument will also be used in the postgraduate training of physicians preparing for a career in pathology. Application received by Commissioner of Customs: December 17, 1984.

Docket No. 85–063. Applicant: U.S. Air Force, MAQCE, Building 321, Kelly AFB, San Antonio, TX 78241. Instrument: Electron Microscope, Model H–800 with Accessories. Manufacturer: Hitachi Scientific Instruments, Japan. Intended use: Support of failure analyses performed in USAF aircraft parts experiencing premature failure. In addition, investigation of aircraft accidents, or loss of life, in support of Aircraft Mishap Investigation boards where metallic material failure is suspected. The instrument will also be used for temperature damage evaluations on used turbine components of aircraft engines returned from service for overhauling. Application received by Commissioner of Customs: December 17, 1984.

Docket No. 85–064. Applicant: National Bureau of Standards, A21 Physics Building, Gaithersburg, MD 20899. Instrument: ICP Mass Spectrometer, Model VG Plasma Quad. Manufacturer: VG Instruments, Inc., United Kingdom. Intended use: Studies of various samples of environmental and other natural sources for accurate analyses of minor and trace elements. Application received by Commissioner of Customs: December 18, 1984.

(Catalog of Federal Domestic Assistance Program No. 11.105, Importation of Duty-Free Educational and Scientific Materials)

Frank W. Creel,

Acting Director, Statutory Import Programs Staff.

[FR Doc. 85–696 Filed 1–9–85; 8:45 am]

BILLING CODE 3510-DS-M

Minority Business Development Agency

Minority Enterprise Development Week, 1985; Public Meetings

AGENCY: Minority Business Development Agency, Commerce.

ACTION: Notice of meeting.

SUMMARY: This notice sets forth a schedule of public meetings. The purpose of these meetings is to obtain public input in planning Minority Enterprise Development Week (MED Week), 1985.

DATES: Meetings will be held the fourth Tuesday of every month from January through September, 1985. For information and/or confirmation call Hattie M. Bickmore, (202) 377–5196.

ADDRESS: Department of Commerce, Herbert C. Hoover Building, 14th and Constitution Avenue, N.W., Washington, D.C. 20230.

FOR FURTHER INFORMATION CONTACT: Betty Waters (202) 377–5196.

SUPPLEMENTARY INFORMATION: Under Executive Order 11625, MBDA is charged with promoting the development of minority business enterprise. The Third annual celebration of MED Week will aid to achieving this goal by providing the Agency with a means of recognizing the contributions made by minority entrepreneurs.

The purpose of these meetings is to obtain public input in the planning of MED Week, 1985. We are seeking the input of individuals who work closely with minority entrepreneurs or are assisting in the development and expansion of the Nation's minority-owned businesses, that will enable us to put together a program which will address the needs of minority business.

Dated: January 4, 1985.

Hattie M. Bickmore,

National Coordinator for MED Week.

[FR Doc. 85–695 Filed 1–9–85; 8:45 am]

BILLING CODE 3510-21-M

National Oceanic and Atmospheric Administration

New England Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

The New England Fishery Management Council will hold a public meeting to discuss reports of the groundfish, scallop, enforcement and foreign fishing committees, as well as other fishery management matters.

The meeting will convene on January 24, 1985, at 9 a.m., King's Grant Inn, Danvers, MA, and adjourn at approximately 5 p.m. For further information, contact Douglas G. Marshall, Executive Director, New England Fishery Management Council, Suntaug Office Park, 5 Broadway (Rte. 1), Saugus, MA 01906; telephone: (617) 231–0422.

Dated: January 3, 1985.

Roland Finch,

Director Office of Fisheries Management, National Marine Fisheries Service.

[FR Doc. 85–745 Filed 1–9–85; 8:45 am]

BILLING CODE 3510-22-M

North Pacific Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service, NOAA, Commerce.

The North Pacific Fishery Management Council has tentatively scheduled a meeting of its Gulf of Alaska Groundfish Plan Team for January 7–8, 1985 in Juneau, AK, to review and prioritize 1985 management proposals for the Gulf of Alaska. The meeting will be held at the office of the National Marine Fisheries Service,

Room 461, and will begin at 11 a.m., January 7. For further information, contact Steve Davis, North Pacific Fishery Management Council, P.O. Box 103136, Anchorage, AK; telephone: (907) 274-4563.

Dated: January 3, 1985.

Roland Finch,

Director, Office of Fisheries Management, National Marine Fisheries Service.

[FR Doc. 85-746 Filed 1-9-85; 8:45 am]

BILLING CODE 3510-22-M

COMMISSION ON EXECUTIVE, LEGISLATIVE AND JUDICIAL SALARIES

Meeting

The Commission on Executive, Legislative and Judicial Salaries will meet on January 22, 1985, from 9:00 a.m. until 12:00 p.m. and from 1:30 p.m. until 4:00 p.m., at 722 Jackson Place, NW, Washington, D.C. 20006. This will be an open organizational meeting with background briefings.

It is anticipated that at the conclusion of the open meeting, the meeting will be closed in accordance with section 10d of the Federal Advisory Committee Act and Title 5 U.S.C. 552b (c)(2) and (c)(9)(B). A request for determination as to the closed portion of the meeting will be presented to the Administrator of the General Services Administration for approval in advance of the meeting.

Due to the Commission's interest in beginning work at the earliest possible date from appointment, it was not feasible to postpone the meeting or to give earlier notice.

For further information, contact Patsy Semple at (202) 377-3914.

Nicholas F. Brady,

Chairman.

[FR Doc. 85-787 Filed 1-9-85; 8:45 am]

BILLING CODE 3510-BX-M

DEPARTMENT OF DEFENSE

Office of the Secretary

Defense Science Board Task Force on Software; Change in Advisory Committee Meeting

The meeting of the Defense Science Board Task Force on Software scheduled for January 11, 1985 in the Pentagon, Arlington, Virginia as published in the **Federal Register** (Vol. 49, No. 235, Wednesday, December 5, 1984, FR Doc. 84-31703) has been changed to January 28, 1985. In all other respects the notice remain unchanged.

Dated: January 7, 1985.

Patricia H. Means,

OSD Federal Register Liaison Officer, Department of Defense.

[FR Doc. 85-699 Filed 1-9-85; 8:45 am]

BILLING CODE 3810-01-M

Department of the Air Force

USAF Scientific Advisory Board; Meeting

January 3, 1985.

The USAF Scientific Advisory Board's Electronic Systems Division Advisory Group will meet at Hanscom Air Force Base, Massachusetts from February 4-5, 1985.

The purpose of the meeting will be to review on-going projects in the field of The Space Defense Initiative and Tactical Battlefield Management. The meeting will convene from 8:30 a.m. to 5:00 p.m. on February 4 and from 8:30 a.m. to 12:00 noon on February 5.

The meeting concerns matters listed in section 552b(c) of Title 5, United States Code, specifically subparagraph (1) thereof, and accordingly, will be closed to the public.

For further information, contact the Scientific Advisory Board Secretariat at 202-697-8845.

Norita C. Koritko,

Air Force Federal Register Liaison Officer.

[FR Doc. 85-714 Filed 1-9-85; 8:45 am]

BILLING CODE 3910-01-M

USAF Scientific Advisory Board; Meeting

January 3, 1985.

The USAF Scientific Advisory Board's Foreign Technology Division Advisory Group will meet at Wright-Patterson Air Force Base, Ohio on February 12-13, 1985.

The purpose of the meeting will be to advise on the relevancy of FTD analyses and assessments of foreign achievements in the technical domain of directed energy, to include lasers, charges particle beam and neutral partical beam technology, and high energy microwave systems with emphasis on determining state of technology and potential for military application. The meeting will convene from 8:00 a.m. to 5:00 p.m. on February 12 and from 8:00 a.m. to 4:00 p.m. on February 13.

The meeting concerns matters listed in section 552b(c) of Title 5, United States Code, specifically subparagraph (1) thereof, and accordingly, will be closed to the public.

For further information, contact the Scientific Advisory Board Secretariat at 202-697-8845.

Norita C. Koritko,

Air Force Federal Register Liaison Officer.

[FR Doc. 85-713 Filed 1-9-85; 8:45 am]

BILLING CODE 3910-01-M

Department of the Navy

Chief of Naval Operations; Executive Panel Advisory Committee; SLCM Defense Task Force; Closed Meeting

Pursuant to the provisions of the Federal Advisory Committee Act (5 U.S.C. App), notice is hereby given that the Chief of Naval Operations (CNO) Executive Panel Advisory Committee SLCM Defense Task Force will meet January 30-31, 1985, from 9 a.m. to 5 p.m. each day, at 2000 North Beauregard Street, Alexandria, Virginia. All sessions will be closed to the public.

The purpose of this meeting is to review technological aspects of cruise missile defense. The entire agenda for the meeting will consist of discussions of key issues regarding the Navy's policy and technical responses to Soviet SLCM deployments and related intelligence. These matters constitute classified information that is specifically authorized by Executive order to be kept secret in the interest of national defense and is, in fact, properly classified pursuant to such Executive order. Accordingly, the Secretary of the Navy has determined in writing that the public interest requires that all sessions of the meeting be closed to the public because they will be concerned with matters listed in section 552b(c)(1) of title 5, United States Code.

For further information concerning this meeting, contact Lieutenant Thomas E. Arnold, Executive Secretary of the CNO Executive Panel Advisory Committee, 2000 North Beauregard Street, Room 392, Alexandria, Virginia 22311. Phone (703) 756-1205.

Dated: January 4, 1985.

William F. Roos, Jr.,

Lieutenant, JAGC, U.S. Naval Reserve, Federal Register Liaison Officer.

[FR Doc. 85-748 Filed 1-9-85; 8:45 am]

BILLING CODE 3810-AE-M

DEPARTMENT OF EDUCATION

National Advisory Council on Women's Educational Program; Meeting

SUMMARY: This notice sets forth the schedule and proposed agenda of a meeting of the National Advisory

Council on Women's Educational Programs and its Executive; Federal Policies, Practices, and Programs; WEEA Program; and Civil Rights Committees. The agenda will include discussion of Council forums on women in non-traditional carriers, the Council's FY 1985 Budget, planning activities for 1985 calendar year and a partially closed meeting for personnel matters and to select a new Executive Director. This notice also describes the function of the Council. Notice of this meeting 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 and that a portion of the meeting will be closed.

DATES: January 17, 1985, 7:30 p.m. to 9:30 p.m.; January 18, 1985, 8:30 a.m. to 10:00 a.m. open session; 10:00 a.m. to 10:30 a.m. partially closed session; and 10:30 a.m. to 5:00 p.m. open session.

ADDRESS: The meeting will be held at the Capitol Holiday Inn, 550 C Street, SW., Washington, D.C. 20202.

FOR FURTHER INFORMATION CONTACT: Sally Todd, Deputy Director, National Advisory Council on Women's Educational Programs, 425 13th Street, NW., Suite 416, Washington, D.C., 20004, (202) 376–1038.

SUPPLEMENTARY INFORMATION: The National Advisory Council on Women's Educational Programs is established pursuant to Pub. L. 95–561. The Council is mandated to: (a) Advise the Secretary on matters relating to equal education opportunities for women and policy matters relating to the administration of the Women's Educational Equity Act of 1978; (b) make recommendations to the Secretary with respect to the allocation of any funds pursuant to the Act, including criteria developed to insure an appropriate geographical distribution of approved programs and projects throughout the Nation; (c) recommend criteria for the establishment of program priorities; (d) make such reports as the Council determines appropriate to the President and Congress on the activities of the Council; and (e) disseminate information concerning the activities of the Council.

The meeting of the Executive Committee will take place on January 17, 1985, from 7:30 p.m. to 9:30 p.m. The agenda will include discussion of the Council's FY 1985 budget.

The meeting of the Federal Policies, Practices and Programs; Civil Rights; and WEEA Program Committees, will take place on January 18, 1985, from 8:30 a.m. to 9:30 a.m. for general discussions.

The full council will meet in open session Friday, January 18, 1985, beginning at 9:30-10:00 a.m. to discuss Council activities, and from 10:00-10:30 a.m. will be a partially closed session for personnel matters and to select a new Executive Director for the National Advisory Council on Women's Educational Programs. These discussions will relate solely to the internal personnel rules and practices of the Council and touch upom matters of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy if conducted in open session. Such matters are protected by exemptions (2) and (6) of Section 552b(c) of Title 5 U.S.C. The full Council will meet from 10:30 a.m. to 5:00 p.m. in open session to discuss Council forum on women in non-traditional careers and planning activities for the 1985 calendar year.

The public is being given less than fifteen days notice of this closed session due to the difficulty in arranging the meeting.

Records will be kept of the proceedings and will be available for public inspection at the office of the National Advisory Council on Women's Educational Programs. A summary of the activities of the closed session and related matters which would be informative to the public consistent with the policy of Section 552b(c) of Title 5 U.S.C. will be available to the public within 14 days of the meeting at the Council's office, 425 13th Street, NW., Suite 416, Washington, D.C. 20004.

Signed at Washington, D.C. on January 7, 1985.

Sally A. Todd,

Acting Executive Director.

[FR Doc. 85–735 Filed 1–9–85; 8:45 am]

BILLING CODE 4000-01-M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. TA 85–1–61–000 and TA85–1–61–001]

Bayou Interstate Pipeline System; Filing

January 7, 1985.

Take notice that Bayou Interstate Pipeline System (Bayou), on December 28, 1984 tendered for filing Second Revised Original Sheet No. 4A and Second Revised Sheet No. 5 of its FERC Gas Tariff, Original Volume No. 1. The tariff sheets were filed pursuant to the Purchased Gas Cost Adjustment and Incremental Pricing Adjustment provisions contained in Sections 15 and 16 of Bayou's tariff. Copies of the filing were served upon Bayou's jurisdictional customer and interested state regulatory commission.

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, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's rules of practice and procedure (18 CFR 385.211, 385.214). All such motions or protests should be filed on or before January 14, 1985. 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. 85–764 Filed 1–9–85; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. EL85–16–000, et al.]

Brigham City, Utah, et al.; Electric Rate Filings

January 4, 1985.

Take notice that the following filings have been made with the Commission:

1. Brigham City, Utah, Complainant, v. Utah Power & Light Company, Respondent, Docket No. EL85–16–000.

Take notice that on December 19, 1984, Brigham City, Utah, (Brigham) submitted for filing a complaint against Utah Power and Light Company (UP&L) pursuant to sections 206 and 306 of the Federal Power Act, and Rule 206 of the Commission's Rules of Practice and Procedure.

Brigham requests that the Commission:

(1) Declare that Brigham City's resale agreement with UP&L permits purchases of power and energy from WAPA in excess of those amounts originally stated in that agreement and declare unlawful any refusal by UP&L to accept or deliver any power and energy scheduled by WAPA for Brigham City;

(2) Order UP&L to cease and desist from refusing to accept or recognize all power and energy scheduled by WAPA for Brigham City in any amounts;

(3) Order UP&L to recalculate its bills from April to September 1984 based on full recognition of all power and energy scheduled for Brigham City by WAPA, to cease and desist from claiming that any amounts remain due from Brigham City on those bills, and to make refunds

to Brigham City on such recalculated bills consistent with the approved settlement agreement in FERC Docket Nos. ER83-427 and ER83-428.

Comment date: February 4, 1985, in accordance with Standard Paragraph E at the end of this notice.

Take notice that on December 21, 1984, Tampa Electric Company (Tampa Electric) tendered for filing a Contract for Sale and Purchase of Capacity and Energy between Tampa Electric and Florida Power & Light Company (FP&L). The Contract provides for the sale by Tampa Electric to FP&L of capacity and energy from Tampa Electric's new coal-fired Big Bend Unit No. 4 generating unit.

Tampa Electric states that the Contract will become effective on the first day of the second month following the month in which Big Bend Unit No. 4 is released for commercial operation. That effective date is expected to be no later than April 1, 1985. The Contract will remain in effect through December 31, 1987.

According to Tampa Electric, FP&L will be entitled under the Contract to purchase quantities of capacity and energy up to specified percentages of the next maximum available capability of Big Bend Unit No. 4, which is estimated to be 417 MW. The applicable percentages for 1985, 1986, and 1987 are 70 percent, 50 percent, and 25 percent, respectively.

Tampa Electric states that the charges under the Contract are to be determined under a cost of service formula calculated to recover FP&L's proportionate share, as defined by the Contract, of the incremental cost of constructing, operating, and maintaining Big Bend Unit No. 4.

Copies of the filing have been served on FP&L and the Florida Public Service Commission.

Comment date: January 17, 1985, in accordance with Standard Paragraph E at the end of this notice.

The filing Company submits the following:

Take notice that American Electric Power Service Corporation (AEP) on December 24, 1984, tendered for filing on behalf of its affiliate Ohio Power Company (OPCO) Supplement No. 14 dated June 1, 1984 to the Interconnection Agreement dated January 1, 1952 between Ohio Edison Company (Edison) and OPCO, OPCO's Rate Schedule FERC No. 25 and Edison's Rate Schedule FERC No. 9.

Section 1 of this Agreement modernizes the Billing and Payment section of the Interconnection Agreement. Section 2 revises that Short Term Power Service Schedule by increasing the demand charges and transmission charges for Short Term Power to $1.25 per kilowatt per week and $0.35 per kilowatt per week respectively when OPCO is the supplying party. This service schedule also includes a provision to allow for Daily Short Term Power and multi-party Daily Short Term Power transactions to take place between the parties and for sale of Operating Capacity from Edison. Language revisions have also been made to this Short Term power Service schedule. Section 3 revises the Interchange Power Service Schedule by including a provision for multi-party transactions. The rates contained in these Service Schedules when OPCO is the supplying party are substantially the same as Service Schedules that OPCO presently has on file and accepted for filing by the Commission. It has been requested that the Commission allow OPCO's Short Term transmission demand provisions to become effective as of June 12, 1984 and the remainder of this agreement effective on February 28, 1985.

AEP requests an effective date of June 12, 1984 for OPCO's Short Term Power transmission demand provisions due to the fact that it was necessary to transmit Daily Short Term Power to Edison on June 13, 1984 and June 14, 1984 for Edison had immediate need for Short Term Power. The delay in filing this agreement until the present time is the result of revising the remaining conditions of the Short Term Power Service Schedule and the other provisions found in Supplement No. 14. It should be noted that OPCO considered these transactions to be a public service to Edison's customers, for without these provisions for the transmission of Daily Short Term power, Edison would have had to contract with OPCO for a week, at a substantially higher cost, to receive this same energy from a third party. The savings to Edison under the proposed Daily Short Term Power Rate was $35,500.

Copies of this filing were served upon the Public Utilities Commission of Ohio and the Ohio Edison Company.

Comment date: January 17, 1985, in accordance with Standard Paragraph E at the end of this notice.

The filing Company submits the following:

Take notice that Minnesota Power & Light Company ("Minnesota Power") on December 21, 1984, tendered for filing an executed Supplement No. 3 to the Integrated Transmission Agreement between Cooperative Power Association and Minnesota Power & Light Company (Rate Schedule FERC No. 89 as supplemented).

Minnesota Power states that Supplement No. 3 was designed to update the Integrated Transmission Agreement on file with the Commission. Supplement No. 3 changes the determination of CPA's investment obligation required to maintain an equitable ownership of facilities in the Integrated Transmission System; the rates used for fixed charges and interest; the number of individuals which each party assigns to the Coordinating Committee; and the factor used to determine transformation losses between points of metering and points of delivery.

Minnesota Power requests waiver of the Commission's Regulations to the extent necessary to permit the executed agreements to become effective May 2, 1984. Cooperative Power Association has concurred in this proposed effective date.

Copies of the executed supplements have been served upon Cooperative Power Association, the Minnesota Public Utilities Commission, and the U.S. Department of Agriculture Rural Electrification Administration.

Comment date: January 17, 1985, in accordance with Standard Paragraph E at the and of this notice.

Standard Paragraphs

E. 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 the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of this filing are on file with the Commission and are available for public inspection.

Kenneth F. Plumb,

Secretary.

[FR Doc. 85-775 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP82-54-016]

Colorado Interstate Gas Filing

January 7, 1985.

Take notice that on December 26, 1984, Colorado Interstate Gas Company (CIG) tendered for filing the following

revised tariff sheets to its FERC Gas Tariff, Original Volume No. 1:

Replacement Twenty-First Revised Sheet No. 8
Substitute Alternate Twentieth Revised Sheet No. 7
Substitute Alternate Twentieth Revised Sheet No. 8
Substitute Nineteenth Revised Sheet No. 7
Substitute Nineteenth Revised Sheet No. 8
Substitute Eighteenth Revised Sheet No. 8
Substitute Seventeenth Revised Sheet No. 8
Substitute Sixteenth Revised Sheet No. 8
Second Substitute Fifteenth Revised Sheet No. 8
Third Substitute Fourteenth Revised Sheet No. 8.

CIG states it is filing these revised tariff sheets in conformance with the Federal Energy Regulatory Commission's (Commission) October 31, 1984, order and the Commission's action in Order No. 380. The sheets (1) state the fixed cost component per Mcf reflected in the effective rates for Rate Schedule F-1, (2) add sentences to the minimum bill provision of Rate Schedule F-1, which state the total fixed costs currently assigned to the F-1 rate schedule, and (3) revise the minimum bill in CIG's combined H-1 and F-1 Service Agreement with Natural Gas Pipeline Company of America (Natural), as required by the October 31, 1984, order. The effective dates are noted on the subject tariff sheets accompanying this filing.

CIG requests whatever waivers of the Commission's regulations as may be necessary to accept this filing in its present form.

Any person desiring to be heard or to 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 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 January 14, 1985. 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. 85-765 Filed 1-9-85; 8:45 am]
BILLING CODE 6717-01-M

[Docket Nos. CP85-165-000, et al.]

Columbia Gas Transmission Corp., et al.; Natural Gas Certificate Filings

January 3, 1985.

Take notice that the following filings have been made with the Commission:

1. Columbia Gas Transmission Corporation, Docket No. CP85-165-000.

Take notice that on December 11, 1984, Columbia Gas Transmission Corporation (Columbia), 1700 MacCorkle Avenue, S. E., Charleston, West Virginia 25314, filed in Docket No. CP85-165-000 a request pursuant to § 157.205 of the Commission's Regulations under the Natural Gas Act (18 CFR 157.205) for authorization to transport natural gas on behalf of Owens-Illinois, Inc. (Owens-Illinois), under the certificate issued in Docket No. CP83-76-000 pursuant to section 7 of the Natural Gas Act, all as more fully set forth in the request which is on file with the Commission and open to public inspection.

Columbia proposes to transport up to 1.5 billion Btu equivalent of natural gas per day for Owens-Illinois through June 30, 1985. Columbia states that the gas to be transported would be purchased from Chatham Resources (Chatham) and would be used as process gas in Owens-Illinois' Toano, Virginia, plant. Columbia further indicates that Texas Eastern Transmission Corporation (TETCO) would also be transporting the specified volumes and has filed its request for authority to do so in Docket No. CP85-112-000.

Columbia indicates that the gas to be transported for Owens-Illinois is from an off-system source and therefore was not released by Columbia. Columbia states that it would charge 29.93 cents per dt equivalent of gas, as set forth in its Rate Schedule TS-1 of Columbia's FERC Gas Tariff. Columbia states that it would retain 2.43 percent of the total quantity of gas delivered into its system for company-use and unaccounted-for gas, as set forth in Columbia's Rate Schedule TS-1.

Columbia states that the August 30, 1984, transportation contract provides for Columbia to receive from TETCO for the account of Owens-Illinois up to 1,500 dt equivalent of gas per day from five specified points in Ohio and redeliver equivalent quantities less volumes retained for company-use and unaccounted for volumes to Commonwealth Gas Pipeline Corporation (Commonwealth) at a point of interconnection of Commonwealth's and Columbia's systems in Greene County, Virginia. Columbia indicates that Virginia Natural Gas, the distributor serving the plant, would make ultimate redelivery to Owens-Illinois at the plant in James City County, Virginia.

Columbia estimates that the annual volume, peak day volume and average day volume would be 527,152 dt, 1,500 dt and 1,465 dt, respectively. Columbia indicates the end use of the gas is process gas which qualifies as a qualified end use. Columbia indicates that the above volumes constitute the total gas requirements at the plant.

Columbia has submitted an affidavit from Virginia Natural Gas indicating it has sufficient capacity to transport the above volumes without interrupting its other customers. Columbia also submitted an affidavit from the producer indicating that the gas is being sold at a rate not in excess of the applicable maximum lawful price under the Natural Gas Policy Act of 1978 and that the gas was not committed or dedicated to interstate commerce prior to November 8, 1978.

In addition, Columbia requests flexible authority to add and delete sources of gas and/or receipt/delivery points if such altered service is on behalf of the same end-user at the same end-use location and would be within the maximum daily and annual volumes authorized herein.

Specifically, within 30 days of the addition or deletion of any gas suppliers and/or receipt/delivery points Columbia agrees to file the following information in this docket:

1. Copy of the gas purchase contract between the seller and end-user;

2. Statement as to whether the supply is attributable to gas under contract to and released by a pipeline or distributor and if so, identification of the parties, and the specification of the current contract price;

3. Statement of the Natural Gas Policy Act of 1978 (NGPA) pricing categories of the added supply, if released gas, and the volumes attributable to each category;

4. Statement that the gas is not committed or dedicated within the meaning of NGPA Section 2(18);

5. Location of the receipt/delivery points being added or deleted. For deletions provide the name of the producer/supplier;

6. Where an intermediary participates in the transaction between the seller and the end-user, the information required by § 157.209(c)(1)(ix) of the Regulations;

7. Identity of any other pipeline involved in the transportation.

Comment date: February 19, 1985, in accordance with Standard Paragraph G at the end of this notice.

2. Louisiana-Nevada Transit Company, Docket No. CP85–159–000.

Take notice that on December 7, 1984, Louisiana-Nevada Transit Company (LNT), Post Office Box 8789, Denver, Colorado 80201, filed in Docket No. CP85–159–000 an application pursuant to section 7 of the Natural Gas Act and § 284.221 of the Commission's Regulations, requesting a blanket certificate of public convenience and necessity authorizing LNT to transport natural gas on behalf of any other interstate pipeline, all as more fully set forth in the application which is on file with the Commission and open to public inspection.

LNT states that it is an interstate pipeline and is seeking to obtain blanket certificate authorization to transport natural gas on behalf of other interstate pipelines in accordance with Part 284, Subpart G, of the Commission's Regulations. LNT agrees to comply with the conditions in § 284.221(d) of the Commission's Regulations.

Comment date: January 24, 1985, in accordance with Standard Paragraph F at the end of this notice.

3. Northern Natural Gas Company, Division of InterNorth, Inc., Docket No. CP85–183–000.

Take notice that on December 17, 1984, Northern Natural Gas Company, Division of InterNorth, Inc. (Northern), 2223 Dodge Street, Omaha, Nebraska 68102, filed in Docket No. CP85–183–000 an application pursuant to section 7(c) of the Natural Gas Act for a certificate of public convenience and necessity authorizing the sale for resale of natural gas to Texas Eastern Transmission Corporation (Texas Eastern) and the construction and operation of facilities necessary to effectuate such sale. Northern also requests, pursuant to section 7(b) of the Natural Gas Act, permission to abandon in order to terminate the sale or to reduce the maximum daily quantity to be sold. Northern's proposals are fully set forth in its application which is on file with the Commission and open to public inspection.

Specifically, Northern requests authority to sell a maximum daily quantity (MDQ) of 75 billion Btu of natural gas from November 1, 1985, through October 31, 1986; 150 billion Btu from November 1, 1986, through October 31, 1987; 225 billion Btu from November 1, 1987, through October 31, 1988; and 300 billion Btu thereafter. Northern states that the term of the gas sales agreement (agreement) is for a period of fifteen years, commencing on the date of initial deliveries, and year to year thereafter. It is explained that the agreement also provides for Texas Eastern to purchase volumes in excess of the MDQ, if Northern makes such volumes available, and that upon the occurrence of certain events specified in Article V of the agreement, Northern and Texas Eastern have the option to reduce the MDQ and Texas Eastern has the right to terminate the agreement. Northern requests authority for such pregranted total as partial abandonment.

Northern proposes to deliver the natural gas to Texas Eastern at three firm delivery points: (1) The existing interconnection between Texas Eastern and Northern in Calcasieu Parish, Louisiana; (2) the existing interconnection between Texas Eastern and ANR Pipeline Company in St. Landry Parish, Louisiana; and (3) a proposed interconnection between Texas Eastern and Northern's Matagorda Island Offshore Pipeline System (MOPS) in Refugio County, Texas. Northern requests authorization to construct and operate eight miles of twelve-inch pipeline and appurtenant facilities to connect Texas Eastern's facilities and Northern's MOPS system in Refugio County, Texas. The estimated cost of these facilities is $2,350,000 and would be financed with Northern's general corporate funds.

Northern also proposes to deliver the natural gas to Texas Eastern at four interruptible delivery points: (1) The existing interconnection between Texas Eastern and Southern Natural Gas Company in Iberville, Louisiana; (2) the existing interconnection between Texas Eastern and Channel Industries in Mont Belvieu, Chambers County, Texas; (3) the existing interconnection between Texas Eastern and Valero Transmission Company in Lavaca County, Texas; and (4) the existing interconnection between Texas Eastern and Tennessee Gas Pipeline Company in Terrebone Parish, Louisiana.

Northern initially proposes to charge Texas Eastern a commodity charge of $3.34 per million Btu of natural gas delivered and a monthly demand charge of $2.60 per million Btu of the effective MDQ. If excess volumes are available, Northern states it would charge Texas Eastern $3.34 per million Btu of natural gas sold and delivered in excess of the effective MDQ.

Northern asserts that in the event of curtailment of sales to Texas Eastern, curtailment would be no greater than 2 percent of the effective MDQ times the number of priority steps being fully curtailed by Northern on its system on that day pursuant to Northern's FERC Gas Tariff, Third Revised Volume No. 1, General Terms and Conditions, Paragraph 9.2. Such curtailment, it is stated, would be ordered on a daily basis as a percentage of the MDQ in effect at the time.

Northern states that its customers would benefit from the proposed sale since the increased sales volume would spread system costs more broadly and Northern's customers would realize a lower average cost of gas. It is indicated that Texas Eastern would purchase this gas to replace partially field reserve depletion and deliverability decline.

Comment date: January 23, 1985, in accordance with Standard Paragraph F at the end of this notice.

4. Tennessee Gas Pipeline Company, a Division of Tenneco Inc., Docket No. CP85–162–000.

Take notice that on December 10, 1984, Tennessee Gas Pipeline Company, a Division of Tenneco Inc. (Tennessee), P.O. Box 2511, Houston, Texas 77001, filed in Docket No. CP85–162–000 an application pursuant to section 7(c) of the Natural Gas Act for a certificate of public convenience and necessity authorizing the transportation of natural gas, all as more fully set forth in the application which is on file with the Commission and open to public inspection.

Tennessee proposes to transport up to 16,0009 Mcf of natural gas per day, on a best-efforts basis, for Columbia Gas Transmission Corporation's (Columbia Gas) account. It is stated that Tennessee will transport the gas from the inlet of the measurement facilities located on the producer platform in South Timbalier Block 50A (ST 50A) and would redeliver the gas to Columbia Gulf Transmission Company (Columbia Gulf), for Columbia Gas' account, at the interconnection of the South Timbalier 50 line and the Project 37 pipeline, jointly owned by Tennessee, Columbia Gulf and Southern Natural Gas Company. It is further stated that Tennessee is currently transporting said gas for Columbia Gas pursuant to the provisions of § 284.221 of the Commission's Regulations and Tennessee's blanket certificate issued February 21, 1980, in Docket No. CP80–132. Reports of this transmission have been filed by Tennessee in Docket No. ST83–5.

It is asserted that the term of the proposed transportation service would be from the date of initial deliveries and would remain in full force and effect for a term of ten years and from year to year thereafter until cancelled by either party upon 180 days written notice given at the end of the primary term or any anniversary date thereof.

For the proposed transportation service, Columbia Gas would pay

Tennessee a demand charge of $40.053 per month. It is maintained that Columbia Gas would provide Tennessee 1.2 percent of the volume of natural gas received by Tennessee for its fuel and use requirements. It is also maintained that Tennessee would transport associated liquids at a current charge of 47.82 cents, adjusted annually.

Comment date: January 24, 1985, in accordance with Standard Paragraph F at the end of this notice.

5. Texas Eastern Transmission Corporation, Docket No. CP85–112–000.

Take notice that on November 14, 1984, Texas Eastern Transmission Corporation (Applicant), Post Office Box 2521, Houston, Texas 77252, filed in Docket No. CP85–112–000 a request pursuant to § 157.205 of the Regulations under the Natural Gas Act (18 CFR 157.205) for authorization to transport natural gas on behalf of Owens-Illinois, Inc. (Owens-Illinois), under the certificate issued in Docket No. CP82–535–000 pursuant to section 7 of the Natural Gas Act, all as more fully set forth in the request which is on file with the Commission and open to public inspection.

Applicant states that the transportation services would be provided pursuant to a gas transportation agreement, dated August 28, 1984, wherein Applicant would transport quantities of fuel oil displacement gas for Owens-Illinois. Applicant is advised that Owens-Illinois has entered into a gas purchase and sale contract with Chatham Resources, Inc. (Chatham Resources), which provides for the purchase of quantities of natural gas produced in Ohio. It is explained that to effectuate delivery of the gas, Applicant on October 20, 1984, commenced transportation service for the account of Owens-Illinois for an initial automatic period of 120 days and subject to Commission authority, has agreed to provide transportation service until 11:59 p.m. on June 30, 1985.

It is stated that pursuant to the service agreement, Applicant would take receipt of up to 1,500 dt equivalent of natural gas per day from Chatham Resources at a point of interconnecton between Applicant and Chatham Resources designated as Applicant's M&R Station 2195 located in Noble County, Ohio, or at other mutually agreeable points of receipt from Chatham Resources. Applicant would then transport and deliver such quantities, less applicable shrinkage, to Columbia Gas Transmission Corporation (Columbia) at points of interconnection between Applicant and Columbia designated as Applicant's M&R Station 041 located in Warren County, Ohio, M&R Station 077 located in Fairfield County, Ohio, M&R Station 081 located in Fayette County, Ohio, and M&R Stations 521 and 907 located in Butler County, Ohio. It is explained that Columbia would in turn transport and redeliver such quantities to Commonwealth Gas Pipeline Corporation (Commonwealth), which company would in turn transport and redeliver such quantities to Virginia Natural Gas Company (Virginia) for redelivery by Virginia to Owens-Illinois at its James City County, Virginia, plant.

Applicant estimates peak day and average day transportation quantities of 1,500 dt equivalent of gas and 1,440 dt equivalent, respectively, and annual quantities of approximately 547,500 dt. Applicant advises that Commonwealth and Virginia have indicated that they have sufficient capacity to perform the transportation service without detriment to their other customers. Applicant indicates that no facilities need be constructed to provide the transportation service. Applicant has also submitted an affidavit from Owens-Illinois indicating that the quantities of gas transported would be utilized for fuel oil displacement.

Applicant proposes to charge Owens-Illinois its currently effective TS–2 (fuel oil displacement) transported rate per dt transported and to reduce volumes received for transportation by its currently effective TS–2 shrinkage rate.

Applicant has submitted an affidavit from the producer indicating that its sales price to Owens-Illinois does not exceed the maximum lawful price under the Natural Gas Policy Act of 1978 and such volumes are not comprised of any gas that as committed or dedicated to interstate commerce on November 8, 1978.

Comment date: February 19, 1985 in accordance with Standard Paragraph G at the end of this notice.

Standard Paragraphs

F. Any person desiring to be heard or make any protest with reference to said filing should on or before the comment date file with the Federal Energy Regulatory Commission, 825 North Capitol Street, N.E., Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214) 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 filing 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 the applicant to appear or be represented at the hearing.

G. Any person or the Commission's staff may, within 45 days after the issuance of the instant notice by the Commission, file pursuant to Rule 214 of the Commission's Procedural Rules (18 CFR 385.214) a motion to intervene or notice of intervention and pursuant to § 157.205 of the Regulations under the Natural Gas Act (18 CFR 157.205) a protest to the request. If no protest is filed within the time allowed therefor, the proposed activity shall be deemed to be authorized effective the day after the time allowed for filing a protest. If a protest is filed and not withdrawn within 30 days after the time allowed for filing a protest, the instant request shall be treated as an application for authorization prusuant to section 7 of the Natural Gas Act.

Kenneth F. Plumb,

Secretary.

[FR Doc. 85–774 Filed 1–9–85; 8:45 am]

BILLING CODE 6717–01–M

[Docket No. TC82–36–002]

The Inland Gas Company, Inc.; Tariff Sheet Filing

January 4, 1985.

Take notice that on December 21, 1984, The Inland Gas Company, Inc. (Inland), 340–17th Street, Ashland, Kentucky 41101, tendered for filing in Docket No. TC82–36–002 First Revised Sheet No. 9 to its FERC Gas Tariff, First Revised Volume No. 1. The tariff sheet bears an issue date of December 21,

1984, and a proposed effective date of January 1, 1985.

Inland states that its currently effectively curtailment procedures include an Index of Affected Customers, which is set forth on Original Sheet No. 9. Inland indicates that the Index identifies the customers that are subject to curtailment, *i.e.*, the industrial customers with maximum daily contract quantities in excess of 300 Mcf, except essential agricultural users.

On March 29, 1984, Inland filed an application in Docket No. CP84-326-000 pursuant to section 7(c) of the Natural Gas Act for a certificate of public convenience and necessity authorizing, *inter alia*, deliveries of natural gas to two new industrial customers, BCR Paving Company (BCR) and Pine Mountain Asphalt Company (Pine Mountain). The requested certificate authorization was granted by order issued June 5, 1984. It is indicated that BCR and Pine Mountain have maximum daily contract quantities of 400 Mcf and 350 Mcf respectively. Inland states that these two new customers should be included in its Index of Affected Customers; thus, Inland proposes to revise its Index to include BCR and Pine Mountain.

Inland requests that the Commission grant a waiver of the notice requirements of § 154.22 of the Regulations because the purpose of this filing is to bring its curtailment procedures into compliance with the Commission's June 5, 1984, order in Docket No. CP84-326-000.

Any person desiring to be heard or to make any protest with reference to said tariff sheet filing should on or before January 14, 1985, 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. 85-766 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TA85-1-53-003]

K N Energy, Inc.; Compliance Filing

January 7, 1985.

Take notice that on December 24, 1984, K N Energy, Inc. (K N) tendered for filing as part of its FERC Gas Tariff, Third Revised Volume No. 1, the following sheets:

Fifth Revised Sheet No. 26
Fourth Revised Sheet No. 26A
Fourth Revised Sheet No. 26B

K N states this filing is made pursuant to the Federal Energy Regulatory Commission's (Commission) order issued November 23, 1984.

Any person desiring to be heard or to 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 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 January 14, 1985. 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. 85-767 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP84-86-004]

Locust Ridge Gas Co.; Filing

January 7, 1985.

Take notice that Locust Ridge Gas Company (Locust Ridge) on December 21, 1984 tendered for filing as part of its FERC Gas Tariff, the following sheets:

Original Volume No. 1

Rate Schedule G-1: Substitute Tenth Revised Sheet No. 1A
Rate Schedule T-1: Substitute Second Revised Sheet No. 27

Original Volume No. 3

Substitute Seventeenth Revised Sheet No. 1A.

Locust Ridge states that these revised sheets are being submitted in compliance with the Commission's order in this proceeding issued October 15, 1984, and the Letter Order issued on November 30, 1984, by the Director of the Office of Pipeline and Producer Regulation.

Any person desiring to be heard or to 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 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 January 14, 1985. 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. 85-768 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-56-000]

Midwestern Gas Transmission Co.; Tariff Filing

January 7, 1985.

Take notice that on December 21, 1984, Midwestern Gas Transmission Company (Midwestern), tendered for filing the following tariff sheets to Original Volume No. 1 of its FERC Gas Tariff to be effective on January 20, 1984:

First Revised Sheet No. 24

Midwestern states that the purpose of this tariff sheet is to increase the limit of eligibility of Midwestern's Rate Schedule SR-1 from 5,000 Mcf per day to 5,100 Mcf per day. Midwestern further states that this change will enable Midwestern to continue to serve the cities of Casey, Martinsville and Marshall, Illinois under Rate Schedule SR-1 while rendering those cities the increased service that Midwestern seeks to render in Docket No. CP84-479-000.

Midwestern further states that copies of the filing have been mailed to all of its customers and affected state regulatory commissions.

Any person desiring to be heard or to 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 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 January 14, 1985. 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. 85-769 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-59-000]

National Fuel Gas Supply Corp.; Tariff Filing

January 7, 1985.

Take notice that on December 31, 1984, National Fuel Gas Supply Corporation ("National"), Ten Lafayette Square, Buffalo, New York 14203, filed proposed Rate Schedule E to its FERC Gas Tariff, First Revised Volume No. 1. The filing consists of a new tariff applicable to the sale of natural gas to customers who are presently purchasing gas from National under its CDS Rate Schedules, all as more fully set forth in the proposed tariff which is on file with the Commission and open to public inspection.

National states that during the last several years, customers purchasing gas from National under its CDS Rate Schedules have from time to time requested additional gas from National under its I-1 Rate Schedule. However, this service could only be performed after receiving authorization from the Commission under section 7 of the Natural Gas Act. Proposed Rate Schedule E is designated to permit these customers to take gas when made available from National without imposing such administrative burdens on the Commission Staff.

It is also stated by National that the price for such service shall be the currently effective rate under Rate Schedule I-1 which is on file and approved by the Commission. National also requests that the Proposed Rate Schedule E be made effective on January 30, 1985.

Any person desiring to be heard or to 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 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 January 14, 1985. 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. 85-770 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket Nos. TA85-1-17-000 and TA85-1-17-001]

Texas Eastern Transmission Corp.; Proposed Changes in FERC Gas Tariff

January 7, 1985.

Take notice that on December 17, 1984, Texas Eastern Transmission Corporation (Texas Eastern) tendered for filing as part of its FERC Gas Tariff, Fourth Revised Volume No. 1, the following tariff Sheets:

Second Revised Seventy-first Revised Sheet No. 14.

According to § 381.103(b)(2)(iii) of the Commission's regulations (18 CFR 381.103(b)(2)(iii)), the date of filing is the date on which the Commission receives the appropriate filing fee, which in the instant case was not until December 26, 1984.

This tariff sheet is being filed pursuant to Section 4.F of Texas Eastern's Rate Schedule SS-II and Section 4.E of Texas Eastern's Rate Schedule ISS-III which provide for an automatic rate adjustment to flow through any changes in Consolidated Natural Gas Transmission Corporation's (Consolidated) GSS rates which underlie Texas Eastern's Rate Schedules SS-II and ISS-III. The effectiveness of such rate change as proposed herein will coincide with the date the Consolidated proposes to commence billing its revised GSS rates pursuant to its filing of November 19, 1984 in Docket No. RP82-115.

The proposed effective date of the above tariff sheet is November 1, 1984.

Copies of the filing were served on Texas Eastern's jurisdictional customers and interested state commisions.

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. All such motions or protests should be filed on or before January 14, 1985. 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. 85-771 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. TA85-1-18-000 and TA85-1-18-001]

Texas Gas Transmission Corp.; Proposed Changes in FPC Gas Tariff

January 7, 1985.

Take notice that Texas Gas Transmission Corporation, on December 31, 1984, tendered for filing Forty-Eighth Revised Sheet No. 7 and Eleventh Revised Sheet No. 7-B to its FPC Gas Tariff, Third Revised Volume No. 1. These sheets are being issued to reflect changes in the cost of purchased gas pursuant to Texas Gas's Purchased Gas Adjustment Clause.

Copies of the filing were served upon the company's jurisdictional customers and interested state commissions.

Any person desiring to be heard or to protest said filing should file a petition to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capital Street, NE, Washington, DC 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 385.214). All such petitions or protests should be filed on or before January 14, 1985. 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. 85-772 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

[Docket No. RP85-53-000]

Western Transmission Corp.; Filing

January 7, 1985.

Take notice that on December 17, 1984, Western Transmission Corporation (Western) tendered for filing Twenty-Third Revised Tariff Sheet No. 3-A to its FERC Gas Tariff, Original Volume No. 1. Western states that the revised sheet includes purchased gas costs for the six months ended September 30, 1984.

Any person desiring to be heard or to protest said filing should file a petition to intervene or protest with the Federal Energy Regulatory Commission, 825 North Capital 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 January 11, 1985. 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. 85-773 Filed 1-9-85; 8:45 am]

BILLING CODE 6717-01-M

ENVIRONMENTAL PROTECTION AGENCY

[OPP-30092; FRL-2756-2]

Ethylene Dibromide; Opportunity To Comment on Requested Amendment to EDB Registration for Use To Fumigate Exported Citrus

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: The Environmental Protection Agency has received a request for an increase in the allowable period for use of the pesticide ethylene dibromide (EDB) to fumigate exported citrus. The requested amendment would remove the restriction that exported citrus be treated only during the months of October through January; as a result of this change, citrus currently exported February through June could also be treated with EDB. The requested amendment would also impose several additional restrictions designed to reduce potential exposure to workers conducting EDB fumigation operations and to workers exposed to fumigated fruit moving through commerce to export. The Agency will consider the requested amendment to EDB registration terms and is hereby requesting public comments for a period of 15 days following publication of this notice.

ADDRESS: Written comments must be identified as OPP-30092.

By mail, address to: Information Services Section, Program Management and Support Division (TS-757C), Office of Pesticide Programs, Environmental Protection Agency, 401 M Street, SW., Washington, D.C. 20460.

In person, bring comments to: Rm. 236, CM #2, 1921 Jefferson Davis Highway, Arlington, VA.

FOR FURTHER INFORMATION CONTACT:

By mail: Richard J. Johnson, Registration Division (TS-767C), Office of Pesticide Programs, Environmental Protection Agency, 401 M Street, SW., Washington, D.C. 20460.

Office location and telephone number: Rm. 711A, CM #2, 1921 Jefferson Davis Highway, Arlington, VA. (703-557-7420).

SUPPLEMENTARY INFORMATION:

Background

On September 28, 1983, EPA issued a notice of intent to cancel registrations of pesticides containing EDB for most uses, including use to fumigate citrus and other fruits and vegetables in order to meet interstate and international quarantine requirements. Fruit growing states and nations had imposed quarantine requirements to prevent fruit fly infestations from fruits moving across their borders. Following the cancellation notice, users of EDB for citrus fumigation, among others, requested an administrative hearing to challenge the cancellation decision. Within the months following the notice, most states with quarantine requirements developed alternative means by which the shippers, primarily in Florida, could meet the quarantine.

By April 3, 1984, EPA had taken several additional steps to address the risks from continued EDB use, especially risks from contamination of the American diet. With respect to dietary risks from citrus fumigation, the Administrator noted that most domestically consumed fruit was no longer treated with EDB. With respect to citrus fumigated before export to other nations, he found that it is appropriate to ensure that citrus fruit leaving this country be able to meet the quarantine requirements of U.S. trading partners, provided that the use can continue without unreasonable adverse effects to American workers.

Based on these findings, the Agency issued an amendment to the September 28, 1983, EDB cancellation notice. The amendment modified the cancellation decision for fumigation of citrus and papayas to provide the registration for use to treat domestically consumed fruit would be cancelled. However, registrations for use to treat exported citrus and payayas were permitted to continue, subject to a number of additional restrictions. The registration requirements were directed toward minimizing exposure of U.S. workers to EDB. They included (1) limitation to use only during October through January for citrus; (2) limitation of application to certified applicators under U.S. or state government supervision; (3) respirator and protective clothing requirements for fumigation operations; (4) fumigation chamber stack height requirements and (5) aeration of trucks transporting fumigated fruit. The limitation to treatment October through January was based upon available information which indicated that cold treatment would provide acceptable, workable quarantine control except on early season citrus.

With respect to continuing risks to U.S. workers under the amended registration terms, the Administrator concluded that the occupational risks were reduced to acceptable levels in light of the benefits.

Following the April 3, 1984 amendment to the Cancellation Notice, Great Lakes Chemical Company sought a conforming amendment to its Registration No. 5785-29-AA, which was granted on June 15, 1984. Thereafter, the persons requesting hearings to challenge the Notice of Intent to Cancel as it applied to citrus withdrew their challenges and the Cancellation Notice, as amended, went into effect.

Pending Amendment Request

EPA received on December 4, 1984 a request from Great Lakes Chemical Company to amend its registration for pesticide products containing EDB for use to fumigate exported citrus. Great Lakes is currently the sole registrant of EDB products for this purpose and seeks certain changes in the required terms and conditions or registration for the exported citrus fumigation use.

By seeking removal of the restriction on treatment of exported citrus to the months October through January, the request makes possible treatment of a volume of citrus two to two and one half times that currently permitted.

In addition to the removal of the limitation on the months during which EDB treatment can occur, the amendment request proposes additional restrictions to address worker exposure issues. These additional restrictions include changes in operation of fumigation chamber doors, additional systematic monitoring of EDB levels, additional exhausting of trailers used to transport citrus from fumigation site to port, requirements that warehouses meet OSHA requirements and ventilation requirements in ship holds

during loading. The requested amendment would not lead to the introduction of EDB into the American diet because it applies only to registration of products which are limited to treatment of exported citrus.

EPA has been informed that Florida citrus exporters have experienced difficulties with alternatives for meeting quarantine requirements of other nations, most notably problems with fruit quality following shipments using cold treatment to control possible fruit fly infestation. EPA has been informed that citrus reaching Japan after cold treatment contained large quantities of unmarketable fruit and that Japanese purchasers are no longer willing to obligate payments for fruit which has been cold treated. Because of these difficulties, EPA has been requested to act on this amendment prior to February, 1984.

Great Lakes proposes that the following labeling be required for all EDB products for use to fumigate exported citrus. Where language from the previously approved terms is proposed for change, the current and requested language are both indicated. Great Lakes does not request any further changes at this time.

Current Label

The following language currently appears on the label:

> After September 1, 1984 citrus fruit for export outside of the territorial United States may be treated only during the months of October, November, December, and January. The treatment of citrus fruit for export in any other month is permitted *only* after a written determination by the U.S. Environmental Protection Agency that a significant fruit fly outbreak has resulted in quarantine requirements for exported fruit which cannot be met by alternative quarantine treatments and that treatment with EDB for such purposes will not cause unreasonable adverse effects on the environment.

Requested Labeling Changes

The requested amendment would delete the language and would require the following additional labeling:

(1) At the state fumigation chambers, installation of and operation of a cable or any other suitable implement for opening the chamber door that will place the individual at least ten feet from the door.

(2) The systematic monitoring of EDB levels at each facility using: (a) OSHA approved methods and/or portable gas chromatographs; and (b) the operation of an infrared analyzer equipped with an alarm system.

(3) Operation of exhaust equipment in the trailers at the port for a minimum of fifteen minutes prior to opening the doors. The blower will circulate 2,000 cubic feet of air per minute and result in a minimum of fifteen air exchanges before the trailer doors are opened.

(4) Where deficiencies exist, operators of warehouses in which fumigated fruit is stored will initiate the necessary procedural changes and/or engineering modifications to comply with all OSHA requirements.

(5) Operator breathing zone levels for forklift drivers shall comply with OSHA requirements through the use of engineering modifications and/or personal protective equipment.

(6) EDB treated fruit will be transported only aboard seagoing vessels that are equipped with a ventilation system in the ship's hold in which the fruit is stored. The ventilation system shall be in operation during loading.

The fumigation of fruit for export in containerized trailers may continue without the above restrictions.

Opportunity To Comment

Acting in its discretion, EPA has decided to solicit public comment on the pending request for amendment to EDB registrations for fumigation of exported citrus. EPA specifically requests comments on the effects of the amendment on risks to United States workers who may experience additional EDB exposure and comments on the need for the amendment by United States citrus exporters. EPA is requesting that additional supporting information be supplied by the registrant relating to the need for the amendment and the potential for reducing worker exposure through the requested additional terms. After considering all available information, EPA could grant or deny the requested amendment, could grant some variation of the requested amendment, or could permit an amendment conditioned on further research or monitoring requirements.

The time for comment has been limited to enable EPA to decide whether approval of the amendment prior to February first is warranted based on available information. EPA has not completed an evaluation of the requested amendment or supporting documentation and this Notice is not intended to announce an EPA decision or proposed decision on this amendment. EPA expects to act on the amendment request in the manner normal for such actions and may take action on the amendment without further public notice. Any person wishing to obtain information on the status of this amendment request may contact Richard J. Johnson at the location/telephone number under **"FOR FURTHER INFORMATION CONTACT"**.

Comments must be received by the Agency on or before January 25, 1985 and must be addressed in the manner described at the outset of this notice. Comments may address any matters relevant to EPA's consideration of the registration amendment request described in this notice.

Dated: January 7, 1985.

Susan H. Sherman,

Acting Director, Office of Pesticide Programs.

[FR Doc. 85-859 Filed 1-9-85; 8:45 am]

BILLING CODE 6560-50-M

[OPP-00191; FRL 5233187]

FIFRA Scientific Advisory Panel; Closed Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: There will be a 1-day meeting of a subpanel of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) Scientific Advisory Panel to review a notification submitted to EPA by Advanced Genetic Sciences, Inc. (AGS), concerning its intent to conduct small-scale field studies with a genetically altered microbial pesticide. The meeting will be closed to the public.

DATES: Tuesday, January 22, 1985, from 10 a.m. to 4 p.m.

ADDRESS: The meeting will be held at: Environmental Protection Agency, Rm. S355, 401 M St., SW., Washington, D.C. 20460.

FOR FURTHER INFORMATION CONTACT:

By Mail: Philip H. Gray, Jr., Executive Secretary, FIFRA Scientific Advisory Panel, Office of Pesticide Programs (TS-766C), 401 M St., SW., Washington, D.C. 20460.

Office location and telephone number: Rm. 1117, Crystal Mall, Building No. 2, Arlington, VA, (703-557-7096).

SUPPLEMENTARY INFORMATION: The agenda for this meeting is:

1. Consideration of a notification of intent to conduct small-scale field studies with a genetically altered microbial pesticide.

2. Review by the subpanel of EPA's preliminary findings and recommendations in response to the notification.

It should be noted that the Federal Advisory Committee Act permits the closure of meetings or portions of meetings when trade secret information is to be discussed or presented. No documents are being made available to the public at this time.

Dated: January 8, 1985.

Lee M. Thomas,

Acting Administrator.

[FR Doc. 85-882 Filed 1-8-85; 2:03 pm]

BILLING CODE 6560-50-M

Science Advisory Board

[SAB-FRL-2754-4]

Radiation Advisory Committee; Open Meeting

Under Pub. L. 92-463, notice is hereby given that a meeting of the Science Advisory Board's (SAB) Radiation Advisory Committee will be held on February 4, 1985 in room 1112 of the U.S. Environmental Protection Agency, Crystal Mall II, 1921 Jefferson Davis Highway, Arlington, Virginia 22202. The meeting will begin at 9:00 a.m. and the estimated time of adjournment is 5:00 p.m.

This is the first in a series of meetings for the Committee. The Radiation Advisory Committee will study the impact of radiation on the environment and human populations. The Committee is expected to provide a review of the scientific quality of the Agency's radiation activities and to offer advice on how its scientific capabilities may be maintained at a high level. Specifically, the Committee is expected to review and comment on the adequacy of scientific information and analyses used in developing risk assessments and other scientific documents on radiation matters.

The following individuals have agreed to serve on the Committee:

Dr. William J. Schull (Chairman), Director and Professor of Population Genetics, Center for Demographic and Population Genetics, School of Public Health, University of Texas Health Science Center at Houston, Houston, Texas 77030

Seymour Jablon, National Research Council, 2101 Constitution Avenue, NW., Washington, D.C. 20418

Dr. James V. Neel, Lee R. Dice University Professor of Human Genetics, The University of Michigan Medical School, Department of Human Genetics, Box 015, 1137 E. Catherine Street, Ann Arbor, Michigan 48109

Dr. Warren Sinclair, National Council on Radiation Protection and Measurements, 7910 Woodmont Avenue, Suite 1016, Bethesda, Md. 20814

Dr. John Till, Route 2, Box 122, Neeses, SC 29107

Dr. Terry Lash, Department of Nuclear Safety, 1035 Outer Park Drive, Springfield, Illinois 62704

Dr. Oddvar Nygaard, Division of Radiation Biology, Department of Radiology, Case Western Reserve University, School of Medicine, Cleveland, Ohio 44106

Dr. Charles Susskind, Professor, Electrical Engineering and Computer Sciences Department, College of Engineering, University of California, Berkeley, California 94720

The meeting is open to the public; however, seating is limited. Any member of the public wishing to attend or obtain information should contact Ms. Kathleen Conway, Executive Secretary, Radiation Advisory Committee, Science Advisory Board, by close of business January 31, 1985, the telephone number is (202) 382-2552.

Dated: January 2, 1985.

Terry F. Yosie,

Director, Science Advisory Board.

[FR Doc. 85-705 Filed 1-9-85; 8:45 am]

BILLING CODE 6560-50-M

FEDERAL HOME LOAN BANK BOARD

[No. 85-25]

Agency Information Collection Activities; Savings and Loan Examiner Candidates' Forms

Dated: January 4, 1985.

AGENCY: Federal Home Loan Bank Board.

ACTION: Notice.

SUMMARY: The public is advised that the Federal Home Loan Bank Board has submitted a request for extension, with revision, of its information collection, "Savings and Loan Examiner Candidates' Forms" to the Office of Management and Budget for approval in accordance with the Paperwork Reduction Act (44 U.S.C. Chapter 35). This information collection (3068-0012) consists of one new form and two forms previously approved under OMB Nos. 3068-0012 and 3068-0013.

Comments: Comments on the information collection request are welcome and should be submitted within 15 days of publication of this notice in the **Federal Register.** Comments regarding the paperwork-burden aspect of the request should be directed to: Office of Management and Budget, Office of Information and Regulatory Affairs, Washington, D.C. 20503. Attention: Desk Officer for the Federal Home Loan Bank Board.

The Board would appreciate commenters sending copies of their comments to the Board.

Requests for copies of the proposed information collection request and supporting documentation are obtainable at the Board address given below: Director, Information Services Section, Office of Secretariat, Federal Home Loan Bank Board, 1700 G Street, NW., Washington, D.C. 20552. Phone: 202-377-6933.

FOR FURTHER INFORMATION CONTACT: Kathleen Thomas, Personnel Management Office. Phone: 202-377-6891.

By the Federal Home Loan Bank Board.

J. J. Finn,

Secretary.

[FR Doc. 85-752 Filed 1-9-85; 8:45 am]

BILLING CODE 6720-01-M

FEDERAL MARITIME COMMISSION

Agreement(s) Filed

The Federal Maritime Commission hereby gives notice of the filing of the following agreement(s) pursuant to section 5 of the Shipping Act of 1984.

Interested parties may inspect and obtain a copy of each agreement at the Washington, D.C. Office of the Federal Maritime Commission, 1100 L Street, N.W., Room 10325. Interested parties may submit comments on each agreement to the Secretary, Federal Maritime Commission, Washington, D.C. 20573, within 10 days after the date of the **Federal Register** in which this notice appears. The requirements for comments are found in § 572.603 of Title 46 of the Code of Federal Regulations. Interested persons should consult this section before communicating with the Commission regarding a pending agreement.

Agreement No.: 224-004010-001

Title: Eastport, Maine Terminal Agreement

Parties: Federal Marine Terminals, Inc. (FMT) Eastport Port Authority (Authority)

Synopsis: Agreement No. 224-004010-001, between FMT and the Authority, extends the lease arrangement for an additional term of three years at increased rentals. The leased premises is located at Eastport Breakwater in the port of Eastport, Maine, and it is used in marine terminal operations.

By Order of the Federal Maritime Commission.

Dated: January 7, 1985.

Francis C. Hurney,

Secretary.

[FR Doc. 85-694 Filed 1-9-85; 8:45 am]

BILLING CODE 6730-01-M

FEDERAL RESERVE SYSTEM

First Colebrook Bancorp, Inc., et al.; Formations of; Acquisitions by; and Mergers of Bank Holding Companies

The companies listed in this notice have applied for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) and § 225.14 of the Board's Regulation Y (12 CFR 225.14) to become a bank holding company or to acquire a bank or bank holding company. 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 is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank or to the offices of the Board of Governors. 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.

Unless otherwise noted, comments regarding each of these applications must be received not later than February 1, 1985.

A. **Federal Reserve Bank of Boston** (Richard E. Randall, Vice President) 600 Atlantic Avenue, Boston, Massachusetts 02106:

1. *First Colebrook Bancorp, Inc.*, Colebrook, New Hampshire; to become a bank holding company by acquiring 100 percent of the voting shares of The First Colebrook Bank, Colebrook, New Hampshire.

B. **Federal Reserve Bank of New York** (A. Marshall Puckett, Vice President) 33 Liberty Street, New York, New York 10045:

1. *Gateway Bancorp, Inc.*, Staten Island, New York; to become a bank holding company by acquiring 100 percent of the voting shares of Gateway State Bank, Staten Island, New York.

C. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *First Clay Corp.*, Brazil, Indiana; to become a bank holding company by acquiring 100 percent of the voting shares of First Bank and Trust Company of Clay County, Brazil, Indiana.

D. **Federal Reserve Bank of Kansas City** (Thomas M. Hoenig, Vice President) 925 Grand Avenue, Kansas City, Missouri 64198:

1. *United Banks of Colorado, Inc.*, Denver, Colorado; to acquire 100 percent of the voting shares or assets of United Bank of University Hills, N.A., Denver, Colorado.

E. **Federal Reserve Bank of Dallas** (Anthony J. Montelaro, Vice President) 400 South Akard Street, Dallas, Texas 75222:

1. *Greater Texas Bancshares, Inc.*, Georgetown, Texas; to acquire 100 percent of the voting shares or assets of National Bank of Oak Hill, Austin, Texas, a *de novo* bank.

2. *Stone Oak Bankshares, Inc.*, San Antonio, Texas; to become a bank holding company by acquiring 100 percent of the voting shares of Stone Oak National Bank, San Antonio, Texas.

Board of Governors of the Federal Reserve System, January 4, 1985.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 85-683 Filed 1-9-85; 8:45 am]

BILLING CODE 6210-01-M

Grand Ridge Bancorporation, Inc., et al.; Applications To Engage De Novo in Permissible Nonbanking Activities

The companies listed in this notice have filed an application under § 225.23(a)(1) of the Board's Regulation Y (12 CFR 225.23(a)(1)) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and Section 225.21(a) of Regulation Y (12 CFR 225.21(a)) to commence or to engage *de novo*, either directly or through a subsidiary, in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies. Unless otherwise noted, such activities will be conducted throughout the United States.

Each application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing 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.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than January 31, 1985.

A. **Federal Reserve Bank of Chicago** (Franklin D. Dreyer, Vice President) 230 South LaSalle Street, Chicago, Illinois 60690:

1. *Grand Ridge Bancorporation, Inc.*, Grand Ridge, Illinois; to engage *de novo* in making and servicing loans.

B. **Federal Reserve Bank of St. Louis** (Delmer P. Weisz, Vice President) 411 Locust Street, St. Louis, Missouri 63166:

1. *First Western Bancshares, Inc.*, Booneville, Arkansas; to engage *de novo* through its subsidiary, First Western Loan Company, Booneville, Arkansas, in originating commercial, consumer, and mortgage loans, then selling such loans to investors. Company will also originate leases for the account of third party lessors. These activities would be conducted in the states of Arkansas, Texas, Oklahoma and Missouri.

Board of Governors of the Federal Reserve System, January 4, 1985.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 85-684 Filed 1-9-85; 8:45 am]

BILLING CODE 6210-01-M

Oxford Agency, Inc.; Formation of, Acquisition by, or Merger of Bank Holding Companies; and Acquisition of Nonbanking Company

The company listed in this notice has applied under § 225.14 of the Board's Regulation Y (12 CFR 225.14) for the Board's approval under section 3 of the Bank Holding Company Act (12 U.S.C. 1842) to become a bank holding company or to acquire voting securities of a bank or bank holding company. The listed company has also applied under § 225.23(a)(2) of Regulation Y (49 FR 794) for the Board's approval under section 4(c)(8) of the Bank Holding Company Act (12 U.S.C. 1843(c)(8)) and § 225.21(a) of Regulation Y (12 CFR 225.21(a)) to acquire or control voting securities or assets of a company engaged in a nonbanking activity that is listed in § 225.25 of Regulation Y as closely related to banking and permissible for bank holding companies, or to engage in such an activity. Unless otherwise

noted, these activities will be conducted throughout the United States.

The application is available for immediate inspection at the Federal Reserve Bank indicated. Once the application has been accepted for processing, it will also be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing 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.

Comments regarding the application must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than February 1, 1985.

A. **Federal Reserve Bank of Kansas City** (Thomas M. Hoenig, Vice President), 925 Grand Avenue, Kansas City, Missouri 64198:

1. *Oxford Agency, Inc.*, Oxford, Nebraska; to become a bank holding company by acquiring 100 percent of the voting shares of Security State Bank, Oxford, Nebraska. Oxford Agency, Inc. has also applied to acquire the assets of Oxford Insurance Agency, Oxford, Nebraska, thereby engaging in the activities of acting as agent for the sale of general insurance in a town with a population not exceeding 5,000.

Board of Governors of the Federal Reserve System, January 4, 1985.

James McAfee,

Associate Secretary of the Board.

[FR Doc. 85-685 Filed 1-9-85; 8:45 am]

BILLING CODE 6210-01-M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control

Improved Methods for Analysis of Crystalline Silica; Open Meeting

The following meeting will be convened by the National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control (CDC) and will be open to the public for observation and participation, limited only by the space available:

Date: January 15, 1985.
Time: 9:00 a.m.–11:30 a.m.
Place: Conference Room B, 5555 Ridge Avenue, Cincinnati, Ohio 45213.

Purpose: To review a project entitled "Improved Methods for Analysis of Crystalline Silica." This project will lead to improvements in the current NIOSH X-ray diffraction method for the analysis of airborne respirable crystalline silica. Viewpoints and suggestions from industry, organized labor, academia, other government agencies, and the public are invited.

Additional information may be obtained from: Thomas P. Carsey, Division of Physical Sciences and Engineering, NIOSH, CDC, 4676 Columbia Parkway, Cincinnati, Ohio 45226. Telephones: FTS: 684-4272; Commercial: 513/684-4272.

Dated: January 4, 1985.

Elvin Hilyer,

Associate Director for Policy Coordination, Centers for Disease Control.

[FR Doc. 85-688 Filed 1-9-85; 8:45 am]

BILLING CODE 4160-19-M

Health Resources and Services Administration

Advisory Committees; Meetings

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463), announcement is made of the following National Advisory bodies scheduled to meet during the month of January 1985:

National Advisory Council on Health Professions Education

Date and Time: January 22-23, 1985, 9:00 a.m.

Place: Conference Room I & J, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

Open on January 22, 9:00 a.m.–5:00 p.m.
Closed for the remainder of meeting.

Purpose: The Council advises the Secretary with respect to the administration of programs of financial assistance for the health professions and makes recommendations based on its review of applications requesting such assistance. This also involves advice in the preparation of regulations with respect to policy matters.

Agenda: The open portion of the meeting will cover: Welcome and opening remarks; report of the Director, Bureau of Health Professions, financial management update, discussion of Council dealing with perspective reimbursement of clinical education costs, presentation on international activities of the Bureau and future agenda items. The meeting will be closed to the public on January 23, 1965, for the remainder of the meeting for the review of grant application for Advance Financial Distress, Family Medicine Residency Training and Area Health Education Centers. The closing is in accordance with the provisions set forth in section 552b(c)(6), Title 5, U.S. Code, and the Determination by the Administrator, Health Resources and Services Administration, pursuant to Pub. L. 92-463.

Anyone wishing to obtain a roster of members, minutes of meetings, or other relevant information should write to or contact Mr. Robert L. Belsley, Executive Secretary, National Advisory Council on Health Professions Education, Bureau of Health Professions, Health Resources and Services Administration, Room 8C-22, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 443-6880.

National Advisory Council on Nurse Training

Date and Time: January 22-23, 1985, 9:00 a.m.

Place: Conference Room G, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

Open on January 22, 9:00 a.m.–10:00 a.m.
Open on January 23, 1:00 p.m.–4:00 p.m.
Closed for the remainder of meeting.

Purpose: The Council advises the Secretary and Administrator, Health Resources and Services Administration, concerning general regulations and policy matters arising in the administration of Title XXVII, National Health Service Corps, Health Professions Education, Nurse Training Omnibus Budget Reconciliation Act of 1981 (Pub. L. 97-35). The Council also performs final review of grant applications for Federal assistance, and makes recommendations to the Administrator, HRSA.

Agenda: Agenda items for the open portion of meeting will cover announcements; consideration of minutes of previous meeting; reports by the Director, Bureau of Health Professions (BHPr.), the Financial Management Officer, BHPr., the Director, Division of Nursing, and staff reports. The meeting will be closed to the public on January 22, 1984 at 10:00 a.m.–5:00 p.m. and January 23, 9:00 a.m.–12:00 p.m., for the review of grant applications for advanced nurse training grants, nurse practitioner grants, special project grants, and research project grants. The closing is in accordance with the provision set forth in section 552b(c)(6), Title 5, U.S. Code and the Determination by the Administrator, Health Resources and Services Administration, pursuant to section 10(d) of Public Law 92-463.

Anyone wishing to obtain a roster of members, minutes of meeting, or other relevant information should write to or contact Dr. Mary S. Hill, Bureau of Health Professions, Health Resources and Services Administration, Room 5C-04, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857, Telephone (301) 443-6193.

Joint Meeting of the National Advisory Council on Health Professions Education and the National Advisory Council on Nurse Training

Date and Time: Thursday, January 24, 1985, 9:00 a.m.

Place: Conference Room C-H, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857.

The entire meeting is open.

Purpose: The Councils advise the Secretary concerning general regulations and policy matters arising in the administration of Title VII and VIII of the Public Health Service Act. The Councils also perform final reviews of grant applications for Federal assistance and make recommendations to the Secretary.

Agenda: Agenda will cover announcements, reports from the Secretary, Health and Human Services, the Administrator, Health Resources and Services Administration, and the Ad Hoc Council group dealing with reimbursement of educational costs. The Councils will discuss the Health Promotion, Disease Prevention workshops and explore approaches to prepare health professions leaders in geriatrics.

Agenda items are subject to change as priorities dictate.

Dated: December 27, 1984.

Jackie E. Baum,

Advisory Committee Management Officer, HRSA.

[FR Doc. 85-686 Filed 1-9-85; 8:45 am]

BILLING CODE 4160-15-M

National Institutes of Health

National Advisory Eye Council and the Vision Research Program Planning Subcommittee; Meeting

Pursuant to Pub. L. 92-463, notice is hereby given of the meeting of the National Advisory Eye Council, National Eye Institute, January 28-29, 1985, Building 31, Conference Room 8, National Institutes of Health, Bethesda, Maryland, and the subcommittee meeting on January 27 at the Bethesda Marriott Hotel.

This meeting will be open to the public from 9:00 a.m. until approximately 12:00 noon on Monday, January 28. Following opening remarks by the Director, National Eye Institute, there will be a report on the mid-course evaluation of *Vision Research: A National Plan, 1983-1987*, a report on the one year results of the Prospective Evaluation of Radial Keratotomy (PERK) Study, a discussion of refractive keratoplasty in general, construction program guidelines and other presentations by the staff of the Institute.

In accordance with provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code and Section 10(d) of Pub. L. 92-463, the meeting will be closed to the public from approximately 12:00 noon until recess on Monday, January 28, and from 9:00 a.m. to adjournment on Tuesday, January 29, for the review, discussion and evaluation of individual grant applications. These applications and the discussions could reveal confidential trade secrets or commercial property such as patentable materials, and personal information concerning individuals associated with the applications, disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

There will also be a meeting of the Vision Research Program Planning Subcommittee on January 27 from 7:00 p.m. to 10:00 p.m. at the Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, Maryland in a room that will be posted in the lobby. This meeting is to discuss the preliminary report on the midcourse evaluation of *Vision Research: A National Plan, 1983-1987*. Attendance by the public will be limited to space available.

Ms. Kay Valeda, Committee Management Officer, National Eye Institute, Building 31, Room 6A03, National Institutes of Health, Bethesda, Maryland 20205 (301) 496-4903, will provide summaries of meetings and rosters of committee members.

Dr. Ronald G. Geller, Associate Director for Extramural and Collaborative Programs, National Eye Institute, Building 31, Room 6A03, National Institutes of Health, Bethesda, Maryland 20205, (301) 496-4903, will furnish substantive program information.

(Catalog of Federal Domestic Assistance Programs Nos. 13.867, Retinal and Choroidal Diseases Research; 13.686, Corneal Diseases Research; 13.869, Cataract Research; 13.870, Glaucoma Research; and 13.871, Sensory and Motor Disorders of Visual Research; National Institutes of Health)

Dated: December 31, 1984.

Betty J. Beveridge,

Committee Management Officer, NIH.

[FR Doc. 85-669 Filed 1-9-85; 8:45 am]

BILLING CODE 4140-01-M

National Advisory Allergy and Infectious Diseases Council, Allergy and Immunology Subcommittee, Microbiology and Infectious Diseases Subcommittee; Meeting

Pursuant to Pub. L. 92-463, notice is hereby given of the meeting of the National Advisory Allergy and Infectious Diseases Council, National Institute of Allergy and Infectious Diseases, and its subcommittees on January 24-25, 1985, at the National Institutes of Health, Building 31C, Conference Room 10, Bethesda, Maryland 20205.

The meeting will be open to the public on January 24 from approximately 9:00 a.m. to 9:30 a.m. for opening remarks of the Institute Director and again from 1:30 p.m. to approximately 5:00 p.m. for discussion of procedural matters, Council business, and a report from the Institute Director which will include a discussion of budgetary matters. The primary program discussions will be on a report by members of the Institute of Medicine on current priorities for vaccine development. On January 25 the meeting will be open to the public from approximately 9:00 a.m. to 9:30 a.m. for the report of the Director of the Microbiology and Infectious Diseases Program; open portions limited to space available.

In accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code, and section 10(d) of Pub. L. 92-463, the meeting of the NAAIDC Allergy and Immunology Subcommittee and of the NAAIDC Microbiology and Infectious Diseases Subcommittee will be closed to the public for approximately three hours for the review, evaluation, and discussion of individual grant applications. It is anticipated that this will occur from 9:30 a.m. until approximately 12:30 p.m. on January 24. The meeting of the full Council will be closed from approximately 10:00 a.m. until adjournment on January 25 for the review, evaluation, and discussion of individual grant applications. These applications and the discussions could reveal confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the applications, disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Mr. Thomas Flavin, Office of Research Reporting and Public Response, National Institute of Allergy and Infectious Diseases, Building 31, Room 7A32, National Institutes of Health, Bethesda, Maryland 20205, telephone (301) 496-5717, will provide summaries of the meetings and rosters of the Council members as requested.

Dr. John W. Diggs, Director, Extramural Activities Program, NIAID, NIH, Westwood Building, Room 703, telephone (301) 496-7291, will provide substantive program information.

(Catalog of Federal Domestic Assistance Program Nos. 13.855, Pharmacological Sciences; 13.856, Microbiology and Infectious Diseases Research, National Institutes of Health)

Dated: December 31, 1984.

Betty J. Beveridge,

NIH Committee Management Officer.

[FR Doc. 85-673 Filed 1-9-85; 8:45 am]

BILLING CODE 4140-01-M

National Advisory Research Resources Council; Meeting

Pursuant to Pub. L. 92–463, notice is hereby given of the meeting of the National Advisory Research Resources Council, Division of Research Resources (DRR), February 7–8, 1985, Conference Room 6, Building 31–C, National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205, at approximately 8:30 a.m.

This meeting will be open to the public February 7 from 8:30 a.m. to 5:30 p.m. to discuss administrative details such as budget and legislative updates, Council Operating Procedures, and to hear an overview of the Minority Biomedical Research Support Program. Attendance by the public will be limited to space available.

In accordance with provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code and Section 10(d) of Pub. L. 92–463, the meeting will be closed to the public on February 8 from 8:30 a.m. to adjournment for review, discussion and evaluation of individual grant applications. The applications and discussions could reveal confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Mr. James Augustine, Information Officer, DRR, Room 5B10, Building 31, National Institutes of Health, Bethesda, Maryland 20205, (301) 496–5545, will provide summaries of the meeting and rosters of the Council members. Dr. James F. O'Donnell, Deputy Director, Division of Research Resources, Room 5B03, Building 31, National Institutes of Health, Bethesda, Maryland 20205, (301) 496–6023 will furnish substantive program information and will receive any comments pertaining to this announcement.

(Catalog of Federal Domestic Assistance Program Nos. 13.306, Laboratory Animal Sciences and Primate Research; 13.333, Clinical Research; 13.337, Biomedical Research Support; 13.371, Biotechnology Resources; 13.375, Minority Biomedical Research Support, National Institutes of Health)

Dated: December 31, 1984.

Betty J. Beveridge,

NIH Committee Management Officer.

[FR Doc. 85–672 Filed 1–9–85; 8:45 am]

BILLING CODE 4140–01–M

Research Grants; Meetings

Pursuant to Pub. L. 92–463, notice is hereby given of the meetings of the following study sections for February through March 1985, and the individuals from whom summaries of meetings and rosters of committee members may be obtained.

These meetings will be open to the public to discuss administrative details relating to study section business for approximately one hour at the beginning of the first session of the first day of the meeting. Attendance by the public will be limited to space available. These meetings will be closed thereafter in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code and Section 10(d) of Pub. L. 92–463, for the review, discussion and evaluation of individual grant applications. These applications and the discussions could reveal confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

The Grants Inquiries Office, Division of Research Grants, Westwood Building, National Institutes of Health, Bethesda, Maryland 20205, telephone 301–496–7441 will furnish summaries of the meetings and rosters of committee members. Substantive program information may be obtained from each executive secretary whose name, room number, and telephone number are listed below each study section. Since it is necessary to schedule study section meetings months in advance, it is suggested that anyone planning to attend a meeting contact the executive secretary to confirm the exact date, time and location. All times are A.M. unless otherwise specified.

Study section	Feb.-Mar. 1985 meetings	Time	Location
Allergy and Immunology: Dr. Eugene Zimmerman, Rm. 320, Tel. 301–496–7380	Feb. 21–23	8:30	Holiday Inn, Georgetown, DC.
Bacteriology and Mycology—1: Dr. Milton Gordon, Rm. 304, Tel. 301–496–7340	Feb. 13–15	8:30	Do.
Bacteriology and Mycology—2: Dr. William Branche, Jr. Rm. 308, Tel. 301–496–7681	Feb. 20–22	8:30	Do.
Behavioral Medicine: Dr. Joan Rittenhouse, Rm. 232, Tel. 301–496–7109	Feb. 13–15	9:00	Do.
Biochemical Endocrinology: Dr. Norman Gold, Rm. 226, Tel. 301–496–7430	Feb. 24–27	8:30	Holiday Inn, Bethesda, MD.
Biochemistry—1: Dr. Adolphus P. Toliver, Rm. 318B, Tel. 301–496–7518	Mar. 13–16	9:00	Georgetown Hotel, Washington, DC.
Biochemistry—2: Dr. Alex Liacouras, Rm. 318A, Tel. 301–496–7517	Feb. 27-Mar. 1	8:30	Linden Hill Hotel, Bethesda, MD.
Bio-Organic and Natural Products Chemistry: Dr. Michael Rogers, Rm. A-27, Tel. 301–496–7107	Feb. 21–23	9:00	Holiday Inn, Georgetown, DC.
Biophysical Chemistry: Dr. John B. Wolff, Rm. 236B, Tel. 301–496–7070	Feb. 21–23	8:30	Room 8, Bldg. 31C, Bethesda, MD.
Bio-Psychology: Dr. A. Keith Murray, Rm. 229, Tel. 301–496–7058	Feb. 4–7	9:00	Holiday Inn, Georgetown, DC.
Cardiovascular and Pulmonary: Dr. Anthony C. Chung, Rm. 2A-04, Tel. 301–496–7316	Feb. 20–22	8:30	Linden Hill Hotel, Bethesda, MD.
Cardiovascular and Renal: Dr. Rosemary Morris, Rm. 321, Tel. 301–496–7901	Feb. 25–27	8:30	Holiday Inn, Georgetown, DC.
Cellular Biology and Physiology—1: Dr. Gerald Greenhouse, Rm. 336, Tel. 301–496–7396	Feb. 20–22	8:30	Room A, Landow Bldg., Bethesda, MD.
Cellular Biology and Physiology—2: Dr. Evelyn Horenstein, Rm. 306, Tel. 301–496–7681	Feb. 27-Mar. 1	8:30	Linden Hill Hotel, Bethesda, MD.
Chemical Pathology: Dr. Edmund Copeland, Rm. 353, Tel. 301–496–7078	Feb. 19–21	8:00	Holiday Inn, Rockville, MD.
Diagnostic Radiology: Dr. Catherine Wingate, Rm. 219B, Tel. 301–496–7650	Feb. 25–27	8:30	Room 8, Bldg. 31C, Bethesda, MD.
Endocrinology: Mr. Morris M. Graff, Rm. 333, Tel. 301–496–7348	Feb. 11–13	1:00 p.m.	Room 6, Bldg. 31C, Bethesda, MD.
Epidemiology and Disease Control—1: Dr. Phyllis B. Eveleth, Rm. 203C, Tel. 301–496–7246	Feb. 12–14	8:30	Ramada Inn, Bethesda, MD.
Epidemiology and Disease Control—2: Dr. Ann Schlusederberg, Rm. 203B, Tel. 301–496–7246	Feb. 12–14	8:30	Do.
Experimental Cardiovascular Sciences: Dr. Richard Peabody, Rm. 234, Tel. 301–496–7940	Feb. 26–28	8:00	Holiday Inn, Georgetown, DC.
Experimental Immunology: Dr. David Lavrin, Rm. 222B, Tel. 301–496–7238	Feb. 27-Mar. 1	9:00	Georgetown Hotel, Washington, DC.
Experimental Therapeutics: Dr. Raymond Bghor, Rm. 319A, Tel. 301–496–7639	Feb. 13–15	8:30	Holiday Inn, Bethesda, MD.
Experimental Virology: Dr. Garrett V. Keefer, Rm. 206, Tel. 301–496–7474	Feb. 25–27	8:30	Room 7, Bldg. 31C, Bethesda, MD.
General Medicine A—1: Dr. Harold Davidson, Rm. 354A, Tel. 301–496–7797	Mar. 4–6	8:30	Room 10, Bldg. 31C, Bethesda, MD.
General Medicine A—2: Dr. Donna J. Dean, Rm. 354B, Tel. 301–496–7140	Feb. 27-Mar. 1	8:30	Do.
General Medicine B: Dr. Antonia Novello, Rm. 322, Tel. 301–496–7730	Feb. 5–8	8:30	Holiday Inn, Georgetown, DC.
Genetics: Dr. David Remondini, Rm. 349, Tel. 301–496–7271	Feb. 14–16	9:00	Room 7, Bldg. 31C, Bethesda, MD.
Hearing Research: Dr. Joseph Kimm, Rm. 225, Tel. 301–496–7494	Feb. 13–15	8:30	Georgetown Hotel, Washington, DC.
Hematology—1: Dr. Clark Lum, Rm. 355A, Tel. 301–496–7508	Feb. 21–23	8:00	Holiday Inn, Georgetown, DC.
Hematology—2: Dr. Bruce Maurer, Rm. 355B, Tel. 301–496–7508	Feb. 6–8	9:00	Do.
Human Development and Aging—1: Dr. Teresa Levitin, Rm. 303, Tel. 301–496–7025	Feb. 27-Mar. 1	9:00	Georgetown Hotel, Washington, DC.
Human Development and Aging—2: Dr. Samuel Rawlings, Rm. 305, Tel. 301–496–7640	Feb. 27-Mar. 1	9:00	Holiday Inn, Chevy Chase, MD.
Human Development and Aging—3: Dr. Susan C. Streufert, Rm. 203, Tel. 301–496–9403	Feb. 26–27	8:30	Room 6, Bldg. 31C, Bethesda, MD.
Human Embryology and Development: Dr. Arthur Hoversland, Rm. 221, Tel. 301–496–7597	Feb. 26-Mar. 1	8:30	Marbury House, Georgetown, DC.
Immunobiology: Dr. William Stylos, Rm. 222A, Tel. 301–496–7780	Feb. 13–15	8:30	Holiday Inn, Georgetown, DC.
Immunological Sciences: Dr. Lottie Kornfeld, Rm. 233A, Tel. 301–496–7179	Feb. 27-Mar. 1	8:30	Holiday Inn, Bethesda, MD.
Mammalian Genetics: Dr. Jerry Roberts, Rm. 349, Tel. 301–496–7271	Feb. 14–16	8:30	Room 3, Bldg. 31A, Bethesda, MD.

Study section	Feb.-Mar. 1985 meetings	Time	Location
Medicinal Chemistry: Dr. Ronald Dubois, Rm. A-27, Tel. 301-496-7107	Feb. 20-22	9:00	Holiday Inn, Chevy Chase, MD.
Metabolism: Dr. Robert Leonard, Rm. 339A, Tel. 301-496-7091	Feb. 27-Mar. 2	8:30	Room 9, Bldg. 31C, Bethesda, MD.
Metallobiochemistry: Dr. John A. Beisler, Rm. 310, Tel. 301-496-7733	Feb. 21-23	9:00	Georgetown Hotel, Washington, DC.
Microbial Physiology and Genetics—1: Dr. Martin Slater, Rm. 238, Tel. 301-496-7183	Feb. 20-22	8:30	Holiday Inn, Rockville, MD.
Microbial Physiology and Genetics—2: Dr. Gerald Liddel, Rm. 357, Tel. 301-496-7130	Feb. 27-Mar. 1	8:30	Do.
Molecular and Cellular Biophysics: Dr. Patricia Straat, Rm. 236A, Tel. 301-496-7060	Mar. 7-9	8:30	Ramada Inn, Bethesda, MD.
Molecular Biology: Dr. Donald Disque, Rm. 328, Tel. 301-496-7830	Feb. 14-16	8:30	Holiday Inn, Georgetown, DC.
Molecular Cytology: Dr. Ramesh Nayak, Rm. 233B, Tel. 301-496-7149	Feb. 14-16	8:30	Marriott Hotel, Washington, DC.
Neurological Sciences: Dr. Allen C. Stoolmiller, Rm. 439B, Tel. 301-496-7280	Feb. 21-23	8:00	Linden Hill Hotel, Bethesda, MD.
Neurology A: Dr. Catherine Woodbury, Rm. 326, Tel. 301-496-7095	Feb. 13-16	8:30	Wellington Hotel, Washington, DC.
Neurology B—1: Dr. Jo Ann McConnell, Rm. 2A03, Tel. 301-496-7422	Feb. 19-22	8:30	Do.
Neurology B—2: Dr. Herman Teitelbaum, Rm. 2A05, Tel. 301-496-7422	Feb. 19-22	8:30	Holiday Inn, Chevy Chase, MD.
Nutrition: Dr. John Schubert, Rm. 204, Tel. 301-496-7178	Feb. 20-22	8:30	Room 6, Bldg. 31C, Bethesda, MD.
Oral Biology and Medicine: Dr. Thomas M. Tarpley, Jr., Rm. 325, Tel. 301-496-7818	Feb. 25-28	8:30	Linden Hill Hotel, Bethesda, MD.
Orthopedics and Musculoskeletal: Ms. Ileen Stewart, Rm. 350, Tel. 301-496-7581	Feb. 14-16	8:30	Room 8, Bldg. 31C, Bethesda, MD.
Pathobiochemistry: Dr. Sharon Johnson, Rm. A-26, Tel. 301-496-7820	Feb. 20-22	8:30	Holiday Inn, Bethesda, MD.
Pathology A: Dr. John L. Meyer, Rm. 337, Tel. 301-496-7305	Feb. 20-22	8:00	Do.
Pathology B: Dr. Martin Padarathsingh, Rm. 352, Tel. 301-496-7244	Feb. 27-Mar. 1	8:30	Holiday Inn, Georgetown, DC.
Pharmacology: Dr. Joseph Kaiser, Rm. 206, Tel. 301-496-7408	Feb. 12-14	8:30	Holiday Inn, Bethesda, MD.
Physical Biochemistry: Dr. Jeanne Ketley, Rm. 216B, Tel. 301-496-7120	Feb. 21-23	8:30	Do.
Physiological Chemistry: Dr. Harry Brodie, Rm. 339B, Tel. 301-496-7837	Feb. 27-Mar. 1	8:30	Do.
Physiology: Dr. Martin Frank, Rm. 209, Tel. 301-496-7878	Feb. 20-23	9:00	Holiday Inn, Chevy Chase, MD.
Radiation: Dr. John Zimbrick, Rm. 219A, Tel. 301-496-7073	Feb. 25-27	9:00	Room 4, Bldg. 31A, Bethesda, MD.
Reproductive Biology: Dr. Dharam Dhindsa, Rm. 307, Tel. 301-496-7318	Feb. 12-15	8:30	Holiday Inn, Bethesda, MD.
Respiratory and Applied Physiology: Dr. Herbert Yellin, Rm. 218A, Tel. 301-496-7320	Feb. 11-13	8:30	Linden Hill Hotel, Bethesda, MD.
Sensory Disorders and Language: Dr. Michael Halasz, Rm. 3A-07, Tel. 301-496-7550	Feb. 20-22	8:30	Capitol Holiday Inn, Washington, DC.
Social Sciences and Population: Ms. Carol Campbell, Rm. 210, Tel. 301-496-7906	Feb. 14-16	9:00	Quality Inn, Washington, DC.
Surgery and Bioengineering: Dr. Paul F. Parakkal, Rm. 303A, Tel. 301-496-7506	Feb. 21-22	8:30	Wellington Hotel, Washington, DC.
Surgery, Anesthesiology and Trauma: Dr. Keith Kraner, Rm. 319B, Tel. 301-496-7771	Feb. 14-15	8:30	Westpark Hotel, Arlington, VA.
Toxicology: Ms. Faye J. Calhoun, Rm. 205, Tel. 301-496-7570	Feb. 20-22	8:00	Linden Hill Hotel, Bethesda, MD.
Tropical Medicine and Parasitology: Dr. Joan Hickman, Rm. 334, Tel. 301-496-1190	Feb. 11-13	8:30	Room 8, Bldg. 31C, Bethesda, MD.
Virology: Dr. Claire Winestock, Rm. 309, Tel. 301-496-7605	Mar. 7-9	8:30	Room 6, Bldg. 31C, Bethesda, MD.
Visual Sciences A—1: Dr. Luigi Giacometti, Rm. 207, Tel. 301-496-7000	Feb. 13-15	9:00	Sheraton Hotel, Washington, DC.
Visual Sciences A—2: Dr. Jane Hu, Rm. 439A, Tel. 301-496-7310	Feb. 20-23	8:30	Holiday Inn, Georgetown, DC.
Visual Sciences B: Dr. Earl Fisher, Jr., Rm. 325, Tel. 301-496-7251	Mar. 13-15	9:00	Room 9, Bldg. 31C, Bethesda, MD.

(Catalog of Federal Domestic Assistance Program Nos. 13.306, 13.333, 13.337, 13.393–13.396, 13.837–13.844, 13.846–13.878, 13.892, 13.893, National Institutes of Health, HHS)

Dated: December 31, 1984.

Betty J. Beveridge,

Committee Management Officer, NIH.

[FR Doc. 85-670 Filed 1-9-85; 8:45 am]

BILLING CODE 4140-01-M

Research Manpower Review Committee; Meeting

Pursuant to Pub. L. 92-463, notice is hereby given of the meeting of the Research Manpower Review Committee, National Heart, Lung, and Blood Institute, National Institutes of Health, on February 10-12, 1985, at the Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, Maryland 20814.

This meeting will be open to the public on February 10, 1985, from 8:00 p.m. until recess, to discuss administrative details and to hear reports concerning the current status of the National Heart, Lung, and Blood Institute.

In accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5, U.S. Code, and section 10(d) of Pub. L. 92-463, the meeting will be closed to the public on February 11 and 12, 1985, from 8:00 a.m. until adjournment for the review, discussion and evaluation of individual grant applications. These applications and the discussions could reveal confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Terry Bellicha, Chief, Public Inquiries and Reports Branch, National Heart, Lung, and Blood Institute, Building 31, Room 4A21, National Institutes of Health, Bethesda, Maryland 20205, phone (301) 496-4236, will provide summaries of the meeting and rosters of the committee members.

Dr. John L. Fakunding, Executive Secretary, NHLBI, Westwood Building, Room 550, Bethesda, Maryland 20205, phone (301) 496-7361, will furnish substantive program information.

(Catalog of Federal Domestic Assistance Program Nos. 13.837, Heart and Vascular Diseases Research; 13.838, Lung Diseases Research; and 13.839, Blood Diseases and Resources Research, National Institutes of Health)

Dated: December 31, 1984.

Betty J. Beveridge,

NIH Committee Management Officer.

[FR Doc. 85-671 Filed 1-9-85; 8:45 am]

BILLING CODE 4140-01-M

Public Health Service

Food and Drug Administration; Statement of Organization, Functions, and Delegations of Authority

Part H, Chapter HF (Food and Drug Administration) of the Statement of Organization, Functions, and Delegations of Authority for the Department of Health and Human Services (35 FR 3685, February 25, 1970, as amended most recently in pertinent parts at 43 FR 16419, April 18, 1978; 45 FR 33728, May 20, 1980; and 49 FR 33052-53, August 20, 1984) is amended to reflect organizational changes in the Food and Drug Administration (FDA).

The changes include: Transferring the conflict of interest functions from the Division of Personnel Management to a new Division of Ethics and Program Integrity, transferring the safety management and occupational health function from the Division of Personnel Management to the Division of Management Services, retitling the Division of Personnel Management as the Division of Human Resources Management, and establishing a performance management function in the Division of Management Systems and Policy. There are also some minor changes to update and clarify several functional statements.

Section HF-B, Organization and Functions is amended as follows:

1. Delete subparagraph (h-2), *Division of Management Services (HFA75)* and insert new subparagraph (h-2), *Division of Management Services (HFA75).*

(h-2) *Division of Management Services (HFA75).* Provides leadership and guidance to Headquarters staff offices, Headquarters operating activities, and field activities for all management services programs

including personal property management and accountability, real property management, space management and utilization, safety management and occupational health, construction and engineering services, communications, graphic arts, printing and reproduction, microform management, and mail and files.

Develops and conducts management programs in directives management, reports and forms management, and other management area as assigned.

Responsible for maintaining effective liaison with the Government Printing Office and for the centralized clearance and coordination of all printing and publication services.

Coordinates the development of Agencywide policies and procedures for such services; plans, executes, evaluates, and adjusts efforts in these activities.

2. Delete subparagraph (h–3), *Division of Management Systems and Policy (HFA76)* and insert new subparagraph (h–3), *Division of Management Systems and Policy (HFA76).*

(h–3) *Division of Management Systems and Policy (HFA76).* Provides leadership and direction in the effective and efficient use of Agency resources; provides Agencywide consulting services in organization and operations analysis and in the analysis, design, implementation, and maintenance of operating systems and procedures.

Provides central control for delegations of authority and maintains control files of delegations to and within the Agency.

Conducts Agencywide organization, management, and industrial engineering studies; designs and recommends systems and procedures; develops and recommends policy to implement study conclusions.

Provides computer systems analysis and application programming services for the staff offices of the Commissioner and data base management services for the Agency.

Receives, examines, evaluates, and processes all documents and correspondence required or permitted in Agency administrative rulemaking procedures; distributes this material to appropriate Agency components.

Provides advice and assistance to the Agency in such areas as training, career development, awards, and performance management.

3. Delete subparagraph (h–4), *Division of Personnel Management (HFA77)* and insert new subparagraph (h–4) *Division of Human Resources Management (HFA77).*

(h–4) *Division of Human Resources Management (HFA77).* Provides personnel management advice and assistance to the Commissioner and to FDA managers within its servicing area, including advice to Headquarters officials on their management responsibilities for FDA field installations.

Participates in the development of Agency goals and operating plans related to personnel management.

Provides, within its servicing area, personnel management and personnel administration services, including employment, recruitment, compensation and classification, and employee relations.

Develops Agencywide programs on manpower planning and utilization, including conducting industrial engineering studies to improve the interaction of employees with changing technologies, and as designated under Departmental guidelines provides service in these areas throughout the Agency.

Prepares staff studies and recommendations to Agency management on personnel needs and problems.

Identifies the need for personnel policies and programs to PHS and collaborates with PHS, as appropriate, in the development of such policies and programs.

4. Insert new subparagraph (h–7), *Division of Ethics and Program Integrity (HFA72).*

(h–7) *Division of Ethics and Program Integrity (HFA72).* Directs the Agency's ADP Security Program; develops policy and guidelines necessary to standardize office/center ADP security applications, and coordinates the Agency ADP risk analysis and audit/review capability.

Directs and coordinates a multidiscipline team of administrative and/or program specialists who conduct scheduled review of field and Headquarters elements of the Agency to determine adherence to existing managerial policy and practices; assures that recommendations resulting from the review findings are implemented.

Evaluates the Agency's personnel and physical security programs and provides professional leadership and authoritative guidance in these areas. Formulates policy and procedures necessary to maintain the integrity of privileged information submitted by industry.

Provides a centralized Agencywide investigative capability for top management.

Implements Internal Control Reviews in accordance with OMB guidelines.

Directs the formulation of FDA policies and procedures concerning conflicts of interest and employee associations with regulated industries, review financial interests including outside activities of FDA employees, decides conflict of interest issues, and counsels and trains employees on the avoidance of conflicts of interests.

Effective Date: December 26, 1984.

Dated: December 26, 1984.

James F. Dickson,

Acting Assistant Secretary for Health.

[FR Doc. 85–702 Filed 1–9–85; 8:45 am]

BILLING CODE 4160–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

Office of Administration

[Docket No. N–84–1488]

Submission of Proposed Information Collections to OMB

AGENCY: Office of Administration, HUD.

ACTION: Notices.

SUMMARY: The proposed information collection requirements described below have been submitted to the Office of Management and Budget (OMB) for review, as required by the Paperwork Reduction Act. The Department is soliciting public comments on the subject proposals.

ADDRESS: Interested persons are invited to submit comments regarding these proposals. Comments should refer to the proposal by name and should be sent to: Robert Neal, OMB Desk Officer, Office of Management and Budget, New Executive Office Building, Washington, D.C. 20503.

FOR FURTHER INFORMATION CONTACT: David S. Cristy, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street SW, Washington, D.C. 20410, telephone (202) 775–6050. This is not a toll-free number.

SUPPLEMENTARY INFORMATION: The Department has submitted the proposals described below for the collection of information to CMB for review, as required by the Paperwork Reduction Act (U.S.C. Chapter 35).

The Notices list the following information: (1) The title of the information collection proposal; (2) the office of the agency to collect the inforamtion; (3) the agency from number, if applicable; (4) how frequently information submissions will be required; (5) what members of the public will be affected by the proposal; (6) an estimate of the total number of hours needed to prepare the information submission; (7) whether the proposal is new or an extension or reinstatement of

an information collection requirement; and (8) the names and telephone numbers of an agency official familiar with the proposal and of the OMB Desk Officer for the Department.

Copies of the proposed forms and other available documents submitted to OMB may be obtained from David S. Cristy, Reports Management Officer for the Department. His address and telephone number are listed above. Comments regarding the proposals should be sent to the OMB Desk Officer at the address listed above.

The proposed information collection requirements are described as follows:

Notice of Submission of Proposed Information Collection to OMB

Proposal: Mortgage Insurance—Single Family Claims Without Conveyance of Title
Office: Housing
Form Number: HUD-91022
Frequency of Submission: On Occasion
Affected Public: Businesses or Other For-Profit
Estimated Burden Hours: 31,000
Status: New
Contact: Sally McCormick, HUD, (202) 755-6672, Robert Neal, OMB, (202) 395-7316.

Authority: Sec. 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; Sec. 7(d) of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d).

Dated: December 27, 1984.

Proposal: Development Program of Indian Housing Authority and Indian Low Income Housing Program, Development Cost Budget
Office: Public and Indian Housing
Form Number: HUD-53045 and 53045A
Freqency of Submission: On Occasion
Affected Public: State or Local Governments
Estimated Burden Hours: 1,620
Status: Reinstatement
Contact: Pat Arnaudo, HUD, (202) 755-6522, Robert Neal, OMB, (202) 395-7316.

Authority: Sec. 3507 of the Paperwork Reduction Act, 44 U.S.C. 3507; Sec. 7(d) of the Department of Housing and Urban Development Act, 42 U.S.C. 3535(d).

Dated: December 27, 1984.

Dennis F. Geer,

Office of Information Policies, and Systems.

[FR Doc. 85-778 Filed 1-9-85; 8:45 am]

BILLING CODE 4210-01-M

Office of the Assistant Secretary for Housing-Federal Housing Commissioner

[Docket No. N-84-1487; FR-2078]

Mortgage and Loan Insurance Programs Under the National Housing Act; Debenture Interest Rates

AGENCY: Office of the Assistant Secretary for Housing-Federal Housing Commissioner, (HUD).

ACTION: Notice of Change in Debenture Interest Rates.

SUMMARY: This notice announces changes in the interest rates to be paid on debentures issued with respect to a loan or mortgage insured by the Federal Housing Commissioner under the provisions of the National Housing Act (the "Act"). The interest rate for debentures issued under section 221(g)(4) of the Act during the six-month period beginning January 1, 1985, is 10⅜ percent. The interest rate for debentures issued under any other provision of the Act is the rate in effect on the date that the commitment to insure the loan or mortgage was issued, or the date that the loan or mortgage was endorsed (or initially endorsed if there are two or more endorsements) for insurance, whichever rate is higher. The interest rate for debentures issued under these other provisions with respect to a loan or mortgage committed or endorsed during the six-month period beginning January 1, 1985, is 11⅝ percent.

FOR FURTHER INFORMATION CONTACT: James B. Mitchell, Financial Policy Division, Room 9132, Department of Housing and Urban Development, 451 Seventh Street SW, Washington, D.C. 20410. Telephone (202) 426-4325 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: Section 224 of the National Housing Act (24 U.S.C. 1715o) provides that debentures issued under the Act with respect to an insured loan or mortgage (except for debentures issued pursuant to section 221(g)(4) of the Act) will bear interest at the rate in effect on the date the commitment to insure the loan or mortgage was issued, or the date the loan or mortgage was endorsed (or initially endorsed if there are two or more endorsements) for insurance, whichever rate is higher. This provision is implemented in HUD's regulations at 24 CFR 203.405, 203.479, 207.259(e)(6) and 220.830. Each of these regulatory provisions states that the applicable rates of interest will be published twice each year as a notice in the **Federal Register.**

Section 224 further provides that the interest rate on these debentures will be set from time to time by the Secretary of HUD, with the approval of the Secretary of the Treasury, in an amount not in excess of the interest rate determined by the Secretary of the Treasury pursuant to a formula set out in the statute.

Section 224 further provides that the interest rate on these debentures will set from time to time by the Secretary of HUD, with the approval of the Secretary of the Treasury, in an amount not in excess of the interest rate determined by the Secretary of the Treasury pursuant to a formula set out in the statute.

The Secretary of the Treasury (1) has determined, in accordance with the provisions of section 224, that the statutory maximum interest rate for the period beginning January 1, 1985, is 11¾ percent and (2) has approved the establishment of the debenture interest rate by the Secretary of HUD at 11⅝ percent for the six-month period beginning January 1, 1985. This interest rate will be the rate borne by debentures issued with respect to any insured loan or mortgage (except for debentures issued pursuant to section 221(g)(4)) with an insurance commitment or endorsement date (as applicable) within the first six months of 1985.

For convenience of reference, HUD is publishing the following chart of debenture interest rates applicable to mortgages committee or endorsed since January 1, 1976:

Effective rate (percent)	On or after	Prior to
7½	Jan. 1, 1976	July 1, 1976.
7	July 1, 1976	Jan. 1, 1977.
6¾	Jan. 1, 1977	July 1, 1977.
7¼	July 1, 1977	Jan. 1, 1978.
7½	Jan. 1, 1978	July 1, 1978.
7¾	July 1, 1978	Jan. 1, 1979.
8	Jan. 1, 1979	July 1, 1979.
8¼	July 1, 1979	Jan. 1, 1980.
9½	Jan. 1, 1980	July 1, 1980.
9½	July 1, 1980	Jan. 1, 1981.
11¼	Jan. 1, 1981	July 1, 1981.
12¾	July 1, 1981	Jan. 1, 1982.
12¾	Jan. 1, 1982	July 1, 1983.
10¼	Jan. 1, 1983	July 1, 1983.
10⅜	July 1, 1983	Jan. 1, 1984.
11⅛	Jan. 1, 1984	July 1, 1984.
13⅛	July 1, 1984	Jan. 1, 1985.
11⅝	Jan. 1, 1985	

Section 221(g)(4) of the Act provides that debentures issued pursuant to that paragraph (with respect to the assignment of an insured mortgage to the Secretary) will bear interest at the "going Federal rate" in effect at the time the debentures are issued. The term "going Federal rate", as used in that paragraph, is defined to mean the interest rate that the Secretary of the Treasury determines, pursuant to a formula set out in the statute, for the six-month periods of January through June

and July through December of each year. Section 221(g)(4) is implemented in the HUD regulations at 24 CFR 221.790.

The Secretary of the Treasury has determined that the interest rate to be borne by debentures issued pursuant to section 221(g)(4) during the six-month period beginning January 1, 1985, is 10⅝ percent.

HUD expects to publish its next notice of change in debenture interest rates in July 1985.

The subject matter of this notice falls within the categorical exclusion from HUD's environmental clearance procedures set forth in 24 CFR 50.21(a)(15). For that reason, no environmental finding has been prepared for this notice.

(Secs. 211, 221, 224, National Housing Act, 12 U.S.C. 1715b, 17151, 1715o; sec. 7(d), Department of HUD Act, 42 U.S.C. 3535(d))

Dated: January 7, 1985.

Maurice L. Barksdale,

Assistant Secretary, for Housing-Federal Housing Commissioner.

[FR Doc. 85-777 Filed 1-9-85; 8:45 am]

BILLING CODE 4210-27-M

Office of the Regional Administrator-Regional Housing Commissioner

[Docket No. D-85-790; FR-1990]

Designation of officials

AGENCY: Department of Housing and Urban Development, HUD.

ACTION: Designation of order of succession.

SUMMARY: The Regional Administrator-Regional Housing Commissioner of the Philadelphia Regional Office is designating officials who may serve as Acting Regional Administrator-Regional Housing Commissioner during the absence, disability, or vacancy in the position of the Regional Administrator-Regional Housing Commissioner.

EFFECTIVE DATE: This designation becomes effective on or before January 10, 1985.

FOR FURTHER INFORMATION CONTACT: Peter M. Campanella, Regional Counsel, U.S. Department of Housing and Urban Development, Philadelphia Regional Office, Sixth and Walnut Streets, Philadelphia, PA. 19106, (215) 597-2655 (This is not a toll-free number).

Designation

Each of the officials appointed to the following positions is designated to serve as Acting Regional Administrator-Regional Housing Commissioner during the absence, disability or vacancy in the position of the Regional Administrator-Regional Housing Commissioner, with all powers, functions, and duties redelegated or assigned to the Regional Administrator-Regional Housing Commissioner: Provided, that no official is authorized to serve as Acting Regional Administrator-Regional Housing Commissioner unless all preceding listed officials in this designation are unavailable to act by reason of absence, disability, or vacancy in the position:

1. Deputy Regional Administrator.
2. Director, Operational Support.
3. Regional Counsel.
4. Director, Office of Administration.
5. Director, Office of Community Planning and Development.
6. Director, Office of Fair Housing and Equal Opportunity.
7. Director, Office of Housing.
8. Director, Program Planning and Evaluation Staff.

Authority: Delegation of Authority, 27 FR 4319 (1962); Section 9(c), Department of Housing and Urban Development Act, 42 U.S.C. 3531 note; and Interim Order II, 31 FR 815 (1966).

Dated: December 18, 1984.

Kenneth J. Finlayson,

Regional Administrator, Regional Housing Commissioner.

[FR Doc. 85-776 Filed 1-9-85; 8:45 am]

BILLING CODE 4210-32-M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

Environmental Impact Report and Statement; Intent Proposed Pacific Texas Pipeline Project

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of intent.

SUMMARY: Notice is hereby given that the Bureau of Land Management in coordination with other Federal Agencies and the Port of Los Angeles will prepare an Environmental Impact Report and Environmental Impact Statement (EIR/EIS) for the proposed Pacific Texas Pipeline.

The pipeline will carry approximately 900,000 barrels of Alaska North Slope crude oil from a berthing facility in the outer harbor of the Port of Los Angeles to a terminal facility at Midland, Texas. Two fixed tanker berths would be constructed in the harbor. The berths will be located on a new landfill to be located in the outer harbor area on the seaward side of Terminal Island.

Oil offloaded at this facility will be transported through two 48-inch pipelines to an inland storage terminal at Carson, California (a distance of about six miles). The eight floating-roof tanks at this terminal will be capable of transient storage of approximately six million barrels of crude oil.

From this terminal, crude oil will be transported through a single, buried 42-inch pipeline to Midland, Texas, a distance of approximately 1,030 miles. The proposed pipeline route would run north from Carson for approximately twenty miles, then would run east generally parallel to the route of Interstate 10 running south of San Bernardino, through the Banning Pass north of Palm Springs, and crossing the Colorado River at Blythe. The route would then follow Interstate 10 into western Arizona, then leave the highway to cross the Gila River near the Gillespie Dam, pass south of Phoenix and north of Tucson, cross Interstate 10 near Casa Grande and then run generally southeastward to cross Interstate 10 again near Wilcox. Turning east, the route would enter New Mexico near Lordsburg and Deming, and cross the Rio Grande midway between El Paso and Las Cruces. The route would then enter Texas, pass south of Guadelupe Mountain National Park, and then would reenter New Mexico, passing south of Carlsbad. Reentering Texas, the pipeline route would run generally east to end at a terminal facility at Midland, Texas. This terminal would provide storage for approximately four million barrels of oil. The terminal would deliver incoming crude to other existing pipelines for transportation to mid-continent, east coast, and Gulf coast regions.

The EIR/EIS will be prepared by an interdisciplinary team which will consider the following general issues:

1. Geologic Hazards
2. Air Quality
3. Biological Resources
4. Cultural Resources
5. Existing Land Uses
6. Water Quality (including river crossings)
7. Groundwater
8. Socioeconomics
9. Oil spill potential
10. Visual Resources

Seven public scoping meetings will be held. Meeting locations are listed below. Issues raised during those meetings will be considered in the EIR/EIS in addition to those described above.

DATES: Following are the proposed Scoping Meeting dates and locations:

Location	Date	Time
Board of Harbor Commissioners Meeting Room, Port of Los Angeles Admin. Office Building, 425 South Palos Verdes, San Pedro, California.	Jan. 28, 1985	2-4 p.m.
Multi-purpose Room, Carson Community Center, 801 East Carson Street, Carson, California.	Jan. 28, 1985	7-9 p.m.
Mission Inn Room, Raincross Square, 343 Orange Street, Riverside, California.	Jan. 31, 1985	7-9 p.m.
Pima County Board of Supervisors Auditorium, 111 West Congress, Tucson, Arizona.	Feb. 4, 1985	7-9 p.m.
Maricopa County Board of Supervisors Auditorium, 205 West Jefferson, Phoenix, Arizona.	Feb. 5, 1985	7-9 p.m.
City Commission Chambers, Las Cruces City Hall, 300 North Church, Las Cruces, New Mexico.	Feb. 6, 1985	7-9 p.m.
Carlsbad Public Library, 101 South Halagueno, Carlsbad, New Mexico.	Feb. 7, 1985	7-9 p.m.

FOR FURTHER INFORMATION CONTACT: Gerald E. Hillier, District Manager, Bureau of Land Management, 1695 Spruce Street, Riverside, California 92507.

Dated: January 5, 1985.

Gerald E. Hillier,

District Manager.

[FR Doc. 85-737 Filed 1-9-85; 8:45 am]

BILLING CODE 4310-40-M

Sale of Public Lands; Idaho

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Lands in Oneida County, Idaho—Amendment.

SUMMARY: This publication will amend the original Notice of Realty Action published October 7, 1963 (48 FR 45852) and April 19, 1984 (49 FR 15637) to reflect recent amendments to the 43 CFR Part 2710 Sale Regulations (49 FR 29112) and modifications to the bidding procedures for this sale.

The following described land will again be offered for sale using competitive (43 CFR 2711.3-1) or modified competitive bidding procedures (43 CFR 2711.3-2). These lands are hereby segregated from appropriation under the public land laws including the mining laws as provided by 43 CFR 2711.1-2(d).

Name	Boise Meridian, Idaho legal description	Acres	Appraised fair market value	Type of bidding
Jensen (I-19673)	T.12S., R.34E., sec. 34, W/ 2NW1/4	80	$6,000.00	Modified.
Elkhorn (I-20341)	T.13S., R.35E., sec. 18, lot 4; sec. 19, lot 1	26.67	1,325.00	Do.
Pocatello Valley (I-19668A)	T.15S., R.34E., sec. 8, NE1/4NW1/4	40.00	2,000.00	Competitive.
Mid Hanzel (I-19668C)	T.15S., R.34E., sec. 18, lot 4, SE1/4SW1/4	87.17	4,350.00	Modified.
Hanzel South (I-19668D)	T.15S., R.34E., sec. 30, lot 1	47.23	2,350.00	Do.
Gwenford (I-19668E)	T.15S., R.35E., sec. 9, SW1/4SW1/4	40.00	2,000.00	Do.

Bidding Procedures: The designated or preference right bidders on parcel I-19673 will be Rosell Mills of Malad, Idaho, and Farrel Williams of Tremonton, Utah. The designated or preference right bidder for parcel I-20341 will be Grant H. Jones of Malad, Idaho. The designated or preference right bidder on parcel I-19668C is Mrs. Duluth Allen (Allen Farms) of Ogden, Utah. The designated or preference right bidders on parcel I-19668D are Mrs. Duluth Allen (Allen Farms) of Ogden, Utah and Mrs. Joseph Bullock of Logan, Utah. The designated bidder on parcel I-19668E is Andrew Chad Bybee of Pleasantview, Idaho. These designated bidders are offered the right to meet the highest bid. Failure to accept this offer to purchase within 15 days after the specified sale date or succeeding sale dates shall constitute a waiver of their preference consideration.

Only sealed bids for no less than the appraised fair market value will be accepted. A bid will also constitute an application for the conveyance of the mineral rights except oil and gas. Each bidder must submit a fifty dollar ($50.00) (non-returnable for the high bidder) filing fee for the mineral conveyance (43 CFR 2720.1-2(c)). Each bid shall be accompanied by certified check, postal money order, bank draft, or cashiers check made payable to the Bureau of Land Management for 30 percent (30%) of the bid price. Failure to submit these sums shall result in disqualification of the bid.

Dates: The above described lands will be offered for sale on March 27, 1985. If unsold on this date, they will be re-offered the first Wednesday of each month for three consecutive months until sold or the sale is otherwise suspended. All sealed bids (with the parcel name and serial number CLEARLY marked in the lower left hand corner of the envelope) must be received by 1:30 p.m. on the designated sale dates at the Burley District Office.

Address: Sealed bids will be accepted at the Burley District Office, Rt. 3, Box 1, 200 South Oakley Highway, Burley, Idaho, 83318. Additional information concerning the land, terms and conditions of the sale, and bidding instructions may be obtained from Terrance M. Costello, Deep Creek Area Manager, at the above address, or by calling (202) 678-5514.

Supplementary Information: For a period of 45 days from the date of this notice, interested parties may submit comments regarding the proposed action. Any adverse comments will be evaluated by the District Manager who may vacate or modify this notice of realty action and issue a final determination. In the absence of any action by the District Manager, this realty action will become the final determination of the Department of the Interior.

The BLM reserves the right to accept or reject any and all offer, or withdraw any land or interest in land from sale if, in the opinion of the authorized officer, consummation of the sales would not be fully consistent with section. 203(g) of FLPMA or other applicable laws.

Dated: January 3, 1985.

John S. Davis,

District Manager.

[FR Doc. 85-712 Filed 1-9-85; 8:45 am]

BILLING CODE 4310-22-M

Filing of Plat of Survey; Idaho

The plat of survey of the following described land was officially filed in the Idaho State Office, Bureau of Land Management, Boise, Idaho, on the date hereinafter stated:

Boise Meridian

T. 32 N., R. 4 E., Accepted December 14, 1984. Officially filed December 19, 1984.

The above plat represents a dependent resurvey and section subdivision.

Inquiries about this land should be addressed to Chief, Branch of Cadastral Survey, Idaho State Office, 3380 Americana Terrace, Boise, Idaho, 83706.

Anita F. Mayers,

Acting Chief, Land Services Section.

[FR Doc. 85-715 Filed 1-9-85; 8:45 am]

BILLING CODE 4301-GG-M

Filing of Survey Plat; Montana

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Filing of Plat of Survey.

SUMMARY: Plat of survey of the land described below accepted October 18, 1984, was officially filed in the Montana State Office effective 10 a.m. on December 17, 1984.

Principal Meridian, Montana

T. 2S., R. 2 E.

The supplemental plat shows lotting for a segregated lode claim in section 17, Township 2 South, Range 2 East, Principal Meridian, Montana. The area described is in Gallatin County.

This plat was prepared to meet certain administrative needs of the Butte District Office.

EFFECTIVE DATE: October 19, 1984.

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, 222 North 32nd Street, P.O. Box 36800, Billings, Montana 59107.

Dated: December 28, 1984.

Peggy J. Davidson,

Chief, Branch of Records.

[FR Doc. 85-718 Filed 1-9-85; 8:45 am]

BILLING CODE 4310-DN-M

Land Resource Management; Filing of Plats of Survey; Montana

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of Filing of Plats of Survey.

SUMMARY: Plats of survey of the lands described below accepted December 12, 1984, were officially filed in the Montana State Office effective 10 a.m. on December 17, 1984.

Principal Meridian, Montana

T. 5 N., R. 34 E.

The plat represents the dependent resurvey of a portion of the north boundary, a portion of the subdivisional lines, and the adjusted original meanders of the former left bank of a channel of the Yellowstone River in section 2; and the survey of the subdivision of section 2, a certain division of accretion line, and portions of the present left bank meanders of a channel of the Yellowstone River in section 2, Township 5 North, Range 34 East, Principal Meridian, Montana. The area described is in Treasure County.

Principal Meridian, Montana

T. 6 N., R. 39 E.

The plat represents the dependent resurvey of a portion of the east and north boundaries, a portion of the subdivisional lines, a portion of the adjusted original meanders of the former bank of an island in the Yellowstone River; and the survey of the subdivision of sections 2, 4, 12, and 14, a portion of the medial line of an abandoned channel of the Yellowstone River, certain partition lines, certain division of accretion lines, and portions of the present right and left bank meanders of the Yellowstone River in section 14, Township 6 North, Range 39 East, Principal Meridian, Montana. The area described is in Rosebud County.

This survey was executed at the request of the Mile City District Office for administrative needs of the Bureau.

Principal Meridian, Montana

T. 27 N., R. 33 W.

The plat represents the dependent resurvey of a portion of the Lake Creek Guide Meridian, through Townships 26 and 27 North, portions of the south, east, and north boundaries, a portion of the subdivisional lines, a portion of the adjusted original meanders of the Clark's Fork of the Columbia River, and a portion of Homestead Entry Survey No. 919; and the survey of the subdivision of sections 5, 24, 25, 26, 31, 32, 33, 34, and 35, Township 27 North, Range 33 West, Principal Meridian, Montana. The area described is in Sanders County.

This survey was executed at the request of the Regional Forester, United States Forest Service, for administrative needs.

Principal Meridian, Montana

T. 1 N., R. 58 E.

The supplemental plat showing amended lotting and lotting aliquot parts of section 18, Township 1 North, Range 58 East, Principal Meridian, Montana. The area described is in Carter County.

This plat was prepared to facilitate a proposed land exchange between the United State Forest Service and other parties.

EFFECTIVE DATE: December 17, 1984.

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, 222 North 32nd Street, P.O. Box 36800, Billings, Montana 59107.

Dated: December 28, 1984.

Peggy J. Davidson,

Chief, Branch of Records.

[FR Doc. 85-719 Filed 1-9-85; 8:45 am]

BILLING CODE 4310-DN-M

National Park Service

Intention To Extend Concession Permit; John Maggi

Pursuant to the provisions of section 5 of the Act of October 9, 1965 (79 Stat. 969; 16 U.S.C. 20), public notice is hereby given that sixty (60) days after the date of publication of this notice, the Department of the Interior, through the Director of the National Park Service, proposes to extend a concession permit with John Maggi authorizing him to continue to provide fast food facilities and mobile services for the public at the Staten Island Unit, Gateway National Recreation Area, New York for a period of two (2) years from January 1, 1985, through December 31, 1986.

This permit extension has been determined to be categorically excluded from the procedural provisions of the National Environmental Policy Act and no environmental document will be prepared.

The foregoing concessioner has performed its obligations to the satisfaction of the Secretary under an existing contract which expires by limitation of time on December 31, 1984, and therefore, pursuant to the Act of October 9, 1965, as cited above, is entitled to be given preference in the renewal of the permit and in the negotiation of a new permit as defined in 36 CFR 51.5.

The Secretary will consider and evaluate all proposals received as a result of this notice. Any proposal, including that of the existing concessioner, must be postmarked or hand delivered on or before the sixtieth (60th) day following publication of this notice to be considered and evaluated.

Interested parties should contact the Regional Director, North Atlantic Region, Boston, MA 02109, for information as to the requirements of the proposed permit.

Dated: December 19, 1984.

Herbert S. Cables, Jr.,

Regional Director, North Atlantic Region.

[FR Doc. 85-779 Filed 1-9-84; 8:45 am]

BILLING CODE 4310-70-M

Proposed Loxahatchee Wild and Scenic River, FL; application for addition of the Northwest Fork of the Loxahatchee River in Southeast Florida to the National Wild and Scenic Rivers System as a State-administered river area.

ACTION: Notice.

SUMMARY: This notice is to acknowledge that on December 3, 1984, the Governor

of the State of Florida made formal application to the Secretary of the Interior to include a 7.5-mile segment of the Loxahatchee River in Florida, a State-designated wild and scenic river, in the National Wild and Scenic Rivers System pursuant to section 2(a)(ii) of Pub. L. 90-542, as amended (82 Stat. 906). Notice of the Governor's application is published herewith as required by section 2(a) of the act.

ADDRESSES: Questions concerning this application may be addressed to the National Park Service, U.S. Department of the Interior, 18th and C Streets, NW., Washington, DC 20240 or handled by phone 202/343-4290.

SUPPLEMENTARY INFORMATION: The segment of the Northwest Fork of the Loxahatchee for which national designation has been requested begins at Riverbend Park in Palm Beach County (river mile 13.5) and extends downstream to the southern boundary of Jonathan Dickenson State Park at approximately river mile 6

As required by section 4(c) of the act, the Secretary of the Interior, through the National Park Service, has notified the heads of affected Federal agencies and provided them with a 90-day period for review and comment on the proposal. After consideration of any timely comments received, the Secretary will make his decision. Should he approve the proposed inclusion of the Northwest Fork of the Loxahatchee, notice to that effect will be published in the **Federal Register.**

Dated: December 31, 1984.

Russell E. Dickenson,

Director, National Park Service.

[FR Doc. 85-780 Filed 1-9-85; 8:45 am]

BILLING CODE 4310-70-M

INTERNATIONAL DEVELOPMENT COOPERATION AGENCY

Agency for International Development

Housing Guaranty Program; Investment Opportunity

The Agency for International development (A.I.D.) has authorized guaranties of loans for Panama as part of A.I.D.'s development assistance program. The proceeds of these loans, amounting to U.S. $8.4 million, will be used to finance shelter projects for low income families in Panama.

Interested lenders should contact the representative of the Government of Panama as follows:

Panama Project No. 525-HG-010 and 525-HG-011

Name: Menalco Solis, Minister of Finance
Mailing address: Apartado 5236, Zona 5, Panama, Republic of Panama
Telex: MINHACIN PG
Telex No.: 2352 (System: INTEL)
Telephone: Panama 25-4488 or 25-3431
Or Mr. Michael G. Kitay, AID, Tel. 202/632-3544

Interested investors should telegram their bids to the Borrower's representatives not later than 5:00 p.m. EST, Wednesday, January 23, 1985. Bids should remain open for 24 hours. Copies of all bids should be simultaneously telexed to the following addresses:

William Gelman, Assistant Director/LA, RHUDO/Panama, USAID/Panama City, Washington, D.C. 20523, Telex: c/o American Embassy, USAID/ Panama City
Michael G. Kitay, Agency for International Development, PRE/H, Room 625, SA-12, Washington, D.C. 20523, Telex No. WU 892703 AID WSA

The loan is expected to be disbursed in one disbursement to occur upon the signing of the loan agreement or as soon as practicable thereafter.

For the $8,400,000 loan, the Borrower is requesting variable rate bids including as an alternative, variable rate bids with an option to convert to fixed rate. Fixed interest rate bids may also be submitted.

Bids should specify maturities between 25 and 30 years, a grace period on repayment of principal from ten (10) to fifteen (15) years. Lenders are also invited to submit alternative bids having a three year grace period on the payment of interest with a third alternative contemplating a three year initial period where one half of the interest coming due is paid and one half capitalized and amortized with the original principal amount.

Selection of investment bankers and/ or lenders and the terms of the loans are initially subject to the individual discretion of the Borrower and thereafter subject to approval by A.I.D. The lender and A.I.D. shall enter into a Contract of Guaranty, covering each of the loans. Disbursements under the loans will be subject to certain conditions required of the Borrowers by A.I.D. as set forth in implementation agreements between A.I.D. and the Borrowers.

The full repayment of the loans will be guaranteed by A.I.D. The A.I.D. guaranty will be backed by the full faith and credit of the United States of America and will be issued pursuant to authority in section 222 of the Foreign Assistance Act of 1961, as amended (the "Act").

Lenders eligible to receive an A.I.D. guaranty are those specified in section 238(c) of the Act. They are: (1) U.S. citizens; (2) domestic U.S. corporations, partnerships, or associations substantially beneficially owned by U.S. citizens; (3) foreign corporations whose share capital is at least 95 percent owned by U.S. citizens; and, (4) foreign partnerships or associations wholly owned by U.S. citizens.

To be eligible for an A.I.D. guaranty, the loans must be repayable in full no later than the thirtieth anniversary of the disbursement of the principal amount thereof and the interest rates may be no higher than the maximum rate established from time to time by A.I.D.

Information as to the eligibility of investors and other aspects of the A.I.D. housing guaranty program can be obtained from:

Director, Office of Housing and Urban Programs, Agency for International Development, Room 625, SA/12, Washington, D.C. 20523, Telephone: (202) 632-3544

John T. Howley,

Deputy Director, Office of Housing and Urban Programs.

January 4, 1985.

[FR Doc. 85-916 Filed 1-9-85; 8:45 am]

BILLING CODE 4710-02-M

INTERSTATE COMMERCE COMMISSION

[Ex Parte No. 388 (Sub-15)]

Intrastate Rail Rate Authority; Minnesota

AGENCY: Interstate Commerce Commission.

ACTION: Notice of decision.

SUMMARY: The Commission has extended the provisional certification of the Minnesota Public Utilities Commission under 49 U.S.C. 11501(b) to regulate intrastate rail rates, classifications, rules and practices. This extension will permit it to modify its standards and procedures as required by the full decision.

DATES: The provisional certification of Minnesota will expire March 11, 1985, unless prior to that date the State files standards and procedures complying with the requirements stated in the full decision. If Minnesota files such standards, interested parties may file comments by April 8, 1985, and Minnesota must reply by April 29, 1985.

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 (DC Metropolitan area) or toll free (800) 424-5403.

Decided: January 2, 1985.

By the Commission, Chairman Taylor, Vice Chairman Andre, Commissioners Sterrett, Gradison, Simmons, Lamboley and Strenio.

James H. Bayne,

Secretary.

[FR Doc. 85-701 Filed 1-9-85; 8:45 am]

BILLING CODE 7035-01-M

DEPARTMENT OF JUSTICE

Consent Decree in an Action Under the Safe Drinking Water Act; Sunny Acres Water Co.

In accordance with Departmental Policy, 28 CFR 50.7, 38 FR 19029, notice is hereby given that on December 14, 1984, a consent decree in *United States* v. *Sunny Acres Water Company*, C.A. 84-417 (D. Ore.), was lodged with the United States District Court for the District of Oregon. The decree requires Sunny Acres to pay to a civil penalty of $2,000.00, to comply with testing requirements for bacterial contaminants and to pay stipulated penalties for future violations of the consent decree.

The Department of Justice will receive for thirty (30) days from the publication date of this notice, written comments relating to the proposed 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 refer to *United States* v. *Sunny Acres Water Company*, 90-5-1-1-2120.

The consent decree may be examined at the Office of the United States Attorney, Room 312, U.S. Courthouse, 620 S.W. Main Street, Portland, Oregon, at the Office of Regional Counsel, U.S.E.P.A. Region X, 1200 Sixth Avenue, Seattle, Washington, and at the Environmental Enforcement Section, Land and Natural Resources Division, Department of Justice (Room 1515), Ninth and Pennsylvania Avenue, NW., Washington, D.C. 20530. A copy of the consent decree can be obtained in person or by mail from the Environmental Enforcement Section at the above address.

F. Henry Habicht II,

Assistant Attorney General, Land and Natural Resources Division.

[FR Doc. 85-711 Filed 1-9-85; 8:45]

BILLING CODE 4410-01-M

NUCLEAR REGULATORY COMMISSION

[Docket No. 50-123]

Finding of No Significant Environmental Impact Facility Operating License No. R-79; University of Missouri, Rolla

The Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License No. R-79 for the University of Missouri research reactor located on the campus in Rolla, Missouri.

The amendment will renew the Operating License until November 20, 1989, in accordance with the licensee's application dated October 15, 1979, as supplemented. Opportunity for hearing was afforded by the Notice of Proposed Renewal of Facility License published in the Federal Register on May 9, 1980 at 45 FR 30752.

Continued operation of the reactor will not require alteration of buildings or structures, will not lead to changes in effluents released from the facility to the environment, will not increase the probability or consequences of accidents, and will not involve any unresolved issues concerning alternative uses of available resources. Based on the foregoing and on the Environmental Assessment for this action dated November 16, 1984, the Commission concludes that renewal of the license will not result in any significant environmental impacts.

Finding of No Significant Impact

The Commission has determined not to prepare an Environmental Impact Statement for the proposed action. The Commission has prepared an Environmental Assessment of this action and has concluded that the proposed action will not have a significant effect on the quality of the human environment.

Summary of Environmental Impacts As Described in the Environmental Assessment

The proposed action would authorize the licensee to continue operating the reactor in the same manner that it has been operated since 1961. The environmental impacts associated with the continued operation of the University of Missouri, Rolla, facility are discussed in an Environmental Assessment associated with this action. The Assessment concluded that continued operation of the University of Missouri, Rolla, reactor will not result in any significant environmental impacts on air, water, land or biota in the area, and that an Environmental Impact Statement need not be prepared. These conclusions were based on the following:

(a) The excess reactivity available under the technical specifications is insufficient to support a reactor transient generating enough energy to cause overheating of the fuel or loss of integrity of the cladding.

(b) Even after prolonged operation at a power level of 200 kilowatts, the inventory of fission products in the fuel cannot generate sufficient radioactive decay heat to cause fuel damage even in the hypothetical event of instantaneous total loss of coolant, and

(c) The hypothetical loss of integrity of a fueled experiment will not lead to radiation exposures in the unrestricted environment that exceed the guideline values of 10 CFR Part 20.

For further details with respect to this proposed action, see the application for license renewal dated October 15, 1979, as supplemented, the Environmental Assessment, and the Safety Evaluation Report prepared by the staff (NUREG-1086).

These documents are available for public inspection at the Commission's Public Document Room, 1717 H Street NW., Washington, D.C. 20555. Copies may be obtained upon request addressed to the U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, ATTENTION: Director, Division of Licensing.

Copies of NUREG-1086 may be purchased by calling (301) 492-9530 or by writing to the Publication Services Section, Document Management Branch, Division of Technical Information and Document Control, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555; or purchased from the National Technical Information Service, Department of Commerce, 5285 Port Royal Road, Springfield, Virginia 22161.

Dated at Bethesda, Maryland, this 7th of January 1985.

For the Nuclear Regulatory Commission.

Dennis M. Crutchfield,

Assistant Director for Safety Assessment, Division of Licensing.

[FR Doc. 85-784 Filed 1-9-85; 8:45 am]

BILLING CODE 7590-01-M

[Docket No. 50-286]

Power Authority of the State of New York; Consideration of Issuance of Amendments to Facility Operating Licenses and Proposed No Significant Hazards Consideration Determination and Opportunity for Hearing

The U.S. Nuclear Regulatory Commission (the Commission) is considering the issuance of an amendment to Facility Operating License No. DPR-64 issued to the Power Authority of the State of New York (the licensee), for operation of the Indian Point Nuclear Generating Unit No. 3 (the facility) located in Westchester County, New York.

Changes to the requirements of 10 CFR 50.55a(g) pertaining to inservice inspection provide assurance that the structural integrity of systems and components important to safety are maintained. The proposed amendment incorporates provisions that would require the inservice inspection to be performed in accordance with the requirements for ASME Code Class 1, 2 and 3 components contained in section XI of the ASME Boiler and Pressure Vessel Code and applicable Addenda as required by 10 CFR 50.55a(g), except where relief had been granted by the NRC.

The revisions to the Technical Specifications would be in accordance with the licensee's application for amendment dated September 15, 1983.

Before issuance of the proposed license amendment, the Commission will have made findings required by the Atomic Energy Act of 1954, as amended (the Act) and the Commission's regulations.

The Commission has made a proposed determination that the amendment request involves no significant hazards consideration. Under the Commission's regulations in 10 CFR 50.92, this means that operation of the facility in accordance with the proposed amendment would not (1) involve a significant increase in the probability or consequences of an accident previously evaluated; or (2) create the possibility of a new or different kind of accident from any accident previously evaluated; or (3) involve a significant reduction in a margin of safety.

The Commission has provided guidance for the application of the standards for determining whether a significant hazards consideration exists by providing examples of amendments that are considered not likely to involve significant hazards considerations (48 FR 14870). One such amendment involves a change to make a license conform to changes in the regulations, where the license change results in very minor changes to facility operations clearly in keeping with the regulations.

The change proposed by the licensee is intended to implement 10 CFR 50.55a(g), which includes inservice inspection of safety-related components. This amendment, therefore, reflects changes to make the licensee conform to changes in the regulations. Since the licensee is presently obligated by these regulations to perform inservice inspection of components, this license change will only result in very minor changes to facility operations which are clearly in keeping with the regulations. Therefore, since the application for amendment involves proposed changes that are similar to an example for which no significant hazards consideration exists, the staff has made a proposed determination that the application for amendment involves no significant hazards consideration.

The Commission is seeking public comments on this proposed determination. Any comments received within 30 days after the date of publication of this notice will be considered in making any final determination. The Commission will not normally make a final determination unless it receives a request for a hearing.

Comments should be addressed to the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, Attn: Docketing and Service Branch.

By February 11, 1985, the licensee may file a request for a hearing with respect to issuance of the amendment to the subject facility operating license and any person whose interest may be affected by this proceeding and who wishes to participate as a party in the proceeding must file a written petition for leave to intervene. Request for a hearing and petitions for leave to intervene shall be filed in accordance with the Commission's "Rules of Practice for Domestic Licensing Proceedings" in 10 CFR Part 2. If a request for a hearing or petition for leave to intervene is filed by the above date, the Commission or an Atomic Safety and Licensing Board, designated by the Commission or by the Chairman of the Atomic Safety and Licensing Board Panel, will rule on the request and/or petition and the Secretary or the designated Atomic Safety and Licensing Board will issue a notice of hearing or an appropriate order.

As required by 10 CFR 2.714, a petition for leave to intervene shall set forth with particularity the interest of the petitioner in the proceeding, and how that interest may be affected by the results of the proceeding. The petition should specifically explain the reasons why intervention should be permitted with particular reference to the following factors: (1) The nature of the petitioner's right under the Act to be made a part to the proceeding; (2) the nature of and extent of the petitioner's property, financial, or other interest in the proceeding; and (3) the possible effect of any order which may be entered in the proceeding on the petitioner's interest. The petition should also identify the specific aspect(s) of the subject matter of the proceeding as to which petitioner wishes to intervene. Any person who has filed a petition for leave to intervene or who has been admitted as a party may amend the petition without requesting leave of the Board up to fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, but such an amended petition must satisfy the specificity requirements described above.

Not later than fifteen (15) days prior to the first prehearing conference scheduled in the proceeding, a petitioner shall file a supplement to the petition to intervene which must include as list of the contentions which are sought to be litigated in the matter, and the bases for each contention set forth with reasonable specificity. Contentions shall be limited to matters within the scope of the amendment under consideration. A petitioner who fails to file such a supplement which satisfies these requirements with respect to at least one contention will not be permitted to participate as a party.

Those permitted to intervene become parties to the proceeding, subject to any limitations in the order granting leave to intervene, and have the opportunity to participate fully in the conduct of the hearing, including the opportunity to present evidence and cross-examine witnesses.

If a hearing is requested, the Commission will make a final determination on the issue of no significant hazards consideration. The final determination will serve to decide when the hearing is held.

If the final determination is that the amendment request involves no significant hazards consideration, the

Commission may issue the amendment and make them effective, notwithstanding the request for a hearing. Any hearing held would take place after issuance of the amendment.

If the final determination is that the amendment involves a significant hazards consideration, and hearing held would take place before the issuance of any amendments.

Normally, the Commission will not issue the amendment until the expiration of the 30-day notice period. However, should circumstances change during the notice period such that failure to act in a timely way would result in derating or shutdown of the facility, the Commission may issue the license amendment before the expiration of the 30-day notice period, provided that its final determination is that the amendment involves no significant hazards consideration. The final determination will consider all public and State comments received. Should the Commission take this action, it will publish a notice of issuance and provide for opportunity for a hearing after issuance. The Commission expects that the need to take this action will occur very infrequently.

A request for a hearing or a petition for leave to intervene must be filed with the Secretary of the Commission, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, ATT: Docketing and Service Branch, or may be delivered to the Commission's Public Document Room, 1717 H Street, NW. Washington, D.C., by the above date. Where petitions are filed during the last ten (10) days of the notice period, it is requested that the petitioner promptly so inform the Commission by a toll-free telephone call to Western Union operator at (800) 325-6000 (in Missouri (800) 324-6700). The Western Union Operator should be given Datagram Identification Number 3737 and the following message addressed to Steven A. Varga, Branch Chief, Operating Reactors Branch No. 1, Division of Licensing: petitioner's name and telephone number; date petition was mailed; plant name; and publication date and page number of **Federal Register** notice. A copy of the petition should also be sent to the Executive Legal Director, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555, and to George F. Trowbridge, Esquire, 1800 M Street, NW., Washington, D.C. 20036, attorney for the licensee.

Nontimely filings of petitions for leave to intervene, amended petitions, supplemental petitions and/or requests for hearing will not be entertained absent a determination by the Commission, the presiding officer or the Atomic Safety and Licening Board designated to rule on the petition and/or request, that the petitioner has made a substantial showing of good cause of the granting of a late petition and/or request. That determination will be based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(i)-(V) and 1.714(d).

For further details with respect to this action, see the application for the amendment which is available for public inspection at the Commission's Public Document Room, 1717 H Street, NW., Washington, D.C., and at the White Plains Public Library, 100 Martine Avenue, White Plains, New York 10601.

Dated at Bethesda, Maryland, this 4th day of January 1985.

For the Nuclear Regulatory Commission.

Steven A. Varga,

Chief, Operating Reactors Branch No. 1, Division of Licensing.

[FR Doc. 85-785 Filed 1-9-85; 8:45 am]

BILLING CODE 7590-01-M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 14303; 812-5968]

Drexel Series Trust; Application for an Order Granting Exemption Approving Certain Offers of Exchange

January 4, 1985.

Notice is hereby given that Drexel Series Trust ("Applicant"), 60 Broad Street, New York, New York, 10004, registered under the Investment Company Act of 1940 ("Act"), as an open-end, diversified, management investment company of the series type, filed an application on October 25, 1984, and an amendment thereto on November 6, 1984, for an order of the Commission, (1) pursuant to section 6(c) of the Act exempting Applicant from the provisions of sections 2(a)(32), 2(a)(35), 22(c) and 22(d) of the Act and Rules 22c-1 and 22d-1 thereunder to the extent necessary to permit Applicant to assess a contingent deferred sales charge on redemptions of its initial and future series of shares, and to permit Applicant to waive the contingent deferred sales charge under certain circumstances, and (2) pursuant to section 11(a) of the Act, for approval of certain offers of exchange. All interested persons are referred to the application on file with the Commission for a statement of the representations contained therein, which are summarized below, and to the Act for the text of the applicable statutory provisions.

Organized as a business trust under the laws of the Commonwealth of Massachusetts on September 24, 1984, Applicant presently consists of six series—Money Market Series, Government Securities Series, Bond Series, Growth Series, Emerging Growth Series and Option Income Series. Although Applicant has no current intention to create or issue any additional series, it requests that the proposed exemptive relief extend to its initial series of shares and any additional series or classes of shares that may at any time hereafter be offered on substantially the same basis.

Applicant proposes to offer its shares without an initial sales charge, thereby enabling investors to invest the entire amount of their puchase payments in its shares. However, Applicant also proposes to finance its own distribution expenses pursuant to a distribution plan adopted under Rule 12b-1 under the Act. Under the proposed distribution plan, Applicant will pay an annual fee to Drexel Burnham Lambert Incorporated, Applicant's principal underwriter (the "Distributor"), for expenses incurred by the Distributor in connection with the offering of Applicant's shares. These expenses include compensation for the expenses of, account executives and other employees of the Distributor, or other broker-dealer affiliates of the Distributor, who engage in distribution of shares; printing of prospectuses and reports for other than existing shareholders; advertising; and preparation, printing and distribution of sales literature. Applicant's distribution fee is equal on an annual basis with respect to each series of the Applicant to 1.0% of the average daily net assets of such series.

It is further stated that pursuant to the distribution plan described above, involving an annual percentage charge applied to the average daily net asset values of each series, neither Applicant nor the Distributor may recoup the expenses incurred in selling shares of any series if such shares should be redeemed prior to their having been held a certain length of time. However, Applicant proposes to pay the Distributor a contingent deferred sales charge from the proceeds of certain redemptions, thereby enhancing the recovery of distribution costs. In no event could the amount of such charges, in the aggregate, exceed 5% of the aggregate purchase payments made by the investor. Applicant represents. It is also stated that in reviewing Applicant's distribution plan pursuant to Rule 12b-1, Applicant's trustees will consider the use by the Distributor of revenues raised by the contingent deferred sales charge.

Applicant further states that the contingent deferred sales charge would

be imposed only if an investor redeems an amount which causes the current value of the investor's account with Applicant to fall below the total dollar amount of purchase payments made by the investor during the preceding five years. Applicant states that no sales charge would be imposed if the amount redeemed is derived from (1) increases in the value of the investor's account above the amount of purchase payments during the preceding five years, or (2) purchase payments made more than five years prior to the redemption.

Applicant further proposes that the imposition of the contingent deferred sales charge be waived on the following redemptions: (i) Redemption following the death or disability, as defined in Section 72(m)(7) of the Internal Revenue Code of 1954 (the "Code"), of a shareholder (including one who owns the shares as joint tenant with his or her spouse), provided the redemption is requested within one year of the death or initial determination of disability; (ii) any partial or complete redemption in connection with certain distributions from Individual Retirement Accounts ("IRAs") or other qualified retirement plans; and (iii) involuntary redemptions pursuant to Applicant's right to liquidate an account if the aggregate net asset value of the shares held in the account is less than $100.

Applicant states that where a contingent deferred sales charge is imposed, the amount of the charge will depend on the number of years since the investor made the purchase payment from which an amount is being redeemed, according to the following table:

Year since purchase payment made	Contingent deferred sales charge as a percentage of amount redeemed
First	5.0
Second	4.0
Third	3.0
Fourth	2.0
Fifth	2.0
Sixth and thereafter	(1)

[1] None.

The amount of the contingent deferred sales charge (if any) is calculated by determining the date on which the purchase payment which is the source of the redemption was made, and applying the appropriate percentage to the amount of the redemption subject to the charge.

Applicant states that in determining whether a contingent deferred sales charge is payable, and the applicable percentage charge, it is assumed that shares held the longest are the first to be redeemed. It is stated further that no contingent deferred sales charge will be imposed on exchanges of shares between the series. Moreover, where shares of one series have been exchanged for shares of another series, the purchase date for the shares of the series exchanged into, for purposes of the contingent charge, is assumed to be the date shares were purchased in the series from which the exchange was made.

Applicant proposes to waive the contingent deferred sales charge on any redemption following the death or disability of a shareholder. An individual will be considered disabled for this purpose if he meets the definition thereof in section 72(m)(7) of the Code. Applicant also proposes to waive the contingent deferred sales charge when a total or partial redemption is made in connection with certain distributions from IRA's or other qualified retirement plans. The charge would be waived for any redemption in connection with a lump-sum or other distribution following retirement or, in the case of an IRA, or Keogh Plan, or a custodial account pursuant to section 403(b)(7) of the Code, upon the investor's attaining age 59½. The charge also would be waived on any redemption which results from the tax-free return of an excess contribution pursuant to section 408(d) (4) or (5) of the Code, or from the death or disability of the employee. Finally, Applicant proposes to waive the contingent deferred sales charge on involuntary redemptions of shares held by the shareholder pursuant to Applicant's right to liquidate shareholder accounts if the aggregate net asset value of the shares held in the account is less than $100.

Applicant submits that the imposition of the proposed contingent deferred sales charge would not cause shares of Applicant to fall outside the definition of "redeemable securities" in section 2(a)(32) of the Act, and Applicant believes, therefore, that it qualifies as an open-end company as defined in section 5(a)(1) of the Act. Applicant further submits that imposition of the proposed contingent deferred sales charge will in no way prevent a shareholder from receiving his proportionate share of Applicant's current net assets, but merely defers the deduction of a sales charge and makes it contingent upon an event which may never occur. Although the proposed contingent deferred sales charge is not a redemption charge in the ordinary sense, Applicant submits that the conditions of section 10(d) of the Act contemplate that an investment company may both be an open-end company and impose a discount from net asset value on redemption of its shares. However, in order to avoid uncertainty in this regard, Applicant requests an exemption from the operation of section 2(a)(32) of the Act to the extent necessary to permit implementation of the proposed contingent deferred sales charge.

Applicant asserts further that the proposed contingent deferred sales charge is consistent with the intent of the definition of "sales load" contained in section 2(a)(35) of the Act. The contingent deferred sales charge is paid to the Distributor to reimburse it solely for expenses related to offering Applicant's shares for sale to the public and, therefore, Applicant submits that this arrangement is within the section 2(a)(35) definition of the term "sales load" but for the timing of the imposition of the charge. Applicant contends that the deferral of the sales charge, and its contingency upon the occurrence of an event which might not occur, does not change the basic nature of this charge, which is in every other respect a sales charge. However, Applicant requests an exemption from the provisions of section 2(a)(35) to the extent necessary to implement the proposed charge.

Applicant submits, in addition, that implementation of the proposed contingent deferred sales charge is in no way violative of section 22(c), or Rule 22c-1 thereunder. When a redemption of shares of Applicant is effected, the price of the shares on redemption will be based on current net asset value. The contingent deferred sales charge will merely be deducted at the time of redemption in arriving at the shareholder's proportionate redemption proceeds. However, in order to remove any question as to whether imposition of the contingent deferred sales charge would be violative of section 22(c) and Rule 22c-1, Applicant requests an exemption from the operation of these provisions to the extent necessary or appropriate to permit Applicant to implement the proposed contingent deferred sales charge.

Applicant submits that the imposition of the contingent deferred sales charge is fair and in the best interests of its shareholders, and consistent with all provisions of the Act. Applicant submits that the proposed transaction permits shareholders to reap the benefit of having a greater portion of their purchase payments invested for them from the time of their purchase of Applicant's shares. It is noted that because the contingent deferred sales charge applies only to redemptions of amounts representing purchase

payments (during the first five years after the payments), it does not apply to increases in the value of a shareholder's account through increases in net asset value per share, or to amounts representing reinvestment of distributions.

Applicant contends that notwithstanding the fairness and reasonableness of imposing the contingent deferred sales charge with respect to all redemptions subject thereto, it would be fair and equitable and in the public interest and in the interest of shareholders for the contingent deferred sales charge to be waived on certain types of redemptions. In each situation in which the charge would be waived, the redeeming shareholder is a member of a class of shareholders which is favored under the tax laws, or the securities laws, or one who should not be penalized by the imposition of a sales charge. Applicant further contends that the proposed waiver is consistent with its purposes, in that Applicant is designed for long-term investors, including those who wish to use its shares as the funding vehicle for IRA's or other tax-deferred retirement plans, rather than investors who intend to liquidate their investments after a short period. In situations in which the contingent deferred sales charge will be waived (other than in the case of an involuntary redemption of a shareholder account), the redemption is either unforeseen by the shareholder at the time of purchase (i.e., resulting from the extraordinary circumstances of death or disability), or is fully intended at the time of purchase (i.e., ordinary retirement planning). Accordingly, Applicant contends that neither situation would be inconsistent with Applicant's objectives, or the investor's initial intention of making a long-term investment in Applicant.

Applicant submits that the requested order is fair to remaining shareholders because Applicant will not be charged with any revenue which may be lost as a result of a waiver of the contingent deferred sales charge in the above circumstances. Applicant states that as with all redemptions subject to the contingent deferred sales charge, amounts of which a contingent deferred sales charge would have been imposed but for the waiver of such charge pursuant to this provision are removed from the base of purchase payments in accordance with Applicant's distribution plan pursuant to Rule 12b-1.

Applicant asserts, in addition, that waiver of the contingent deferred sales charge in the extraordinary circumstances of death or total disability of the investor is justified by basic considerations of fairness. Applicant states that waiving the charge on certain distributions from a qualified retirement plan is fully consistent with the policies reflected in (i) the Code provisions granting favored tax treatment to accumulations under such plans and imposing additional taxes on early distributions from IRA's and other plans, and (ii) Rules 22d-1(a)(3) and 22d-1(b)(3) under the Act, which permit quantity discounts for plans qualified under section 401 of the Code, and Rule 22d-1(f) under the Act, which permits variations in the sales load for qualified and non-qualified employee benefit plans (which need not be based on realization of economies where the plans are qualified under section 401 of the Code).

It is asserted further that waiving the charge with respect to involuntary redemptions of accounts having an aggregate net asset value below $100 is justifiable on the basis of fairness considerations. To impose a contingent deferred sales charge in the case of an involuntary liquidation, Applicant states, would be tantamount to the assessment of a penalty upon the shareholder—a penalty which Applicant does not desire.

Applicant proposes, as well, to offer to exchange shares of each of its series for shares of any other such series on the basis of the relative net asset values of the shares being exchanged. No contingent deferred sales charges are to be imposed on such exchanges, but a $5.00 service fee is proposed to be charged on such transactions, to be paid to Applicant, and deducted from the series from which the exchange was effectuated by liquidation of shares. The minimum amount which could be exchanged for a series of which shares were not held immediately prior to such exchange, is $1000. No exchange from a series (other than by a complete exchange) could be made if it would reduce the shareholder's interest in that series below $100.

Applicant requests an exemption from section 11(a) of the Act to permit the proposed exchanges of shares of various series, in order to remove any obstacle to such proposal which the $5.00 service charge on such transactions might present under section 11. It is asserted that the imposition of the $5.00 service charge is not violative of section 11(a), in that the charge constitutes merely an administrative fee which is applied to defray the expense of facilitating the internal exchange of shares between series. No unfairness, discrimination among, or other harm to shareholders should be expected to result from Applicant's institution of the service charge.

Notice is further given that any interested person wishing to request a hearing on the application may, not later than January 29, 1985, at 5:30 p.m., do so by submitting a written request setting forth the nature of his/her interest, the reasons for the request, and the specific issues of fact or law that are disputed, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549. A copy of the request should be served personally or by mail upon Applicant at the address stated above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) shall be filed with the request. After said date, an order disposing of the application will be issued unless the Commission orders a hearing upon request or upon its own motion.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 85-781 Filed 1-9-85; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 14301; 812-5949]

Narragansett Capital Corp., et al.; Filing of Application for an Order

January 4, 1985.

Notice is hereby given that Narragansett Capital Corporation ("Narragansett"), 40 Westminster Street, Providence, RI, 02903, registered under the Investment Company Act of 1940 ("Act") as a closed-end, non-diversified, management investment company and licensed as a small business investment company under the Small Business Investment Act of 1958, and Bevis Industries, Inc. ("Bevis"), a corporation presumed to be controlled by Narragansett (collectively, "Applicants") filed an application on October 3, 1984, for an order, pursuant to sections 17(b) and 17(d) of the Act and Rule 17d-1 thereunder, exempting from the provisions of section 17(a) of the Act and permitting under section 17(d) of the Act, a group of interrelated refinancing transactions. All interested persons are referred to the application on file with the Commission for a statement of the representations contained therein, which are summarized below.

According to the application, the transactions consist of the refinancing of indebtedness involving (1) the agreement by the holders of certain

subordinated installment notes ("6% Notes") of Greenville Tube Corporation ("Greenville"), a wholly-owned subsidiary of Bevis, to the deferral of a portion of the installments of principal totaling $3,750,000 due September 30, 1984, under the 6% Notes; (2) the agreement by Narragansett as the holder of certain other subordinated installment notes of Greenville ("Subordinated Notes") to the deferral of principal payments totaling $1,700,000 due one month after the 6% Notes are paid or October 31, 1984, whichever occurs first and (3) concessions made by Bevis and Greenville to obtain those agreements.

The application indicates that Bevis conducts its business through two wholly-owned subsidiaries, Greenville and MD Pneumatics, Inc. ("MD"); Bevis has issued 2,924,963 shares of common stock, of which 1,064,225 shares are held as treasury shares and 1,860,738 are outstanding. The stock is traded in the over-the-counter market. The application states that the only person known by Bevis to own more than 5% of such common stock, as of June 30, 1984, is Narragansett, which owned 836,952 shares (44.98%).

Applicants state that Arthur D. Little is president of Bevis; Arthur H. McGonigal, Sr. and George K. Painter are president and executive vice president, respectively, of Greenville. All three serve as directors of Bevis (of which there are seven) with Frederick G. Frost, III, who is a nominee on the Bevis board and a director of Narragansett, Robert G. Huckins, Gordon E. Cadwgan and Warren B. Hamby; McGonigal and Painter are both directors of Greenville serving with Huckins.

According to Applicants, the refinancing transactions are the result of negotiations starting in February, 1984, between Bevis and the holders of the 6% Notes ("Noteholders") to obtain the agreement of the Noteholders to the deferral of the final installments thereunder totaling $3,750,000 which would otherwise be payable September 30, 1984. The 6% Notes were issued on December 28, 1976, pursuant to a Stock Purchase Agreement dated September 28, 1976 ("Stock Purchase Agreement"), under which Narragansett, McGonigal, Joseph H. Filner, R.J. Goss, Raymond Landfried, Donald Weaver, M.W. Weaver and Painter, (the former stockholders, other than Narragansett, are collectively referred to as the "Individual Noteholders") sold all of the stock of the former Greenville Tube Corporation to a subsidiary of Bevis for $125,000 in cash and $13,000,000 of 6% Notes, of which $6,500,000 were issued to Narragansett and $6,500,000 to the Individual Noteholders.

The application indicates that the 6% Notes were originally payable in interim installments totaling $1,500,000 due on January 15, of 1977 through 1981, and final installments totaling $5,500,000 due January 15, 1982, of which $2,000,000 was payable to the Individual Noteholders and $3,500,000 to Narragansett. By a Guaranty and Pledge Agreement dated December 28, 1976, Bevis guaranteed the payment of the 6% Notes and pledged the stock of Greenville as collateral for that guaranty. At the closing held December 28, 1976, (1) McGonigal and Painter entered into employment agreements with Greenville for terms ending on the later of January 15, 1982, or the date of payment of the 6% Notes ("McGonigal and Painter Employment Agreements"); (2) Narragansett granted McGonigal and Painter options to purchase shares of the common stock of Bevis owned by Narragansett at a price of $1.51 per share exercisable at any time during the month of January, 1982, or if the 6% Notes had not been paid by January 31, 1982, during the 30 days following the date of such payment (in no event after December 31, 1982), provided the 6% Notes have been paid and Greenville has a tangible net worth of at least $5,000,000 and does not have indebtedness in excess of $3,000,000 ("McGonigal and Painter Options from Narragansett"); and (3) Narragansett agreed to defer payment of $1,700,000 principal amount of Subordinated Notes until the first to occur of February 15, 1982, or payment of the 6% Notes.

On September 27, 1976, Bevis, Narragansett, Bernhardt Denmark, Royal Little, Sol Kittay and Stanley Goldstein entered into an agreement ("Bevis Stockholders Agreement") pursuant to which certain restrictions were placed on the sale of the shares of common stock of Bevis owned by the parties (other than Bevis) and Denmark was entitled, until the 6% Notes were paid, to have vacancies on the board of directors of Bevis caused by the resignations or inability to serve of Denmark, Kittay or Jack Brier filled by persons agreeable to him. Narragansett was entitled to fill two other vacancies.

On May 1, 1979, at the time of the purchase by Bevis of the stock of MD, the Bevis Stockholders Agreement was amended to add Earl Fester as a party, to make the commitments with respect to the right of Denmark and others to fill vacancies on the Bevis board of directors effective until the payment of not only the 6% Notes but also the $4,900,000 of 6% Subordinated Installment Notes issued as part of the purchase price for the stock of MD ("MD Notes"), and to make certain other changes. The above described prior transactions were the subject of applications and Commission orders permitting the transactions (Investment Company Act Release Nos. 9584 and 10752). Applicants state that the MD Notes were paid in full on December 30, 1983, and January 3, 1984.

The application states that, pursuant to a First Amendment to the Stock Purchase Agreement executed in October, 1978, and a Second Amendment thereto executed in January, 1980, certain installments of principal due under the 6% Notes on January 15, 1979, and January 15, 1980, were partially deferred. All such deferred payments had been fully paid by March 13, 1980. However, according to the Applicants, it became clear at that time that the final installments totaling $5,500,000 which would otherwise come due January 15, 1982, could not be paid when due without substantial borrowing by Bevis or Greenville and that efforts should be made to negotiate a deferral of the final installments agreeable to the Noteholders as well as a deferral agreeable to Narragansett of the $1,700,000 payable on February 15, 1982, under the Subordinated Notes.

Applicants state that, following negotiations among Bevis, Greenville, Narragansett, Denmark, the Noteholders, McGonigal and Painter, a Third Amendment dated September 18, 1981, to the Stock Purchase Agreement was executed and a closing for the contemplated transactions of that amendment was held February 23, 1982 ("1982 Transactions"). The application indicates that the 1982 Transactions consisted of two groups, the first of which consisted of the purchase by Bevis of 639,225 shares of the Bevis common stock from three substantial stockholders of Bevis (Denmark, Kittay and Goldstein), the resignation from the Bevis Board of Directors of Denmark and his two nominees and the release by Denmark, Kittay and Goldstein of any rights under the Bevis Stockholders Agreement, as amended.

Applicants state that the second group consisted of the deferral of the installments of principal totaling $5,500,000 due January 15, 1982, under the 6% Notes with the consent of the Noteholders, deferral of the $1,700,000 due February 15, 1982, under the Subordinated Notes with the consent of Narragansett and concessions made by Bevis and Greenville to obtain such consents. As a result of this second group of transactions closed on

February 23, 1982. Applicants state that the final installments under the 6% Notes totaling $5,500,000 were made payable as to principal $750,000 on January 15, 1982, $500,000 on January 15, 1983, and January 15, 1984, and $3,750,000 on September 30, 1984 (of which $2,625,000 would be paid to Narragansett and $1,125,000 to the Individual Noteholders), and the annual payments by Greenville to Bevis to cover general corporate overhead would be increased as of January 1, 1981, and again as of January 15, 1983. In addition, the application indicates that Narragansett agreed to defer payment of the $1,700,000 owed to it by Greenville under the Subordinated Notes until one month after the 6% are paid or October 31, 1984, whichever occurs first; Bevis and Greenville, in turn, agreed to increase the annual rate of interest on both the 6% Notes and the Subordinated Notes to 15% commencing January 15, 1982. Bevis obtained the agreement of Narragansett to extend the option periods under the McGonigal and Painter Options from Narragansett from January 31, 1982, until December 31, 1985, provided the other conditions precedent to their exercise were satisfied.

Applicants state that Bevis and Greenville in the Third Amendment also obtained the agreement of McGonigal and Painter to amend the McGonigal and Painter Employment Agreements in consideration of (1) an increase in their minimum salaries; (2) to extend the terms thereof until December 31, 1984; and (3) to increase the duration of their agreements not to compete. Bevis also granted additional options to McGonigal and Painter to purchase shares of Bevis common stock at $2 per share, exercisable during the period from January 1, 1985, to December 31, 1985, provided the 6% Notes and the Subordinated Notes have been paid in full, and Bevis granted additional options covering in the aggregate 100,000 shares of common stock (12,500 shares to each) to eight other key employees at Greenville ("Employee Option Holders") on the same terms, except that the options are exercisable until December 31, 1986.

The above-described transactions in both the first and second groups were the subject of an application and Commission order (Investment Company Act Release No. 12233, February 18, 1982). Applicants represent that at the time of the application all payments under the 6% Notes and the Subordinated Notes were current, the installments of principal under the 6% Notes due January 15, 1982, 1983 and 1984, and all interest payments under the 6% Notes and the Subordinated Notes have been paid. The application indicates that the current ownership of the 6% Notes is such that the $3,750,000 of final installments that came due September 30, 1984, will be payable with $2,625,000 being owed to Narragansett, $798,750 to one Individual Noteholder (McGonigal), the remainder being apportioned among the five remaining Individual Noteholders.

According to the application, shortly after the payment of the January 15, 1984, installments under the 6% Notes, Little commenced negotiations with McGonigal and Painter to work out a deferral of the $3,750,000 of final installments due September 30, 1984, since it had become clear that Greenville could not make these payments without extensive bank borrowing, to which McGonigal and Painter were both opposed (both indicated that they would not renew their employment agreements if bank borrowing was done). In addition, the application states that any refinancing that involved payment in full of the 6% Notes when due would terminate the McGonigal and Painter Employment Agreements, and without their agreement to employment extensions, Greenville would lack experienced management, a condition which would make it impractical to obtain loans from banks with which to pay the final installments. Applicants state that the waiver of any of the provisions of the Stock Purchase Agreement, as amended, or of the 6% Notes requires the consent of the holders of 80% of the 6% Notes so that both McGonigal and Narragansett (who own 35.5% and 50%, respectively, of the 6% Notes) would have to consent to any such action; the waiver of a default in payment of the installments due September 30, 1984, under the 6% Notes would require the consent of all of the Noteholders. It was therefore clear that an agreement would have to be worked out with Narragansett, McGonigal, Painter and the other Individual Noteholders for a deferral of (i) the installments due September 30, 1984, to the Noteholders under the 6% Notes totaling $3,750,000 and (ii) the payments due on the first to occur of October 31, 1984, or a date one month after payment in full of the 6% Notes, to Narragansett on the Subordinated Notes totaling $1,700,000.

The application indicates that on July 12, 1984, all of the Directors of Bevis and of Greenville evidenced their consent to an understanding reached by Little with McGonigal and Painter, and at a special meeting held September 5, 1984, the Directors unanimously approved this understanding, which provides for the following: (1) The 6% Notes owned by all of the Noteholders except McGonigal and Narragansett are to be paid in full (a total of $326,250) on the closing date; (2) the principal payments under the 6% Notes owned by McGonigal and Narragansett due September 30, 1984 in the amounts of $798,750 and $2,625,000, respectively, will be deferred and paid as follows: (a) Six fixed payments of $497,025 ($380,025 to Narragansett, $117,000 to McGonigal) will be paid on January 30 of each of the six years commencing January 30, 1985 through January 30, 1990 and one of $441,600 on January 30, 1991 ($344,850 to Narragansett, $96,750 to McGonigal); (b) contingent payments on the 6% Notes will be made in addition to the fixed payments on January 30 of each year commencing January 30, 1985, in an aggregate amount equal to 66.27% of the excess, if any, as of December 31 of the preceding year, of $4,000,000 over the total of (i) the amount of cash or cash equivalents, including certificates of deposit, treasury bills and commercial paper, and (ii) the book value of all inventories; provided, however, that no payment would be made if the total cash or cash equivalents was less than $1 million; however, if the total of cash or cash equivalents was over $1.5 million, the amount of such excess would be paid regardless of the value of the inventories. Applicants also state that the contingent payments would be divided between the 6% Notes owned by McGonigal and those owned by Narragansett in proportion to the unpaid balances and would be applied against the fixed payments under the 6% Notes in the inverse order of their maturities. The amounts of cash, cash equivalents and inventories will be established by the independent public accountants of Greenville in the course of their audit. Applicants represent that there would be no change in the rate of interest (15%) payable on the 6% Notes.

The application indicates that the principal payments under the Subordinated Notes owned by Narragansett will be deferred and paid as follows: (a) Fixed payments of $252,975 each will be paid on January 30 of each of the six years commencing January 30, 1985, through January 30, 1990, and one of $182,150 on January 30, 1991, (for a total of $1,700,000) (b) contingent payments will be made and applied as stated above in the case of the 6% Notes, except that 33.73% of the excess of $4,000,000 over the total cash or cash equivalents plus inventories will be paid on the Subordinated Notes.

Applicants represent that there will be no change in the rate of interest (15%) payable on the Subordinated Notes. Applicants state that the employment agreements between Greenville and McGonigal and between Greenville and Painter dated December 28, 1976, as amended February 22, 1981, are to be further amended to extend the employment period until the last to occur of (i) December 31, 1989, in the case of McGonigal and December 31, 1985, in the case of Painter, or (ii) payment in full of the 6% Notes; their annual salaries will be increased (subject to annual review) and annuities will be purchased for each of them.

Applicants assert that the terms of the Fourth Amendment and related transactions were negotiated in arms-length negotiations between the various parties who are sophisticated and were represented by independent counsel who were familiar with the various factors involved because of prior participation in the acquisition of Greenville by Bevis and the 1982 negotiations and the 1982 Transactions. Applicants also assert that there is no overreaching of any person involved in the refinancing transactions and that the transactions benefit each party to them. Applicants state that the Noteholders, other than McGonigal and Narragansett, are benefitted in that their 6% Notes will be paid on the closing date. Applicants argue that McGonigal and Narragansett are benefitted in that their 6% Notes and the Subordinated Notes are adjusted to the fastest payment schedule that the projected earnings of Greenville can support, and no indebtedness to banks or lending institutions senior to the 6% Notes is to be created as would be possible under the currently effective subordination provisions of the 6% Notes. Applicants further assert that Narragansett as the owner of the Subordinated Notes is benefitted in that those notes share *pro rata* with the fixed and contingent payments on the 6% Notes while defaults on the 6% Notes or the Subordinated Notes and creation of senior debt is avoided. Applicants state that McGonigal and Painter benefit by having their salaries increased and annuities pruchased; in the case of McGonigal; he benefits by having his position as president of Greenville assured through December 31, 1989. Applicants also argue that the extension of the McGonigal and Painter Employment Agreements benefits Bevis and its stockholders, including Narragansett.

Applicants assert that the participation of Narragansett and Bevis in the proposed transactions is consistent with the provisions, policies and purposes of the Act, and to the extent that such participation is on a basis different or less advantageous than that of other participants, the transactions are fair and reasonable and do not involve any overreaching. Applicants further assert that the participation of Narragansett and McGonigal in the payment of the deferred installments under the 6% Notes and the Subordinated Notes pursuant to the Fourth Amendment results from arms-length negotiations between McGonigal, Narragansett and Bevis.

Notice is further given that any interested person wishing to request a hearing on the application may, not later than January 28, 1985, at 5:30 p.m., do so by submitting a written request setting forth the nature of his interest, the reasons for his request, and the specific issues, if any, of fact or law that are disputed, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549. A copy of the request should be served personally or by mail upon Applicant at the address stated above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) shall be filed with the request. After said date, an order disposing of the application will be issued unless the Commission orders a hearing upon request or upon its own motion.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 85-782 Filed 1-9-85; 8:45 am]

BILLING CODE 8010-01-M

[Release No. 14302; 811-3306]

Nationwide Multi-Flex Money Market Trust; Filing of Application for an Order Declaring That Applicant Has Ceased To Be an Investment Company

January 4, 1985.

Notice is hereby given that Nationwide Multi-Flex Money Market Trust ("Applicant"), One Nationwide Plaza, Columbus, Ohio, 43216, an open-end, diversified, management investment company registered under the Investment Company Act of 1940 ("Act"), filed an application on October 30, 1984, pursuant to section 8(f) of the Act, for an order of the Commission declaring that Applicant has ceased to be an investment company. All interested persons are referred to the application on file with the Commission for a statement of the representations contained therein, which are summarized below, and are referred to the Act and the rules thereunder for the applicable provisions.

Applicant states that on October 29, 1981 it filed a notification of registration on Form N-8A and a registration statement on Form N-1. Such registration statement was never declared effective.

Applicant states that it has never made a public offering of any of its securities. Applicant further states that it has no securityholders, no assets, debts or other liabilities, and that it is not a party to any litigation or administrative proceedings. Applicant maintains that it is not engaged, nor does it propose to engage, in any business activities other than those necessary for the winding up of its affairs in accordance with the laws of the State of Michigan, the state of creation. On October 26, 1984, the Board of Trustees of Applicant authorized the termination of the Applicant, effective December 31, 1984.

Notice is further given that any interested person wishing to request a hearing on the application may, not later than January 31, 1985, at 5:30 p.m., do so by submitting a written request setting forth the nature of his interest, the reasons for his request, and the specific issues, if any, of fact or law that are disputed, to the Secretary, Securities and Exchange Commission, Washington, D.C. 20549. A copy of the request should be served personally or by mail upon Applicant at the address stated above. Proof of service (by affidavit or, in the case of an attorney-at-law, by certificate) shall be filed with the request. After said date, an order disposing of the application will be issued unless the Commission orders a hearing upon request or upon its own motion.

For the Commission, by the Division of Investment Management, pursuant to delegated authority.

John Wheeler,

Secretary.

[FR Doc. 85-783 Filed 1-9-85; 8:45 am]

BILLING CODE 8010-01-M

DEPARTMENT OF TRANSPORTATION
Coast Guard

[CGD 85-003]

Houston/Galveston Navigation Safety Advisory Committee; Subcommittee Meeting

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463; 5 U.S.C. App. I) notice is hereby given of a meeting of the Inshore Waterway Management Subcommittee of the Houston/Galveston Navigation Safety Advisory Committee. The meeting will be held on Thursday, February 21, 1985 at the offices of the Captain of the Port, U.S. Coast Guard, Port Safety Station, 9640 Clinton Drive, Galena Park, Texas. The meeting is scheduled to begin at 2 p.m. and end at 5 p.m. The agenda for the meeting consists of the following items:

1. Call to Order.
2. Discussion of previous recommendations made by the full Advisory Committee and the Inshore Waterway Management Subcommittee.
3. Presentation of any additional new items for consideration to the Subcommittee.
4. Adjournment.

Attendance is open to the public. With advance notice, members of the public may present oral statements at the meeting. Prior to presentation of their oral statements, but no later than the day before the meeting, members of the public shall submit, in writing, to the Executive Secretary of the Houston/Galveston Navigation Safety Advisory Committee, the subject of their comments, a general outline signed by the presenter, and the estimated time required for presentation. The individual making the presentation shall also provide their name, address, and, if applicable, the organization they are representing. Any member of the public may present a written statement to the Advisory Committee at any time.

Additional information may be obtained from Commander R. A. Brunell, USCG, Executive Secretary, Houston/Galveston Navigation Safety Advisory Committee, c/o Commander, Eighth Coast Guard District (mps), Room 1341, Hale Boggs Federal Building, 500 Camp Street, New Orleans, LA 70130, telephone number (504) 589-6901.

Dated: December 28, 1984.

T.T. Matteson,

Acting Chief of Staff, Eighth Coast Guard District.

[FR Doc. 85-740 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-14-M

[CGD 85-004]

Houston/Galveston Navigation Safety Advisory Committee; Subcommittee Meeting

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92-463; 5 U.S.C. App. I) notice is hereby given of a meeting of the Offshore Waterway Management Subcommittee of the Houston/Galveston Navigation Safety Advisory Committee. The meeting will be held on Thursday, February 28, 1985 at the offices of the West Gulf Maritime Association, 2618 South Loop West, Suite 600, Houston, Texas. The meeting is scheduled to begin at 10 a.m. and end at 12 p.m. The agenda for the meeting consists of the following items:

1. Call to Order.
2. Discussion of previous recommendations made by the full Advisory Committee and the Offshore Waterway Management Subcommittee.
3. Presentation of any additional new items for consideration to the Subcommittee.
4. Adjournment.

Attendance is open to the public. With advance notice, members of the public may present oral statements at the meeting. Prior to presentation of their oral statements, but no later than the day before the meeting, members of the public shall submit, in writing, to the Executive Secretary of the Houston/Galveston Navigation Safety Advisory Committee, the subject of their comments, a general outline signed by the presenter, and the estimated time required for presentation. The individual making the presentation shall also provide their name, address, and, if applicable, the organization they are representing. Any member of the public may present a written statement to the Advisory Committee at any time.

Additional information may be obtained from Commander R. A. Brunell, USCG, Executive Secretary, Houston/Galveston Navigation Safety Advisory Committee, c/o Commander, Eighth Coast Guard District (mps), Room 1341, Hale Boggs Federal Building, 500 Camp Street, New Orleans, LA 70130, telephone number (504) 589-6901.

Dated: December 28, 1984.

T.T. Matteson,

Acting Chief of Staff, Eighth Coast Guard District.

[FR Doc. 85-739 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-14-M

Federal Aviation Administration

Proposed Advisory Circular 25.994-XX; Flammable Fluid Components Affected by Wheels-Up Landing

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of availability of proposed Advisory Circular (AC) 25.994-XX, and request for comments.

SUMMARY: This notice announces the availability of and requests comments on a proposed advisory circular (AC) concerning flammable fluid components affected by wheels-up landing. This notice is necessary to give all interested persons an opportunity to present their views on the proposed AC.

DATES: Comments must be received on or before April 10, 1985.

ADDRESS: Send all comments on the proposed AC to: Federal Aviation Administration, Attention: Regulations and Policy Office, ANM-110, Northwest Mountain Region, 17900 Pacific Highway South, C-68966, Seattle, Washington 98168. Comments may be inspected at the above address between 7:30 a.m. and 4:00 p.m. weekdays, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: James Walker, Regulations and Policy Office, at the address above, telephone (206) 431-2116.

SUPPLEMENTARY INFORMATION:

Comments Invited

A copy of the draft AC may be obtained by contacting the person named above under **FOR FURTHER INFORMATION CONTACT.** Interested persons are invited to comment on the proposed AC by submitting such written data, views, or arguments as they may desire. Commenters should identify AC 25.994-XX and submit comments, in duplicate, to the address specified above. All communications received on or before the closing date for comments will be considered by the Regulations and Policy Office before issuing the final AC.

Background

Release of fuel from damaged fuel system components causes a potential fire hazard. The rules prior to the Notice of Proposed Rulemaking (NPRM) 68-18 (33 FR 11193; August 22, 1968) and Amendment 25-23 (35 FR 5665; April 8, 1970) addressed only fuel tanks and did not specifically address other fuel system components that should be protected from damage as a result of a wheels-up landing. Amendment 25-23 corrected this omission and Amendment

25-57 [49 FR 6832; February 23, 1984] further clarified the rule with respect to the intent of the protection required and the nature of the landing terrain for the wheels-up landing event.

This AC is proposed for the purpose of providing some guidelines and installation practices which, if used, will comply with the intent of the rule.

Issued in Seattle, Washington, on December 18, 1984.

Leroy A. Keith,

Manager, Aircraft Certification Division, ANM-100.

[FR Doc. 85-667 Filed 1-9-85; 8:45 am]

BILLING CODE 4910-13-M

VETERANS ADMINISTRATION

Availability of Report of 38 U.S.C. 219 Program Evaluation

Notice is hereby given that the program evaluation of the Veterans Administration's Life Insurance Program has been completed.

Single copies of the Life Insurance Program evaluation are available free. Reproduction of multiple copies can be arranged at the user's expense.

Direct inquiries, specifying the name of the program evaluation desired, to Mrs. Lynn H. Covington, Director, Program Evaluation Service, Veterans Administration (074), 810 Vermont Avenue, N.W., Washington, D.C. 20420.

Dated: January 3, 1985.

By direction of the Administrator.

Everett Alvarez, Jr.,

Deputy Administrator.

[FR Doc. 85-687 Filed 1-9-85; 8:45 am]

BILLING CODE 8320-01-M

Sunshine Act Meetings

Federal Register
Vol. 50, No. 7
Thursday, January 10, 1985

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

COMMODITY CREDIT CORPORATION

TIME AND DATE: 2:00 p.m., January 9, 1985.

PLACE: Room 104A-Administration Building, U.S. Department of Agriculture, Washington, D.C.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. Minutes of CCC Board meeting on August 28, 1984.
2. Memorandum re: Barley, Corn, Oats, Rye, and Sorghum Loan and Purchase, Payment, and Production Adjustment Programs for the 1982 through 1985 Marketing Years, XCP-137a, Advisory Memorandum No. 3.
3. Memorandum re: Rice Loan and Purchase, Payment, and Production Adjustment Programs for the 1982 and through 1985 Marketing Years, XCP-33a, Advisory Memorandum No. 3.
4. Memorandum re: Wheat Loan and Purchase, Payment, and Production Adjustment Programs for the 1982 through 1985 Marketing Years, XCP-2a, Advisory Memorandum No. 3.
5. Memorandum re: Update of Commodity Credit Corporation (CCC)-Owned Inventory.
6. Resolution re: Ratification of Repurchase Offers on Export Credit Guarantees for Jamaica.
7. Resolution re: Ratification of Docket CZ-266, Resolution No. 22, Commodities Available for Public Law 480 During Fiscal Year 1985.

CONTACT PERSON FOR MORE INFORMATION: Richard A. Ashworth, Secretary, Commodity Credit Corporation, Post Office Box 2415, Room 3086 South Building, U.S. Department of Agriculture, Washington, D.C. 20013; telephone (202) 447-8165.

Dated: January 7, 1985.

Richard A. Ashworth,

Secretary, Commodity Credit Corporation.

[FR Doc. 85-829 Filed 1-8-85; 11:35 am]

BILLING CODE 3410-05-M

2

EQUAL EMPLOYMENT OPPORTUNITY COMMISSION

DATE AND TIME: Tuesday, January 15, 1985, 9:30 AM (Eastern Time).

PLACE: Clarence M. Mitchell, Jr., Conference Room No. 200-C on the 2nd Floor of the Columbia Plaza Office Building, 2401 "E" Street, NW., Washington, D.C. 20507.

STATUS: Part will be open to the public and part will be closed to the public.

MATTERS TO BE CONSIDERED:

1. Announcement of Notation Vote(s)
2. A Report on Commission Operations (Optional)
3. Proposed Compliance Manual Section 8, Intake of Commission Initiated Actions
4. Proposed Compliance Manual Section 26, Selection and Analysis of Evidence
5. Two Proposed Contracts for Expert Services in Connection With Court Cases
6. Final Regulation Implementing Section 4(g) of the ADEA 29 U.S.C. § 623(g)

Closed

1. Litigation Authorization; General Counsel Recommendations
2. Proposed Decisions, Settlements, and Subpoenas
3. Options Paper on Enforcement of an ORA Decision

Note.—Any matter not discussed or concluded may be carried over to a later meeting. (In addition to publishing notices on EEOC Commission meetings in the **Federal Register**, the Commission also provides a recorded announcement a full week in advance on future Commission sessions. Please telephone (202) 634-6748 at all times for information on these meetings).

CONTACT PERSON FOR MORE INFORMATION: Cynthia C. Matthews, Executive Officer, Executive Secretariat at (202) 634-6748.

Dated: January 8, 1985.

Cynthia C. Matthews,

Executive Officer.

[FR Doc. 85-873 Filed 1-8-84; 12:54 pm]

BILLING CODE 6570-06-M

3

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Change in Subject Matter of Agency Meeting

Pursuant to the provisions of subsection (e)(2) of the "Government in the Sunshine Act" (5 U.S.C. 552b(e)(2)), notice is hereby given that at its open meeting held at 2:00 p.m. on Monday, January 7, 1985, the Corporation's Board of Directors determined, on motion of Chairman William M. Isaac, seconded by Director C. T. Conover (Comptroller of the Currency), concurred in by Director Irvine H. Sprague (Appointive), that Corporation business required the addition to the agenda for consideration at the meeting, on less than seven days' notice to the public, of the following matter:

Recommendation regarding the liquidation of a bank's assets acquired by the Corporation in its capacity as receiver, liquidator, or liquidating agent of those assets: Case No. 46,167-L, The First National Bank of Midland, Texas.

By the same majority vote, the Board further determined that no earlier notice of this change in the subject matter of the meeting was practicable.

Dated: January 7, 1985.

Federal Deposit Insurance Corporation.

Hoyle L. Robinson,

Executive Secretary.

[FR Doc. 85-823 Filed 1-8-85; 11:04 am]

BILLING CODE 6714-01-M

4

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Change in Subject Matter of Agency Meeting

Pursuant to the provisions of subsection (e)(2) of the "Government in the Sunshine Act" (5 U.S.C. 552b(e)(2)), notice is hereby given that at its closed meeting held at 2:30 p.m. on Monday, January 7, 1985, the Corporation's Board of Directors determined, on motion of Chairman William M. Isaac, seconded by Director Irvine H. Sprague (Appointive), concurred in by Director C.T. Conover (Comptroller of the Currency), that Corporation business required the addition to the agenda for consideration at the meeting, on less than seven days' notice to the public, of the following matters:

Memorandum regarding liquidation activities.

Application for capital assistance pursuant to section 13(i) of the Federal Deposit Insurance Act: (Name and location of bank

authorized to be exempt from disclosure pursuant to the provisions of subsections (c)(4), (c)(6), (c)(8), and (c)(9)(A)(ii) of the "Government in the Sunshine Act" (5 U.S.C. 552b(c)(4), (c)(6), (c)(8), and (c)(9)(A)(ii)).

The Board further determined, by the same majority vote, that no earlier notice of these changes in the subject matter of the meeting was practicable; that the public interest did not require consideration of the matters in a meeting open to public observation; and that the matters could be considered in a closed meeting by authority of subsections (c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), and (c)(9)(B) of the "Government in the Sunshine Act" (5 U.S.C. 552b(c)(4), (c)(6), (c)(8), (c)(9)(A)(ii), and (c)(9)(B)).

Dated: January 7, 1985.

Federal Deposit Insurance Corporation.

Hoyle L. Robinson,

Executive Secretary.

[FR Doc. 85-824 Filed 1-8-85; 11:04 am]

BILLING CODE 6714-01-M

5

FEDERAL ELECTION COMMISSION

DATE AND TIME: Tuesday, January 15, 1985, 10:00 a.m.

PLACE: 1325 K Street, NW., Washington, D.C.

STATUS: This meeting will be closed to the public.

ITEMS TO BE DISCUSSED: Compliance. Litigation. Audits. Personnel.

* * * * *

DATE AND TIME: Thursday, January 17, 1985, 10:00 a.m.

PLACE: 1325 K Street, NW., Washington, D.C. (fifth floor).

STATUS: This meeting will be open to the public.

MATTERS TO BE CONSIDERED:

Setting of dates of future meetings
Correction and approval of minutes
Eligibility for candidates to receive Presidential Primary Matching Funds.
Notice of proposed rulemaking (11 CFR 110.1 and 110.2)
Routine administrative matters

PERSON TO CONTACT FOR INFORMATION: Mr. Fred Eiland, Information Officer, 202-523-4065.

Marjorie W. Emmons,

Secretary of the Commission.

[FR Doc. 85-893 Filed 1-8-85; 3:28 pm]

BILLING CODE 6715-01-M

6

FEDERAL ENERGY REGULATORY COMMISSION

FEDERAL REGISTER CITATION OF PREVIOUS ANNOUNCEMENT: 49 FR 593, January 4, 1985.

PREVIOUSLY ANNOUNCED TIME AND DATE OF MEETING: January 9, 1985, 10:00 a.m.

CHANGE IN THE MEETING: The following Docket Numbers and Companies have been added:

Item No., Docket No. and Company

ER-2—ER82-616-000 (Remand), Middle South Energy, Inc.; ER84-348-001, American Electric Power Service Corporation

Kenneth F. Plumb,

Secretary.

[FR Doc. 85-913 Filed 1-8-85; 3:59 pm]

BILLING CODE 6717-02-M

7

FEDERAL RESERVE SYSTEM BOARD OF GOVENORS

TIME AND DATE: 10:00 a.m., Wednesday, January 16, 1985.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, N.W., Washington, DC 20551.

STATUS: Open.

MATTERS TO BE CONSIDERED:

1. Consideration of real estate activities of state bank subsidiaries of bank holding companies.
2. Any items carried forward from a previously announced meeting.

Note—This meeting will be recorded for the benefit of those unable to attend. Cassettes will be available for listening in the Board's Freedom of Information Office, and copies may be ordered for $5 per cassette by calling (202) 452-3684 or by writing to: Freedom of Information Office, Board of Governors of the Federal Reserve System, Washington, D.C. 20551.

CONTACT PERSON FOR MORE INFORMATION: Mr. Joseph R. Coyne, Assistant to the Board; (202) 452-3204

Dated: January 8, 1985.

William W. Wiles,

Secretary of the Board.

[FR Doc. 85-896 Filed 1-8-85; 3:37 pm]

BILLING CODE 6210-01-M

8

FEDERAL RESERVE SYSTEM BOARD OF GOVERNORS

TIME AND DATE: Approximately 12:00 noon, Wednesday, January 16, 1985, following a recess at the conclusion of the open meeting.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, D.C. 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.
2. 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. You may call (202) 452-3207, beginning at approximately 5 p.m. two business days before this meeting, for a recorded announcement of bank and bank holding company applications scheduled for the meeting.

Dated: January 8, 1985.

William W. Wiles,

Secretary of the Board.

[FR Doc. 85-897 Filed 1-8-85; 3:37 pm]

BILLING CODE 6210-01-M

9

NATIONAL SCIENCE BOARD

DATE AND TIME:

January 17, 1985
1:30 p.m.—Open Session

January 18, 1985
9:30 a.m.—Closed Session
9:45 a.m.—Open Session

PLACE: National Science Foundation, Washington, D.C.

STATUS: Most of this meeting will be open to the public. Part of the meeting will be closed to the public.

MATTERS TO BE CONSIDERED AT THE OPEN SESSIONS:

Thursday, January 17, 1985—1:30 p.m.

1. NBS Review

Friday, January 18, 1985—9:45 a.m.

5. Minutes—November 1984 Meeting
6. Chairman's Report
7. Director's Report
8. NSB Review—continued
9. Reports of Board Committees
10. Board Representation at Advisory Committee and Other Meetings
11. Other Business
12. Next Meetings

MATTERS TO BE CONSIDERED AT THE CLOSED SESSION:

Friday, January 18, 1985—9:30 a.m.

2. Minutes—November 1984 Meeting
3. NSB and NSF Staff Nominees
4. Grants, Contracts, and Programs

Margaret L. Windus,

Executive Officer.

[FR Doc. 85-876 Filed 1-8-85; 1:18 pm]

BILLING CODE 7555-01-M

10

NATIONAL SCIENCE BOARD

The National Science Board's Executive Committee acted on behalf of

the Board at its December 20, 1984 meeting regarding a Proposed Resolution on Support of Mathematical Sciences.

CONTACT PERSON FOR MORE INFORMATION: Ms. Margaret L. Windus, Executive Officer, NSB, 202/357–9582.

Margaret L. Windus,

Executive Officer.

[FR Doc. 85–883 Filed 1–8–85; 8:45 am]

BILLING CODE 7555-01-M

11

SECURITIES AND EXCHANGE COMMISSION

Notice is hereby given, pursuant to the provisions of the Government in the Sunshine Act, Pub. L. 94–409, that the Securities and Exchange Commission will hold the following meetings during the week of January 7, 1985, at 450 Fifth Street, NW., Washington, D.C.

A closed meeting will be held on Tuesday, January 8, 1985, at 10:00 a.m. An open meeting will be held on Thursday, January 10, 1985, at 2:30 p.m., in Room 1C30.

The Commissioners, Counsel to the Commissioners, the Secretary of the Commission, and recording secretaries will attend the closed meeting. Certain staff members who are responsible for the calendared matters may be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, the items to be considered at the closed meeting may be considered pursuant to one or more of the exemptions set forth in 5 U.S.C. 552b(c) (4), (8), (9)(A) and (10) and 17 CFR 200.402(a)(4), (8), (9)(i) and (10).

Commissioner Peters, as duty officer, voted to consider the items listed for the closed meeting in closed session.

The subject matter of the closed meeting scheduled for Tuesday, January 8, 1985, at 10:00 a.m., will be:

Formal orders of investigation.

Institution of administrative proceedings of an enforcement nature.

Withdraw Institution of administrative proceeding of an enforcement nature.

Settlement of administrative proceedings of an enforcement nature.

Institution of injunctive actions.

Regulatory matter regarding financial institution.

Opinions

The subject matter of the open meeting scheduled for Thursday, January 10, 1985, at 2:30 p.m., will be:

1. Consideration of whether to grant an order authorizing Middle South Utilities, Inc. ("MSU"), a registered holding company under the Public Utility Holding Company Act of 1935, to purchase from its subsidiary, Middle South Energy, Inc. ("MSE"), and for MSE to issue and sell at $1,000 per share, up to 160,000 common shares ($160 million) on or before July 31, 1985. This proposal was noticed by the Commission on September 6, 1984 (HCAR No. 23413) and the Arkansas Public Service Commission has intervened and requested a hearing. For further information, please contact Catherine Fisher at (202) 272–7647.

2. Consideration of whether to adopt an amendment to rule 204–2 under the Investment Advisers Act of 1940 to permit advisers to preserve required records on microfilm immediately and to retain required records on computer tape or disk under certain conditions. For further information, please contact Mary S. Podesta at (202) 272–2107.

3. Consideration of whether to issue a release soliciting comment on the financial responsibility rules for broker-dealers and a report entitled, *The Financing and Regulatory Capital Needs of the Securities Industry*. For further information, please contact Michael A. Macchiaroli at (202) 272–2904 or Williams J. Atkinson at (202) 272–2850.

At times changes in Commission priorities require alterations in the scheduling of meeting items. For further information and to ascertain what, if any, matters have been added, deleted or postponed, please contact: Barry Mehlman at (202) 272–2648.

John Wheeler,

Secretary.

December 28, 1984.

[FR Doc. 85–832 Filed 1–8–85; 11:54 am]

BILLING CODE 8010-01-M

12

SYNTHETIC FUELS CORPORATION

Meeting of the Board of Directors

ENTITY: United States Synthetic Fuels Corporation.

ACTION: Notice of Meeting.

SUMMARY: Interested members of the public are invited to attend and observe a meeting of the Board of Directors of the United States Synthetic Fuels Corporation to be held at the time, date and place specified below. This public announcement is made pursuant to the open meeting requirements of Section 116(f)(1) of the Energy Security Act (9 Stat. 611, 637; 42 U.S.C. 8701, 8712(f)(1) and Section 4 of the Corporation's Statement of Policy on Public Access to Board meetings. During the meeting, the Board of Directors will consider a resolution to close a portion of the meeting pursuant to Article II, Section 4 of the Corporation's By-laws, Section 116(f) of the said Act and Sections 4 and 5 of the said policy.

MATTERS TO BE CONSIDERED:

Open Session

1. Chairman's Opening Remarks
2. Approval of Minutes of December 13, 1984 Board Meeting
3. Report of the Comprehensive Strategy Committee of the Board
4. Financial Interests of Directors
5. Consideration of Pending Coal-Water Fuel Solicitation
6. Resolution to Close Meeting

Closed Session

7. Consideration of Pending Solicitation Projects/Designation of Qualified Projects
   1. Coal-Water Fuel Solicitation
   2. Fourth General Solicitation
   3. Retrofit Solicitation
8. Report on Great Plains Coal Gasification Project
9. Report on Seep Ridge Project

Open Session Resumed

10. Reports of the Committees of the Board
    a. Audit Committee
    b. Compensation Committee
11. Annual Report of the Inspector General
12. Discussion of Annual Report of the Corporation

TIME AND DATE: 9:30 a.m., January 15, 1985.

PLACE: U.S. Synthetic Fuels Corporation, 2121 K Street, NW., Room 503, Washington, D.C. 20586.

PERSON TO CONTACT FOR MORE INFORMATION: If you have any questions regarding this meeting, please contact Mr. Owen J. Malone, Assistant Secretary, at (202) 822–6341..

United States Synthetic Fuels Corporation.

Robert Gambino,

Group Vice President-Corporate.

January 8, 1985.

[FR Doc. 85–891 Filed 1–8–85; 3:49 pm]

BILLING CODE 0000-00-M

federal register

Thursday
January 10, 1985

Part II

Department of the Interior

Bureau of Land Management

43 CFR Part 3140

Combined Hydrocarbon Leasing; Amendment Covering Paying Quantities and Diligent Development of Combined Hydrocarbon Leases; Proposed Rulemaking

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 3140

Combined Hydrocarbon Leasing; Amendment Covering Paying Quantities and Diligent Development of Combined Hydrocarbon Leases

AGENCY: Bureau of Land Management, Interior.

ACTION: Proposed rulemaking.

SUMMARY: This proposed rulemaking would provide definitions of and procedures for meeting the production in paying quantities and the diligent development requirements for tar sand in all combined hydrocarbon leases. The definitions and procedures provided by the proposed rulemaking would be used by the Secretary of the Interior in carrying out his responsibilities under the Combined Hydrocarbon Leasing Act of 1981.

DATE: Comments should be submitted by March 11, 1985. Comments postmarked or received after the above date may not be considered as part of the decisionmaking process on issuance of a final rulemaking.

ADDRESS: Comments should be sent to: Director (140), Bureau of Land Management, 1800 C Street, NW., Washington, D.C. 20240. Comments will be available for public review in Room 5555 of the above address during regular business hours (7:45 a.m. to 4:15 p.m.), Monday through Friday.

FOR FURTHER INFORMATION CONTACT:

Edward E. Coggs, (202) 343–3258;

or

Richard J. Aiken, (202) 343–3258

or

Robert C. Bruce, (202) 343–8735.

SUPPLEMENTARY INFORMATION: The Combined Hydrocarbon Leasing Act of 1981 (95 Stat. 1070) amended the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.) to establish a competitive leasing program for combined hydrocarbons located in 11 designated areas in eastern Utah. These areas were designated by the Secretary of the Interior's Orders of November 20, 1980 (45 FR 76800), and January 21, 1981 (46 FR 6077). This proposed rulemaking would provide amendments to the existing regulations under which all combined hydrocarbon leases are managed. The amendments would provide clarification of questions involving production in paying quantities and diligent development of the tar sand resource. The proposed rulemaking would add a new subpart 3142 to the existing regulations, a new subpart that provides the procedures to be used by lessees in meeting production in paying quantities and diligent development requirements for the combined hydrocarbon resources. The amendments are as follows:

The term "production in paying quantities" would be added to the existing regulations on hydrocarbon leasing by the proposed rulemaking. The definition would recognize the differences between production of oil and gas by conventional methods and its production from tar sand, all of which are leased under a combined hydrocarbon lease. The term "production in paying quantities" for conventional oil and gas production will remain as currently used in 43 CFR Part 3160 for Federal oil and gas leasing. Production of oil and gas by nonconventional methods as used in the proposed rulemaking refers to oil and gas produced through development of the tar sand resource, including that used for road mix. The proposed definition recognizes the difficulties in applying terms and procedures designed for well established fluid mineral development programs to emerging, untested development efforts which, in many cases, involve solid or semi-solid minerals. The definition in the proposed rulemaking is designed to encourage orderly development and, when coupled with the diligence requirements of the proposed rulemaking, allow leasing procedures to be more in line with the type of activity that can be expected on the lease.

The new section on diligent development added by the proposed rulemaking outlines the diligent development requirement that all combined hydrocarbon lease holders would have to meet. The purposes of this diligent development requirement are to ensure that: (1) Sufficient time is provided to allow adequate exploration work to be accomplished prior to the initiation of efforts toward commercial development; (2) efforts toward commerical development of the lease continue once the minimum requirements for production in paying quantities are met; (3) these efforts toward commercial development of the lease progress in an orderly and economically efficient manner; and (4) the numerous risks inherent in tar sand development, particularly the future price of crude oil, may be factored into the investment decision without undue penalty.

The determination of estimated recoverable tar sand reserves is an integral step in the establishment of diligent development of tar sand leases. The Department of the Interior has not yet established the final procedures for making this determination. The public is specifically asked to comment on potential methodologies to be used to determine recoverable reserves, as part of their comments on this proposed rulemaking.

The principal authors of this proposed rulemaking are Richard J. Aiken and Edward E. Coggs, Division of Solid Mineral Leasing, assisted by the staffs of the Division of Solid Mineral Operations, the Resources Evaluation and Program Development Staff, the Office of Legislation and Regulatory Management, all of the Bureau of Land Management, and the Office of Solicitor, Department of the Interior.

It is hereby determined that this rulemaking does not constitute a major Federal action significantly affecting the quality of the human environment and that no detailed statement pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969 (42 U.S.C. 4332(2)(C)) is required.

The Department of the Interior has determined that this document is not a major rule under Executive Order 12291 and will 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.).

The leasing procedures provided in this proposed rulemaking are available to all entities who wish to avail themselves of the opportunity to lease combined hydrocarbon resources, regardless of the size of the entity. The proposed rulemaking follows the guidance set out in the Combined Hydrocarbon Leasing Act and is designed to provide an equitable process for leasing and development of combined hydrocarbon resources.

The information collection requirements contained in 43 CFR Subpart 3142 have been submitted to the Office of Management and Budget for approval as required by 44 U.S.C. 3507. The collection of this information will not be required until it has been approved by the Office of Management and Budget.

List of Subjects 43 CFR Part 3140

Administrative practice and procedure, Environmental protection, Mineral royalties, Oil and gas reserves, Public lands—mineral reserves.

Under the authority of the Combined Hydrocarbon Leasing Act of 1981 (95 Stat. 1070), the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.), the Mineral Leasing Act for Acquired Lands, as amended (30

U.S.C. 351–359) and the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1701 et seq.), it is proposed to amend Part 3140, Group 3100, Subchapter C, Chapter II of Title 43 of the Code of Federal Regulations as set forth below:

1. Part 3140 is amended by adding a new subpart 3142 to read:

PART 3140—(AMENDED)

Subpart 3142—Paying Quantities/Diligent Development

Sec.
3142.0–1 Purpose.
3142.0–3 Authority.
3142.0–5 Definitions.
3142.1 Diligent Development.
3142.2 Minimum production levels.
3142.2–1 Minimum production schedule.
3142.2–2 Advance royalties in lieu of production.
3142.3 Expiration.

Subpart 3142—Paying Quantities/ Diligent Development

§ 3142.0–1 Purpose.

This subpart provides definitions and procedures for meeting the production in paying quantities and the diligent development requirements for tar sand in all combined hydrocarbon leases.

§ 3142.0–3 Authority.

These regulations are issued under the authority of the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.), the Mineral Leasing Act for Acquired Land (30 U.S.C. 351–359), the Federal Land Policy and Management Act of 1976 (43 U.S.C. 1701 et seq.) and the Combined Hydrocarbon Leasing Act of 1981 (95 Stat. 1070).

§ 3142.0–5 Definitions.

As used in Part 3140 of this title, the term "production in paying quantities" means: (a) Production, in compliance with an approved plan of operations and by nonconventional methods, of oil and gas which can be marketed; or (b) production of oil or gas by conventional methods as the term is currently used in Part 3160 of this title.

§ 3142.1 Diligent Development.

A lessee shall meet his/her diligent development obligation if:

(a) The lessee is conducting activity on the lease in accordance with an approved plan of operations;

(b) If the lessee files with the authorized officer, not later than the end of the eighth lease year, a supplement to the approved plan of operations which shall include the estimated recoverable tar sand reserves and a detailed development plan for the next stage of operations; and

(c) The lessee annually produces the minimum amount of tar sand established by the authorized officer in the minimum production schedule contained in the lease or pays annually advance royalty in lieu of this minimum production.

§ 3142.2 Minimum production levels.

§ 3142.2–1 Minimum production schedule.

Upon receipt of the supplement to the plan of operations described in § 3142.1(b) of this title, the authorized officer shall determine if the reserve estimates are adequate and reasonable. The authorized officer shall then establish, based upon the reserve estimates, a minimum annual tar sand production schedule for the lease or unit operation which shall start in the eleventh year of the lease. These production levels shall escalate in equal annual increments to a maximum of 1 percent of the estimated recoverable tar sand reserves in the twentieth year of the lease and remain at 1 percent each year thereafter.

§ 3142.2–2 Advance royalties in lieu of production.

Failure to meet the minimum annual tar sand production level in any year shall result in the assessment of an advance royalty in lieu of production which shall be credited to future production royalty assessments applicable to the lease or unit.

§ 3142.3 Expiration.

Failure of the lessee to pay advance royalty within the time prescribed by the authorized officer, or failure of the lessee to comply with any other provisions of this subpart following the end of the primary term of the lease, shall result in the automatic expiration of the lease as of the first of the month following notice to the lessee of its failure to comply. The lessee shall remain subject to the requirement of applicable laws, regulations and lease terms which have not been met at the expiration of the lease.

October 4, 1984

J. Steven Griles,

Acting Assistant Secretary of the Interior

[FR Doc. 85–663 Filed 1–9–85; 8:45 am]

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federal register

Thursday
January 10, 1985

Part III

Department of the Interior

Bureau of Land Management

43 CFR Part 1880

Financial Assistance, Local Governments; Amendments to Payment in Lieu of Taxes Regulations; Final Rulemaking

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 1880

[Circular No. 2556]

Financial Assistance, Local Governments; Amendments to Payment in Lieu of Taxes Regulations

AGENCY: Bureau of Land Management, Interior.

ACTION: Final rulemaking.

SUMMARY: This final rulemaking makes changes in the existing payment in lieu of taxes regulations to incorporate amendments made to the authorizing legislation by recent Acts of Congress.

EFFECTIVE DATE: February 11, 1985.

ADDRESS: Suggestions or inquiries should be submitted to: Director (820), Bureau of Land Management, 1800 C Street, N.W., Washington, D.C. 20240.

FOR FURTHER INFORMATION CONTACT:
Edward P. Greenberg, (202) 343–6743
or
Robert C. Bruce, (202) 343–8735.

SUPPLEMENTARY INFORMATION: A proposed rulemaking amending the existing payment in lieu of taxes regulations was published in the **Federal Register** of August 7, 1984 (49 FR 31473). During the 60-day comment period provided in the proposed rulemaking, two comments were received, one from an association representing local governmental organizations and one from a Federal agency.

One of the comments suggested that the final rulemaking include a provision permitting counties and other potentially affected units of general local government to participate in the decisionmaking process on whether a State law conforms with the provisions of the Payment in Lieu of Taxes statute. The decision as to whether a State law conforms to the provisions of the Payment in Lieu of Taxes statute is a responsibility of the Department of the Interior. The Department may use any procedure determined appropriate in reaching that decision. In making a decision, the Department will consult with the Office of the Solicitor, the Comptroller General or other authority deemed appropriate. The official making the decision could request the views of outside parties, such as local governmental agencies, in making a decision. However, the discretion of the official making the decision should not be limited by the establishment of a formal procedure, including required standards, that could unnecessarily delay the final decision. Nothing in the existing regulations or this final rulemaking would prevent the authorized official from requesting the views of affected parties or using any standards that comply with the Payment in Lieu of Taxes statute in reaching a decision. Further, the affected parties have other avenues for making their views known, such as presenting their position to the State legislature or filing a protest with the Department of the Interior under the existing regulations, or requesting the opinion of the Comptroller General of the United States or seeking redress in the courts. The final rulemaking has not adopted this suggested change.

A second suggestion by one of the comments was that the final rulemaking provide objective standards for testing the procedures of a State receiving direct payments to see if they are in compliance with the requirement in 31 U.S.C. 6907(a) which provides: "Such reallocation or distribution shall generally reflect the level of services provided by, and the number of entitlement acres within, the smaller unit of local government." The Payment in Lieu of Taxes statute gives the States considerable authority, within defined parameters, to determine how the funds provided under the statute are to be allocated if a State accepts the responsibility for making a distribution of the funds allocated to it. It would be inappropriate interference with the State's authority for the Department of the Interior to try to limit the authority of the State in making the distribution of allocated funds having once determined that the State law under which the State assumed that responsibility was legally sufficient. An affected party that felt that the State was not following the requirements of the Payment in Lieu of Taxes statute in making its distribution of allocated funds would have to pursue other avenues of protest, such as a court challenge. The final rulemaking has not adopted this suggestion.

Another comment suggested that the final rulemaking provide language that would permit counties or other units of local government to petition for decertification of a State that has been certified to receive a direct payment of its allocated payment in lieu of taxes funds. This suggestion has not been adopted by the final rulemaking because 31 U.S.C. 6907 does not authorize the decertification of State once certified. A unit of local government would have to pursue other courses of action, such as legal action or an effort to have the State repeal its distribution legislation.

One comment suggested that the final rulemaking provide that a direct payment should not be make to the State until the fiscal year in which the final determination is made by the authorized officer that the State statute legally conforms to the requirements of 31 U.S.C. 6109. The final rulemaking has adopted this suggestion. This change will allow the Department of the Interior time to determine whether a State distribution statute is legally sufficient before making a direct payment.

A comment suggested that the final rulemaking should contain language requiring a unit of general local government other than a county to share payments on the same basis that a county is now required to share such payments with a unit of general local government. This suggestion was based on the belief that the obligation to share payments should be reciprocal. 31 U.S.C. 6907 specifies that: "Notwithstanding any other provisions of this chapter, a State may enact legislation which requires that any payments which would be made to units of general local government pursuant to this chapter be reallocated and redistributed in whole or in part to other smaller units of general purpose government. * * *" This language specifically authorizes the reallocation or redistribution of payments to units of general local government by a State statute; however, the Payment in Lieu of Taxes statute does not contain language authorizing reallocation or redistribution of payments from smaller units of general local government to a county. Because of the lack of statutory authorization for reallocation or redistribution of payments from smaller units of general local government to a county, the final rulemaking cannot adopt the suggestion.

One comment recommended that the final rulemaking delete from the proposed rulemaking the language of § 1881.1–5(a)(3) which prohibits a State from enacting legislation that would differentiate between funds received for the various types of entitlement lands in reallocating its direct payment in lieu of taxes receipts to units of general local government. In recognition of the fact that the language of 31 U.S.C. 6907 allowing payments to "be reallocated and redistributed in whole or in part to other smaller units of general government" confers discretion on a State to make such reallocation, the final rulemaking has not adopted this suggestion because it would restrict that discretion.

A final comment recommended that the Department of the Interior provide each State receiving a direct payment with a list of distributions to be made to counties that contain entitlement lands.

In accordance with this recommendation, the Department will, to the extent possible, provide each State receiving a direct payment with a list of distributions to be made to counties that contain entitlement lands. In completing the distribution list, it should be kept in mind that Federal records on entitlement lands are generally not available below county level. Furthermore, it is often impossible to allocate payment in lieu of taxes payments to any particular class or category of entitlement lands. This is particularly true for payments affected by population limitation and/or fiscal year public land payments to units of general local government containing categories of entitlement lands that do not generate these revenues. This recommendation is being adopted through administrative action by the Department and no change is being made in the final rulemaking.

The principal author of this final rulemaking is Edward P. Greenberg, Division of Finance, Bureau of Land Management, assisted by the staff of the Office of Legislation and Regulatory Management, Bureau of Land Management.

The Department of the Interior has determined that this document is not a major rule under Executive Order 12291 and will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 et seq.).

The changes made by this final rulemaking are in compliance with the amendments made to the Payment in Lieu of Taxes legislation by the Congress and will have no direct impact on small entities.

The information collection requirements contained in this final rulemaking do not require approval by the Office of Management and Budget under 44 U.S.C. 3507 because there are fewer than 10 respondents per year.

Lists of Subjects in 43 CFR Part 1880

Administrative practice and procedure, Civil rights, Grant programs—natural resources, Intergovernmental relations, Loan programs—natural resources, Public lands, Public lands—mineral resources.

Under the authority of 31 U.S.C. 6901–6907, as amended, Part 1880, Group 1880, Subchapter A, Chapter II of Title 43 of the Code of Federal Regulations is amended as set forth below.

J. Steven Griles,

Acting Assistant Secretary of the Interior.

December 14, 1984.

PART 1880—[AMENDED]

§ 1881.0–3 [Amended]

1. Section 1881.0–3 is amended by removing the phrase "Pub. L. 94–565, 90 Stat. 262, 31 U.S.C. 1601–1607," and replacing it with the phrase ", as amended, 31 U.S.C. 6901–6907,".

§ 1881.0–5 [Amended]

2. Section 1881.0–5(b) is amended by:

A. Amending paragraph (1)(i) by adding after the word "general" the word "local";

B. Amending paragraph (1)(ii) by adding after the word "general", in the two places it appears, the word "local"; and

C. Amending paragraph (2) by adding after the word "general" the word "local".

3. Section 1881.0–5(c)(1) is amended by:

A. Removing from the end of paragraph (vi) the word "or";

B. Removing the period from the end of paragraph (vii) and replacing it with a semicolon and the word "or"; and

C. Adding a new paragraph (viii) to read:

§ 1881.0–5 Definitions.

* * * * *

(c)(1) * * *

(viii) Lands located in the vicinity of Purgatory River Canyon and Pinon Canyon, Colorado, that were acquired by the United States after December 23, 1981, to expand the Fort Carson military installation.

§ 1881.1–2 [Amended]

4. Section 1881.1–2 is amended by:

A. Amending paragraph (a) by adding after the word "general", in the two places it appears, the word "local"; and

B. Adding a new paragraph (f) to read:

§ 1881.1–2 Procedures, Section 1 payments.

* * * * *

(f) If a unit of general local government eligible for payments under this part reorganizes, the authorized officer shall, for the fiscal year in which the reorganization occurred, calculate payments as if the reorganization had not occurred and issue any payments due under this part jointly to all of the newly formed units of general government.

§ 1881.1–3 [Amended]

5. Section 1881.1–3(d) is amended by inserting after the phrase "March 27, 1978,", where it appears the second time, the phrase "and lands acquired in the Tahoe Lake Basin under the Act of December 23, 1980 (Pub. L. 96–586),".

6. A new § 1881.1–5 is added to read:

§ 1881.1–5 Requirement to report enactment of State distribution legislation.

(a) Section 6907 of the Act provides that a single payment may be made to a State for reallocation and redistribution to units of general local government other than the principal provider of services as determined by the Secretary. If the State decides to avail itself of this provision, it shall comply with the following conditions:

(1) The State shall notify the authorized officer that it has enacted legislation that conforms to section 6907 of the Act and within 60 days of its enactment, provide the authorized officer with a copy of the legislation and the name and address of the State office to which payment is to be made.

(2) The State legislation shall conform to the requirements of the Act, particularly section 6907(a).

(b) If the authorized officer finds that a State's legislation complies with the conditions set forth in paragraph (a) of this section, he/she shall notify the State that a single payment will be made to the designated State government office beginning with the Federal fiscal year following the fiscal year in which the conforming legislation was approved by the authorized officer. The authorized officer shall provide the State with appropriate information that identifies the entitlement lands data on which the payments are based.

(c)(1) If a State that has enacted conforming legislation as described in paragraphs (a) and (b) of this section later repeals or amends that legislation, the State shall immediately notify the authorized officer of such change(s), in writing, and shall furnish the authorized officer a copy of the legislation.

(2) If a State's conforming legislation is repealed or if the authorized officer finds from a review of the legislation that it is so altered as a result of amendments that it no longer complies with the conditions stated in paragraph (a) of this section, he/she shall notify the State office designated under paragraph (a)(1) of this section that payment shall be made directly to eligible units of local government. These payments shall begin with the Federal fiscal year in which a copy of the State's legislation repealing or amending the State's conforming legislation is

received by the authorized officer. However, if a copy of the State's repealing or amending legislation is received after July 1, payments made directly to eligible units of local government shall not begin until the subsequent Federal fiscal year.

[FR Doc. 85-664 Filed 1-9-85; 8:45 am]
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Thursday
January 10, 1985

Part IV

Department of the Interior

Bureau of Land Management

43 CFR Part 2880

Rights-of-Way Under the Mineral Leasing Act; Procedures for Collection of Reimbursable Costs; Final Rule

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

43 CFR Part 2880

[Circular No. 2557]

Rights-of-Way Under the Mineral Leasing Act; Procedures for Collection of Reimbursable Costs

AGENCY: Bureau of Land Management, Interior.

ACTION: Final rulemaking.

SUMMARY: This final rulemaking amends 43 CFR Part 2880 by providing cost reimbursement procedures that are currently contained in 43 CFR Part 2800 and updates them to provide more adequately for recovery by the United States of the costs of processing and monitoring rights-of-way and temporary use permits granted under authority provided by section 28 of the Mineral Leasing Act of 1920, as amended and supplemented.

EFFECTIVE DATE: February 11, 1985.

ADDRESS: Any suggestions or inquiries should be sent to: Director (330), Bureau of Land Management, 1800 C Street NW., Washington, D.C. 20240.

FOR FURTHER INFORMATION CONTACT:

Theodore G. Bingham, (202) 343–5441;

or

Robert C. Bruce, (202) 343–8735.

SUPPLEMENTARY INFORMATION: The proposed rulemaking amending for the second time the procedures for cost recovery for right-of-way grants and temporary use permits granted under the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.) was published in the **Federal Register** on June 25, 1984 (49 FR 25972). During the 60-day comment period, 16 comments were received; 8 from businesses engaged in the oil and gas industry, 5 from Federal agencies, 2 from associations and 1 from an attorney. The comments and the action taken on them are discussed below.

Several of the comments questioned the appropriateness of the costs shown in the fee schedule, with some feeling that they were too high, while others felt that they were not sufficient to cover the costs incurred by the United States. As discussed in the preamble to the proposed rulemaking of June 25, 1984, the costs shown in the fee schedules are based on current average costs incurred in processing right-of-way grant and temporary use permit applications and monitoring those grants by various offices of the Bureau of Land Management. Since these costs are average costs, there are instances where the cost of handling specific applications by the various offices may be higher or lower than those shown in the schedule. The use of current average costs to set a fee schedule is a commonly accepted practice in both the private and public sectors. The Department has further determined that this method results in less administrative expense than accounting for and reporting actual costs for each right-of-way activity. Therefore, no change has been made in the fee schedule in the final rulemaking.

Several of the comments expressed concern that the process in the proposed rulemaking for determining the appropriate category would delay completing the processing of a right-of-way grant or temporary use permit application. The comments stated this delay could be expecially lengthy in those instances where an application is submitted through the mail. The concern was that the procedures provided in the proposed rulemaking would require the authorized officer to review an application and to return it if it was found inadequate because of the failure to submit a sufficient fee. This would add time to the processing of an application. After careful review of the procedures in the proposed rulemaking, the final rulemaking changes those procedures to permit the acceptance of an application for the purpose of determining the category and nonrefundable fee. Once this determination is made, the applicant will be notified of the category determination and the amount of the nonrefundable fee. No action will be taken on processing an application until the nonrefundable fee has been submitted in full. The final rulemaking also provides for refunding any overpayment of the nonrefundable fee submitted with an application.

The Bureau of Land Management continues to urge right-of-way applicants to take advantage of the pre-application activity provided in the existing regulations. Experience has shown that this process saves the applicant/holder and the Bureau time and avoids problems. Applicants who find it impossible to participate in face-to-face pre-application activity may find that they can save time and avoid problems by working out questions over the telephone. These direct communications are invaluable in reducing delays that can result from misunderstanding.

A few of the comments again raised the point that in their view the collection of reimbursable costs and an annual rental is a double charge for the use of the lands covered by an application/grant. The Mineral Leasing Act requires the collection of costs incurred by the United States in processing and monitoring a right-of-way grant or temporary use permit and the collection of an annual rental. The proposed and final rulemakings follow the requirements of the Mineral Leasing Act regarding cost recovery and no change has been made in these provisions by the final rulemaking.

A couple of comments suggested that the value of the lands involved in a specific application should be considered when setting the fee schedule. The fee schedule is based upon the costs incurred by the Bureau of Land Management in processing an application and monitoring a grant. Those costs were based on the average costs of actions by Bureau personnel in carrying out their responsibilities. These costs would be the same for a visit, whether to lands of high or low value. Any difference in the return received by the United States on lands of high or low value is in the annual rental received once a grant or permit has been issued.

A few of the comments again raised the point that there was an inadequate explanation of how the fee schedules were derived. The preamble to the proposed rulemaking contained a discussion of the process the Bureau of Land Management used in arriving at its fee schedules. The schedules are based on the Bureau's experience in handling application/grants over the past few years. The data that are the basis of the fee schedules are available for review. The Bureau will continue to collect data as it processes/monitors right-of-way grants and temporary use permits. Those data will be the basis for any future revisions of the fee schedules if that should prove necessary.

One comment pointed out that the proposed rulemaking did not clearly provide that the category for monitoring would be the same as that for application processing. This comment is well taken and the final rulemaking incorporates language clarifying the point that the category for processing and monitoring will be based on a single determination by the authorized officer.

A couple of comments raised the issue that the descriptions of categories V and VI in the proposed rulemaking made it impossible to distinguish between a category V and category VI application. The final rulemaking changes the description of category VI to remove this ambiguity.

A few of the comments expressed concern that there would be a variance in the determination of the categories because of the differences in judgment of the various authorized officers. Even though individuals can reasonably reach

a different conclusion using the same data, the Bureau of Land Management has provided careful instructions in this area through its Manual an other instructions. Further, and applicant who feels that a category determination is inappropriate may use the appeal procedure provided in the regulations for an administrative review of that decision.

A couple of the comments requested that the final rulemaking give the authorized officer greater authority than was provided in the proposed rulemaking to change the category determination once it has been made. The Bureau of Land Management's experience in processing applications and monitoring grants indicates that there is very small probability for a change in the category determination once it has been made and that small probability does not justify the additional time and expense that would be incurred by all concerned in the effort to obtain a change of categories. Both of the rulemakings provide authority to change the category to Category VI when it is determined that an environmental impact statement is required, because of the high cost of preparing such a document.

One comment suggested that the final rulemaking should provide relief for an activity of marginal value where there would be an adverse economic effect from the collection of reimbursable costs. The Mineral Leasing Act provides only limited authority for waiving the collection of reimbursable costs. In addition, waiving such costs for a project would provide an indirect government subsidy from all the taxpayers to that project, giving it an unfair competitive advantage over those projects that are required to pay such costs. This suggestion was not adopted by the final rulemaking.

A couple of comments raised questions about the category determination for a large project that encompasses rights-of-way for various purposes, i.e., roads, pipelines, communications sites, working sites, etc. If an application is filed for a pipeline right-of-way, that application will be processed under the provisions of 43 CFR Part 2880, Rights-of-Way Under the Mineral Leasing Act.

The other activities are considered "related facilities" and may be consolidated into the application for the pipeline right-of-way, with the category determination being based on the entire package. Any needed ancillary temporary use permits may also be consolidated into this right-of-way application. However, there is nothing in the existing regulations or this final rulemaking that would prevent an applicant from filing several applications for the various parts of a large project and having them treated as separate applications. No change has been made in the final rulemaking as a result of this comment.

The final rulemaking adds a new paragraph (d) which contains the language of paragraph (b) of the temporary final rulemaking that was published in the **Federal Register** on August 3, 1984 (49 FR 31208). This language has been added to continue in effect the provisions of that temporary final rulemaking until such time as a decision is made on the permanent adoption of those provisions. The Department of the Interior is continuing its review of the comments on the temporary final rulemaking and a final decision on its implementation will be issued in the near future.

Editorial and grammatical changes as needed have been made by the final rulemaking.

The principal author of this final rulemaking is Sheldon Weil, Division of Right-of-Way, Bureau of Land Management, assisted by the staff of the Office of Legislation and Regulatory Management, Bureau of Land Management.

The Department of the Interior has determined that this document is not a major rule under Executive Order 12291 and will 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.).

The changes made by this final rulemaking will not, when the payments for all right-of-way and temporary use permit applications are considered, substantially increase the payments made by right-of-way applicants/holders for processing and monitoring. The changes made by this final rulemaking make the reimbursement of costs procedures used by the Bureau of Land Management more equitable and will recover for the United States a greater portion of the costs incurred in the processing and monitoring of right-of-way grants and temporary use permits.

The changes made by this final rulemaking will be equally applicable to all entities that make application to the Bureau of Land Management for use of the Federal lands for oil or gas right-of-way grants or temporary use permits for related facilities.

There are no additional information collection requirements in this final rulemaking requiring approval by the Office of Management and Budget under 44 U.S.C. 3507.

List of Subjects in 43 CFR Part 2880

Administrative practice and procedure, Common carriers, Oil and gas industry, Pipelines, Public lands—rights-of-way.

Under the authority of section 28 of the Mineral Leasing Act of 1920, as amended and supplemented (30 U.S.C. 181 et seq.), Part 2880, Group 2800, Subchapter B, Chapter II of Title 43 of the Code of Federal Regulations is amended as set forth below.

Dated: December 17, 1984.

J. Steven Griles,

Acting Assistant Secretary of the Interior.

§ 2882.1 [Amended]

1. Section 2882.1(c) is amended by removing the citation "§ 2803.1–1" and replacing it with the citation "§ 2883.1–1".

2. Subpart 2883 is amended by revising § 2883.1–1 to read:

§ 2883.1–1 Cost reimbursement.

(a) (1) An applicant for a right-of-way grant or a temporary use permit shall reimburse the United States for administrative and other costs incurred by the United States in processing the application, including the preparation of reports and statements pursuant to the National Environmental Policy Act of 1969 (42 U.S.C. 4321–4347), prior to the United States having incurred such costs. All costs shall be paid before the right-of-way grant or temporary use permit shall be issued under the regulations of this title.

(2) The regulations contained in this subpart do not apply to State or local governments or agencies or instrumentalities thereof where the Federal lands are used for governmental purposes and such lands and resources continue to serve the general public, except as to right-of-way grants or temporary use permits issued to State or local governments or agencies or instrumentalities thereof or a municipal utility or cooperative whose principal source of revenue is derived from charges levied on customers for services rendered that are similar to services rendered by a profit making corporation or business enterprise.

(3) The applicant shall submit with each application a nonrefundable application processing fee in the amount required by a schedule of fees for this purpose contained in paragraph (c) of this section which shall be based on a review of the use of the Federal lands for which the application is made, the resources affected and the complexity and costs to the United States for processing required by an application

for a right-of-way grant and shall be established according to the following general categories:

(i) *Category I.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the data necessary to comply with the National Environmental Policy Act are available in the office of the authorized officer; and no field examination of the lands affected by the application is required;

(ii) *Category II.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the data necessary to comply with the National Environmental Policy Act are available in the office of the authorized officer; and one field examination of the lands affected by the application to verify the existing data is required;

(iii) *Category III.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the data necessary to comply with the National Environmental Policy Act are available in the office of the authorized officer; and two field examinations of the lands affected by the application to verify the data are required;

(iv) *Category IV.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which some original data are required to be gathered to comply with the National Environmental Policy Act; and two or three field examinations of the lands affected by the application are required;

(v) *Category V.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which original data are required to be gathered to comply with the National Environmental Policy Act and evaluation of these data require formation of an interdisciplinary team; and three or more field examinations of the lands affected by the application are required;

(vi) *Category VI.* An application for a right-of-way grant or temporary use permit to authorize a use of Federal lands for which the cost of processing activities will be in excess of $5,000.

(4)(i) The authorized officer may accept an application for the purpose of determining the appropriate category and the nonrefundable application processing fee; however, the authorized officer shall collect the full amount of the nonrefundable application processing fee prior to processing such application. A record of the authorized officer's category determination shall be made and given to the applicant, and the decision is a final decision for purposes of appeal under § 2884.1 of this title. Notwithstanding the pendency of such appeal, an application shall not be processed without payment of the fee determined by the authorized officer, and where such payment is made, the application may be processed and, if proper, the grant or permit issued. The authorized officer shall make any refund directed by the appeal decision. Where the amount of the nonrefundable application processing fee submitted by an applicant exceeds the amount of such fee as determined by the authorized officer, the authorized officer shall refund any excess unless requested in writing by the applicant to apply all or part of any such refund to the grant monitoring fee required by paragraph (b) of this section or to the rental payment for such grant or permit.

(ii) During the processing of an application, the authorized officer may change a category determination to place an application in Category VI at any time that it is determined that the application requires preparation of an environmental impact statement. A record of change in category determination under this paragraph shall be made, and the decision is appealable in the same manner as an original category determination made under paragraph (a)(4)(i) of this section.

(5) (i) An applicant whose application is determined to be in Category VI shall, in addition to the nonrefundable application processing fee, reimburse the United States for the full actual administrative and other costs of processing the application. The nonrefundable application processing fee required under the fee schedule shall be credited toward the total cost reimbursement obligation of such applicant. When such an application is filed, the authorized officer shall estimate the costs expected to be incurred in processing the application, inform the applicant of the estimated amount to be reimbursed and require the applicant to make periodic payments of such estimated reimbursable costs prior to such costs being incurred by the United States.

(ii) If the payments required by paragraph (a)(5)(i) of this section exceed the actual costs to the United States, the authorized officer may adjust the next billing to reflect the overpayment, or make a refund from applicable funds under the authority of 43 U.S.C. 1734. An applicant may not set off or otherwise deduct any debt due to it or any sum claimed to be owed it by the United States without the prior written approval of the authorized officer.

(iii) Prior to issuance of a right-of-way grant or temporary use permit, an applicant subject to paragraph (a)(5)(i) of this section shall pay such additional amounts as are necessary to reimburse the United States for any costs which exceed the payments required by paragraph (a)(5)(i) of this section.

(iv) An applicant subject to paragraph (a)(5)(i) of this section whose application is denied is responsible for costs incurred by the United States in processing the application, and such amounts as have not been paid in accordance with paragraph (a)(5)(i) of this section are due within 30 days of receipt of a bill from the authorized officer giving the amount due.

(v) An applicant subject to paragraph (a)(5)(i) of this section who withdraws an application before a decision is reached is responsible for costs incurred by the United States in processing the application up to the date the authorized officer receives written notice of the withdrawal, and for costs subsequently incurred in terminating the application review process. Such amounts as have not been paid in accordance with paragraph (a)(5)(i) of this section are due within 30 days of receipt of a bill from the authorized officer giving the amount due.

(6) When 2 or more applications for right-of-way grants are filed which the authorized officer determines to be in competition with each other, each applicant shall reimburse the United States as required by paragraph (a)(3) of this section. If reimbursement of actual costs is required under paragraph (a)(5)(i) of this section, each applicant shall be responsible for the costs identifiable with his/her application. Costs that are not readily identifiable with one of the applications, such as costs for portions of an environmental impact statement that relate to all of the applications generally, shall be paid by each of the applicants in equal shares or such other proration as may be agreed to in writing by the applicants and authorized officer prior to the United States incurring such costs.

(7) When, through partnership joint venture or other business arrangement, more than one person partnership, corporation, association or other entity apply together for a right-of-way grant or temporary use permit, each such applicant shall be jointly are severally liable for costs under this section.

(8) When 2 or more noncompeting applications for right-of-way grants are received for what, in the judgment of the authorized officer, is one right-of-way system, all of the applicants shall be jointly and severally liable for costs under this section for the entire system.

subject, however, to the provisions of paragraph (a)(7) of this section.

(b) (1) After issuance of a right-of-way grant or temporary use permit for which a fee was assessed under paragraph (a) of this section, the holder thereof shall, prior to the United States having incurred such costs, reimburse the United States for costs incurred by the United States in monitoring the construction, operation, maintenance and termination of authorized facilities on the right-of-way or permit area, and for protection and rehabilitation of the lands involved. The monitoring cost category shall be the same as that for the application processing category for that project.

(2) The holder shall submit a monitoring cost fee along with the written acceptance of the terms and conditions of the grant or permit pursuant to § 2882.3(1) of this title. The amount of the required fee shall be determined by the schedule of fees described in paragraph (c) of this section. Acceptance of the terms and conditions of the grant or permit shall not be effective unless the required fee is paid.

(3) A holder whose application was determined to be in Category VI for application processing purposes shall reimburse the United States for the actual administrative costs and other costs of monitoring the grant or permit. When such a grant or permit is issued, the authorized officer shall estimate the costs expected to be incurred in monitoring the grant or permit, inform the holder of the estimated amount to be reimbursed and require the holder to make periodic payment of such estimated reimburseable costs prior to such costs being incurred by the United States.

(4) If the payments required by paragraph (b)(3) of this section exceed the actual costs of the United States, the authorized officer may adjust the next billing to reflect the overpayment, or make a refund from applicable funds under the authority of 43 U.S.C. 1734. A holder may not set off or otherwise deduct any debt due to it or any sum claimed to be owed it by the United States without the prior written approval of the authorized officer.

(5) Following termination of a right-of-way grant or temporary use permit, any grantee or permittee that was determined to be in Category VI shall pay such additional amounts as are necessary to reimburse the United States for any costs which exceed the payments required by paragraph (b)(3) of this section.

(c) The schedules of nonrefundable fees are as follows:

(1) For processing an application for a right-of-way and/or temporary use permit:

Category	Fee
I	$125
II	275
III	350
IV	600
V	1,000
VI	[1] 5,000

[1] A minimum of.

(2) For monitoring a right-of-way grant or temporary use permit:

Category	Fee
I	$25
II	50
III	75
IV	150
V	250
VI	(1)

[1] As required.

(d) Reimbursement of costs for application processing and administration of right-of-way grants and temporary use permits pertaining to the Trans-Alaska Pipeline System shall be made by payment of such sums as the Secretary determines to be required to reimburse the Department of the Interior for the actual costs of these services. In processing applications and administering right-of-way grants and temporary use permits relating to the Trans-Alaska Pipeline System, the Department of the Interior shall avoid unnecessary employment of personnel and needless expenditure of funds as determined by the Secretary. Reimbursement of costs shall be made for each quarter ending on the last day of March, June, September and December. On or before the 16th day after the close of each quarter, the authorized officer shall submit to the permittee a written statement of costs incurred during that quarter which are reimbursable.

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federal register

Thursday
January 10, 1985

Part V

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 405 and 417

Medicare Program; Payment to Health Maintenance Organizations and Competitive Medical Plans; Final Rule With Comment Period

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 405 and 417

[BERC-247-F]

Medicare Program; Payment to Health Maintenance Organizations and Competitive Medical Plans

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

ACTION: Final rule with comment period.

SUMMARY: These regulations implement section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 by authorizing Medicare reimbursement for health care services to eligible health maintenance organizations (HMOs) and competitive medical plans (CMPs) on a prospective basis for those entities that have a risk contract or on a reasonable cost basis for those that have a cost contract. The regulations set forth the requirements that an entity must meet in order to be—

- Eligible to enter into a Medicare contract (either risk or reasonable cost) as an eligible organization; and
- Reimbursed by Medicare on a capitation basis (either prospectively or retrospectively) for items and services furnished to Medicare enrollees.

In addition, these regulations implement sections 2322 and 2350 (b) and (c) of Pub. L. 98-369 [Deficit Reduction Act of 1984], which further amended the Social Security Act concerning payments to HMOs and CMPs.

DATES: Effective Date: These regulations are effective February 1, 1985. However, for further information and a detailed discussion of effective dates, we refer the reader to section V. of this preamble.

Comment Date: Although these regulations are final, comments may be submitted as described in section VIII of this preamble. To assure consideration, comments must be received by February 11, 1985.

ADDRESS: Address comments in writing to: Department of Health and Human Services, Health Care Financing Administration, Attention: BERC-247-FC, P.O. Box 26676, Baltimore, Maryland 21207.

In commenting, please refer to file code BERC-247-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.

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:

Frank Emerson, 301-597-1807 (Reimbursement)

Rita McGrath, 301-594-8558 (Qualifying Conditions, Enrollment, Contract Procedures, Change of Ownership and Leasing of Facilities, and Hearings and Appeals).

SUPPLEMENTARY INFORMATION:

I. Background

A health maintenance organization (HMO) may be generally defined as an entity that provides health care in a geographic area to a group of persons who are enrolled as members. The HMO agrees to provide or otherwise assure delivery of an agreed upon set of health services and to be reimbursed through a predetermined, fixed periodic payment made by or on behalf of the enrollees, without regard to the amounts of actual services provided. Because the HMO receives a fixed payment from enrollees, regardless of the volume of services provided, there is a financial incentive to the HMO to control costs and to provide the least expensive services appropriate to its enrollees' needs.

Section 226 of the Social Security Amendments of 1972 (Pub. L. 92-603, enacted October 30, 1972) added section 1876 to the Social Security Act (the Act) to authorize Medicare payment to HMOs on a capitation basis. Prior to this legislation, reimbursement to HMOs for Medicare Parts A and B services was made on the basis of the costs to the organization of providing the specific services to the beneficiaries. Because of this, the financial incentives that HMOs might have had in their regular non-Medicare business to provide a continuum of services, to keep costs low, and to control utilization of services were not fully incorporated directly into their relationship with Medicare.

Adding section 1876 to the Act was an attempt by Congress to reimburse HMOs in a manner that would conform more closely to the usual way in which HMOs operate. Under section 1876 of the Act, as enacted by Pub. L. 92-603, HMOs that enter into Medicare contracts can receive interim per capita payments, subject to retrospective adjustments, in return for providing to their Medicare enrollees services covered under Medicare Part A and Part B (or Part B only for certain enrollees). Two types of contracts are available to HMOs: one that permits reimbursement on a reasonable cost basis, and one that allows reimbursement on a risk-sharing basis.

Under the reasonable cost reimbursement method, payment is made to the HMO on an interim basis using a monthly capitation. At the end of the HMO's contract year, payments are adjusted to equal the reasonable costs of the covered services the HMO furnished to its Medicare enrollees, using the Medicare reimbursement principles that are commonly used to calculate reasonable costs (as defined in section 1861(v) of the Act) for providers of services as a model.

An alternative form of reimbursement, reimbursement on a risk-sharing basis, is available to HMOs that have demonstrated a capacity to provide health care of acceptable quality in an organized and effective manner. Under risk reimbursement, HMOs receive monthly payments based on an interim per capita reimbursement rate, similar to reasonable cost HMOs. This rate reflects the estimated costs to the HMO for its enrolled Medicare population. However, the rate cannot exceed 100 percent of the estimated "adjusted average per capita costs" (AAPCC). The AAPCC is an actuarial measure of the cost that would have been incurred by Medicare on behalf of enrollees of the HMO if they had received their covered services from providers and suppliers of services, other than the HMO, in the same geographic area (or a similar area) served by the HMO.

At the end of its contract year, the HMO's reasonable costs of furnishing services to its Medicare enrollees are compared to the retrospectively determined AAPCC incurred for that year. If the HMO's costs are less than the AAPCC, the amount of the difference is called "savings". The HMO receives 50 percent of the savings, up to a maximum of ten percent of the AAPCC, as a bonus. Conversely, if the HMO's costs are higher than the AAPCC, the HMO must absorb that difference ("losses"). However, these losses can be carried forward into subsequent years and offset from savings realized in future years.

Both of these Medicare reimbursement mechanisms present problems for HMOs because, although they are an improvement over the payment methods available before the enactment of Pub. L. 92-603, they are

essentially cost basis methods. Consequently, they are inconsistent with HMOs' usual method of receiving payment on a prepaid capitation basis with no retroactive adjustments. In the non-Medicare portion of an HMO's business, the fixed, prospectively determined payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and provide appropriate services in the most cost efficient manner.

In addition, HMOs report relatively little financial data to any outside organizations. However, since both Medicare risk and reasonable cost reimbursement entail retrospective determination of costs, HMOs do not know their actual Medicare revenues until sometime after the contract year has ended. This retrospective reimbursement is an awkward arrangement for HMOs since these organizations are designed to operate under a prospective budget without extensive reporting requirements to other third-party payors. Moreover, cost-based reimbursement provides HMOs with a mixed set of incentives. HMOs under Medicare cost contracts are not rewarded for cost-conscious behavior, and, in fact, revenue is reduced as the cost per Medicare enrollee decreases.

Even the risk reimbursement provisions of Pub. L. 92–603 are considered inadequate by HMOs, because in addition to the problems described above, the HMO may receive, at a maximum, only half of the savings it achieves (up to a maximum of ten percent of the AAPCC), while absorbing all the losses. This lack of a strong incentive to contract under risk reimbursement has resulted in only two HMOs entering into this type of contract. A further disincentive for HMOs to contract with Medicare arises under section 1876 of the Act in that it requires all organizations to meet the fairly prescriptive requirements of section 1301 of the Public Health Service (PHS) Act.

In an effort to improve Medicare reimbursement methods for HMOs, Congress enacted section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (Pub. L. 97–248). Section 114 amends section 1876 of the Act in two major areas.

First, the new legislation expands the definition of organizations that are eligible to contract for Medicare reimbursement under section 1876 of the Act. In addition to HMOs that meet the definition of an HMO contained in the PHS Act, other medical plans, commonly referred to as competitive medical plans (CMPs), are eligible to contract with HCFA for Medicare reimbursement. The requirements for CMPs are set forth in § 417.407. Also, the amended statute permits payment to be made on a prepaid capitation basis without retroactive adjustments of the rate to organizations with a risk contract. The reasonable cost contract option remains in the law while the old risk-sharing contract option is eliminated by this amendment.

As we note below in the discussion of effective dates, section 1876 of the Act as it existed prior to enactment of Pub. L. 97–248 and the implementing regulations in 42 CFR Part 405, Subpart T have continued applicability for HMOs that have existing contracts. On May 25, 1984, we published a notice of proposed rulemaking (NPRM) in the **Federal Register** (49 FR 22198) to implement section 114 of Pub. L. 97–248. This proposal elicited approximately 30,000 pieces of correspondence from the public. The provisions of the NPRM, an analysis of the public comments, our responses to the comments, and a summary of the changes we are making in these final regulations as a result of the comments are presented below.

II. Major Provisions of the Proposed Regulations

A. Organization Eligibility Requirements

1. *Definition of Eligible Organization.* The proposed regulations, in accordance with the section 1876(b) of the Act, defined an "eligible organization" as one that is organized under State law and is either a qualified HMO, as defined in section 1301 of the PHS Act, or an entity that meets the following requirements:

a. It provides its enrolled members at least the following services:

- Physicians' services performed by physicians.
- Inpatient hospital services (unless excepted under the provisions of section 1876(b)(2) of the Act, following (E)).
- Laboratory, X-ray, emergency, and preventive services.
- Out-of-area coverage.

b. It receives compensation, except for deductibles, coinsurance, and copayment, for the health care services it provides enrolled members on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided.

c. It provides physicians' services primarily through physicians or groups of physicians that are either employees or partners of the organization or through contracts with physicians.

d. It assumes full financial risk on a prospective basis for the provision of the health care services listed above in item a., except the organization may—

- Obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in item a., if the aggregate value of the services exceeds $5,000 in any year;
- Obtain insurance or make other arrangements for the cost of providing health care services listed in item a. to enrolled members other than through the organization because medical necessity required that the services be provided before they could be secured through the organization;
- Obtain insurance or make other arrangements for not more than 90 percent of the amount by which the organization's costs for any of its fiscal years exceed 115 percent of its income for that fiscal year; and
- Make arrangements with physicians or other health professionals, health care institutions, or any combinations of these to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

e. It provides against the risk of insolvency to the Secretary's satisfaction.

The Assistant Secretary for Health of the Department has the authority to determine whether an entity is an eligible organization within the meaning of section 1876(b) of the Act. The delegation of this authority was published in the **Federal Register** on April 22, 1983 (48 FR 17395).

2. *Procedures for Contract Approval.* We proposed that an eligible organization that wishes to contract with HCFA under Medicare on either a reasonable cost basis or a risk basis would have to submit an application and supporting information to us in the form and detail required. This information would be needed to ascertain whether an eligible organization meets certain necessary contract requirements (discussed in section III.F. of this preamble). We further proposed that, whenever feasible, we would not require an organization to resubmit information that it has already submitted to the Assistant Secretary for Health in connection with the determination of whether an entity is an eligible organization.

We proposed that, if we determine that the organization meets the contract eligibility requirements, we would notify the organization in writing of the type of contract for which it is eligible, the requirements for submitting a written

contract, and its appeal rights if it is dissatisfied with HCFA's determination.

In like manner, if we determine that an organization does not meet the contract requirements, we will notify the entity in writing of its ineligibility; the reasons why it does not meet the requirements; and its appeal rights if it is dissatisfied with HCFA's determination.

B. Qualifying Conditions

We proposed that, in order to receive Medicare reimbursement as an eligible organization, an entity would have to enter into a contract with HCFA. The NPRM also contained the following provisions:

- If an organization meets the applicable requirements of the statute and regulations and HCFA is satisfied that the organization can bear the risk of potential losses, then the organization may contract on a risk basis. If HCFA is not satisfied that the organization is capable of bearing potential losses, or if the organization cannot meet the requirements in the statute and regulations for contracting on a risk basis, the organization must contract with HCFA on a reasonable cost basis.
- Also, if the entity has voluntarily terminated or failed to renew a risk contract under section 1876 of the Act in the preceding five years, then that entity would not be eligible for a risk contract unless HCFA determines that circumstances warrant special consideration. However, organizations that are qualified to contract on a risk basis would nevertheless be permitted to elect reimbursement on a reasonable cost basis.

We proposed a series of qualifying conditions for eligible organizations that are designed to assure the organization's ability to fulfill the requirements as provided in the statute. Generally, we proposed that each qualifying condition would be interpreted through a series of standards. Thus, to qualify as an eligible organization under Medicare, an organization would have to meet applicable qualifying conditions and standards pertaining to the following:

- The effective and efficient implementation of section 1876 of the Act.
- Sufficient enrollment and operating experience.
- Composition of enrollment.
- Range of services furnished.
- Method of furnishing services.
- Quality assurance program.

We further stated that, in some cases, HCFA would have the authority to waive specific elements of the qualifying conditions.

C. Enrollment

Under the NPRM, a beneficiary would be able to enroll in any organization that services the geographic area in which he or she resides and that has qualified under the law by contracting with HCFA to be reimbursed under section 1876 of the Act for covered Medicare services. An exception to the general rule of open enrollment for Medicare beneficiaries is contained in the amended section 1876(d) of the Act, which prohibits enrollment of individuals medically determined to have end-stage renal disease (ESRD).

Payments to organizations on behalf of Medicare enrollees are made out of the Federal Hospital Insurance trust fund or the Federal Supplementary Medical Insurance trust fund, or both, as appropriate. The payments discharge the liability of Medicare enrollees to pay for the covered services furnished to them by the organization. We proposed that the organization may require payment from Medicare enrollees, in the form of premiums or otherwise, for services not covered under Parts A and B of Medicare, as well as deductibles and coinsurance amounts attributable to services furnished under parts A and B. In addition, organizations would be able to seek payment for services from Medicare enrollees to the extent that enrollees have been reimbursed for the services by a workers' compensation policy or plan, automobile medical, or no-fault insurance, or any liability insurance, and, under certain circumstances, an employer group health plan.

As stated in the NPRM, in the case of organizations with risk contracts, only the organization would be entitled to receive Medicare payments for services furnished to Medicare enrollees of the risk organization. Essentially, this provision would serve to restrict Medicare enrollees to receiving services from the risk organization, except for emergency or urgently needed services.

As proposed, eligible organizations would be required to—

- Conduct an open enrollment period annually of at least 30 days duration; and
- Accept eligible Medicare beneficiaries without restriction, except as authorized in regulations, up to the limits of its capacity in the order in which eligible beneficiaries apply, unless the enrollment would result in the organization violating a qualifying condition (including the limitation on enrollment of Medicare and Medicaid beneficiaries) or would result in an enrollment that is substantially nonrepresentative of the population of the organization's geographic area. Denial of enrollment under the latter condition must be in accordance with written selection policies approved by us. We will carefully monitor all enrollment denials made under these regulations to ensure that this provision does not result in biased selection policies.

In addition, the NPRM set forth the procedures and conditions under which an organization under contract with HCFA would be permitted to advertise and enroll eligible Medicare beneficiaries. In particular, we specified the type of marketing techniques that organizations would be prohibited from using as a means of encouraging Medicare beneficiaries to enroll. Also, we proposed the establishment of a uniform standard of acceptance of applications in chronological order and timely action by the organization on applications. These requirements were included to ensure that Medicare beneficiaries are enrolled in the organization on the required first-come, first-served basis and that applications are acted upon in a reasonable period of time. Generally, under the NPRM, an organization would be able to deny enrollment to an otherwise qualified Medicare beneficiary only for purposes of maintaining the organization's compliance with certain enrollment and qualifying conditions.

We proposed that an individual who already is an enrollee of an organization at the time he or she becomes entitled to Medicare must be converted by the organization to a Medicare enrollee. A Medicare enrollee could not be disenrolled except under the following circumstances:

- The enrollee fails to pay required premiums or other charges.
- The enrollee moves out of the organization's geographic area.
- A nonrisk enrollee refuses to convert to risk after HCFA decides that all of the organization's nonrisk enrollees must convert.
- The enrollee commits fraud or permits abuse of his membership privileges.
- The enrollee loses entitlement to Medicare benefits, dies, or requests disenrollment.

Even though under section 1876(d) of the Act, a beneficiary entitled to Medicare under the ESRD provisions may not enroll in an eligible organization, we included a provision in the NPRM that provides that individuals who are already enrolled in these organizations and who either are ESRD patients at the time the organization enters into a contract with HCFA or

later develop ESRD may not be disenrolled.

D. Entitlement to Services

We stated in the NPRM that Medicare enrollees of organizations would be entitled to receive health care services and supplies directly from the organization, of through arrangements made by it. Medicare enrollees would also be entitled to receive services outside of the organization if the services were emergency or urgently needed services that, because of the circumstances, could not have reasonably been obtained through the organization. The organization is responsible for payment of these services. Under the NPRM, the entitlement would be effective for any month for which a per capita payment is made by HCFA to the organization on behalf of the enrollee. Entitlement would extend to the Medicare services to which the enrollee is entitled (that is, covered Part A and Part B services, or Part B only).

In addition, a Medicare enrollee would be entitled to receive any supplemental services offered by the organization for which the enrollee elects to pay. Supplemental services are those services outside the scope of Medicare coverage (except those furnished as additional benefits by risk organizations as described in the next paragraph) for which the enrollee pays a premium. Supplemental services could include those items or services excluded from Medicare coverage (see section 1862 of the Act), as well as those items or services for which Medicare coverage is limited, such as inpatient hospital days during a spell of illness (see section 1812(a)(1) of the Act) or expenses incurred in treatment of mental disorders (see section 1833(c) of the Act). Furthermore, after receiving HCFA's approval, a risk organization could require that its enrollees receiving benefits under the risk reimbursement portions of its contract accept and pay for supplemental services as a condition of enrollment. HCFA's approval will be based on whether or not these services will discourage enrollment. For example, a mandatory supplemental package that would include a wide range of services not covered by Medicare and that would be costly, would not be approved if the high cost would prevent low-income Medicare beneficiaries from enrolling as members in the organization.

The NPRM stated that Medicare enrollees of organizations with a risk contract could also be eligible for benefits in addition to covered Part A and Part B services, all or part of which would be paid for by the monthly capitation payment made by HCFA, as discussed below in section II. F. These additional benefits could consist of one or both of the following:

- A reduction in the organization's premium rate or in other charges for services furnished to the enrollee.
- Health benefits or services and supplies beyond the required Part A and Part B services.

We also proposed that an organization could make a special supplemental benefits plan available to current nonrisk Medicare enrollees who receive benefits under the reasonable cost reimbursement portion of the organization's contract if the plan meets certain requirements set forth in the NPRM.

Medicare enrollees of an organization that currently has a nonrisk contract and that enters into a risk contract would not automatically be covered under the risk portion of the contract (section 114(c)(1)(A) of Pub. L. 97-248). As proposed in the NPRM, they would not be entitled to the additional benefits the organization offers under the contract until one of the following sets of circumstances exists:

- HCFA determines that, for administrative reasons (for example, an insufficient number of Medicare enrollees to warrant the administrative effort of cost report determination), all current nonrisk Medicare enrollees must be covered under the risk portion of the new contract. We have decided that, as a minimum standard, current nonrisk Medicare enrollees must be converted to risk status if there are fewer than 75 of these enrollees remaining in the organization. If these enrollees do not wish to convert, they must be disenrolled. In this case, the following requirements would have to be met:

—HFCA notifies each affected enrollee 90 days before the effective date of the decision.

—The current nonrisk Medicare enrollee completes and signs a form stating that the enrollee understands the new rules and benefits applicable to him or her.

—The organization notifies the enrollee of the coverage, in writing, at least 30 days before the date on which his or her coverage under the risk portion of the contract takes effect.

- The current nonrisk Medicare enrollee requests that he or she be covered under the risk portions of the contract. In this case, the following requirements would have to be met:

—The organization enrolls two new Medicare enrollees for each of these current nonrisk Medicare enrollee.

—In cases where there are more Medicare enrollees than can be accommodated due to the two-for-one rule (explained below), selection of the current nonrisk Medicare enrollees to be covered under the risk portion of the contract is made in a nonbiased manner.

We also proposed that unless HCFA determines otherwise, a current nonrisk Medicare enrollee may remain under the reasonable cost provision of a contract (that is, receive reasonable cost reimbursment for all covered Part A and Part B services).

As noted above, under the provisions of the NPRM an organization would have to enroll two new Medicare enrollees for each current nonrisk Medicare enrollee it wishes (or is required) to cover under the risk portions of its contract. As defined in the law (section 114(c)(2)(D) of Pub. L. 97-248), a new Medicare enrollee is an individual entitled to Medicare who was not enrolled in the organization in which he or she subsequently enrolls at the time the organization entered into a risk contract, or at any previous time he or she was entitled to Medicare.

The NPRM also included provisions for beneficiary liability.

- An item or service not covered under Part A or Part B is the financial responsibility of the beneficiary entitled to both Parts. In addition, the beneficiary enrolled under Part B only would be liable for services covered under Part A.
- The beneficiary (or someone on his or her behalf) would also be financially responsible for services for which Medicare is not the primary payor (that is, services covered under workers' compensation, automobile medical, or no-fault insurance, or any liability insurance, and, under certain circumstances, an employer group health plan). An organization would be able to offer an optional supplemental benefit plan, which pays for services not covered under Parts A and B for enrollees entitled to both Parts, or Part A services and items and services not covered under Part B for enrollees entitled to Part B only. Payment of premiums or other charges for such a plan would be the responsibility of the Medicare enrollee.

Medicare deductibles and coinsurance would be the responsibility of the Medicare enrollees, or someone on their behalf. If the organization offers a supplemental plan that covers additional services and pays for Medicare deductibles and coinsurance, the amounts attributable to each Medicare enrollee for these additional

services and payments would have to be computed separately and disclosed to enrollees prior to their selection of such plans. Coverage of additional services would have to be optional for the Medicare enrollees of reasonable cost organizations.

E. Contract Requirements

This section of the NPRM contained proposals to implement those provisions of section 1876 of the Act that pertain to the contract between HCFA and an eligible organization under the Medicare program. Those provisions of the law include—

- Content of contract; and
- Procedures for contract termination, renewals, and changes in ownership.

We proposed that, in order to be reimbursed for Medicare services section 1876 of the Act, an eligible organization would have to sign and submit a written contract that meets the requirements of the regulations. A contract between an eligible organization and HCFA would be renewed automatically unless the organization of HCFA gives notice of its intent not to renew the contract, as set forth in the proposed regulations.

We did not include in the proposed rules a specific contractual requirement that an organization must agree to comply with title VI of the Civil Rights Act because, since all entities that furnish Part A services to Medicare beneficiaries are subject to the civil rights statute and regulations (including those at 45 CFR 80.4(a) and 84.5(a)), inclusion of a specific requirement in the contract is not necessary.

F. Reimbursement

Under the NPRM, eligible organizations that contract under the provisions of section 1876 of the Act would be reimbursed on either a risk or a reasonable cost basis. Payment made to an organization under section 1876 of the Act for the provision of covered Medicare services would be in lieu of payment that would otherwise be made to the organization for covered services under sections 1814(b) and 1833(a) of the Act.

As stated in the NPRM, in addition to the payment made by HCFA, an organization would be permitted to charge Medicare enrollees an amount equal to the actuarial value of the deductible and coinsurance for which Medicare enrollees would otherwise be liable had they not enrolled in the organization. Also, there are a number of situations where Medicare is the secondary payor for covered services. For example, if a Medicare enrollee receives covered services from the organization for which the enrollee is entitled to benefits under a workers' compensation law or plan, automobile medical or no-fault insurance, or any liability insurance, or, under certain circumstances, an employer group health plan, the organization would be able to charge the insurance carrier, employer, or other entity that is responsible to pay for the services.

Alternatively, the organization could charge the Medicare enrollee to the extent that the enrollee has been paid by the law, plan, or policy for those services. In addition, in the case of Medicare enrollees in the age group 65–69 who, through employment, have elected their employer's health benefits plan over Medicare, the organization could charge an employer group health plan for services for which Medicare is a secondary payor. The regulations describe these situations, including the coordination of benefits, and emphasize Medicare's secondary liability.

If an organization furnishes supplemental services to its Medicare enrollees, each enrollee, or his or her representative, would be liable for payment of the service. This would not apply to the additional benefits furnished without charge by an organization in accordance with the provisions of its risk contract. Regardless of the form of payment, in no case could the sum of the amounts the organization charges its Medicare enrollees for supplemental services exceed the adjusted community rate (ACR) (as explained below) for these services.

We proposed that we would pay an organization with a risk contract, in advance, its monthly per capita rate of payment for each Medicare enrollee. As provided in the amended section 1876(a) of the Act, this amount would equal 95 percent of the organization's adjusted average per capita cost (AAPCC) for the class of the enrollee (that is, a group of enrollees that is constructed on the basis of actuarial factors). The amount of payment made under this section of the regulations would be retroactively adjusted when necessary to take into account any differences between the organization's actual number of Medicare enrollees in each class and the number of individuals estimated to be enrolled in each class in determining the amount of advance payment. When necessary, HCFA would conduct an annual reconciliation for a contract period to assure that the organization has received the proper payment amount from HCFA for the contract period.

The NPRM allowed a risk organization to elect direct reimbursement by HCFA to hospitals that furnish covered inpatient hospital services to the organization's Medicare enrollees. This election would be binding for the entire contract period, and we would pay the hospital directly for the covered inpatient hospital services provided to the organization's Medicare enrollees. Each month, we would deduct from the organization's per capita payment an amount we estimate we would pay to hospitals on behalf of the organization's Medicare enrollees and administrative costs we would expect to incur in making those payments to hospitals.

We explained in the NPRM that the AAPCC is an actuarial estimate made by HCFA before an eligible organization's contract period begins. The AAPCC is an estimate of the average per capita cost that would have been incurred by Medicare on behalf of each class of Medicare enrollee of the organization if that class of enrollee had received its covered services from providers and suppliers other than an eligible organization in the same or similar geographic area served by the organization. We proposed that an organization would receive notification at least 90 days before the beginning of the organization's contract period of the AAPCC for each class of Medicare enrollee the organization anticipates having enrolled for that contract period.

Although by definition the AAPCC is an estimate, the statute (section 1876(a)(4) of the Act) requires that the method of calculation of the AAPCC ensure "actuarial equivalence" in comparing the health care needs of Medicare beneficiaries enrolled in an eligible organization and those beneficiaries who receive care outside an eligible organization (for example, in a fee-for-service setting). The law (section 114(c)(4) of Pub. L. 97–248) also requires that we notify Congress that we are reasonably certain the methodology we have developed for calculating the AAPCC will assure actuarial equivalence. The NPRM described the method of calculating the AAPCC in general terms based on the method that HCFA has used in the past to calculate a retrospective AAPCC, except that the new calculation would be made prospectively.

The NPRM specified that an organization that contracts on a risk basis would be required to determine, using a prescribed method of computation, its per capita financial requirements (reduced by Medicare deductibles and coinsurance) for furnishing Medicare covered services to its Medicare enrollees. We use the term

"adjusted community rate" (ACR) to describe these financial requirements. The ACR is the equivalent of the premium that the risk organization would have charged to Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees, if the benefit package is limited to covered Medicare services.

We provided in the NPRM that if an organization's proposed ACR is less than the average of the per capita rates of payment to be made to the organizaion, the organization would either thave to provide its Medicare enrollees with additional benefits or accept a reduced monthly payment from HCFA. The additional benefits could be either health benefits beyond the required Parts A and B services; or a reduction in the organization's premium rate or in other charges for services furnished to the enrollee; or a combination of these benefits.

The organization's calculation of its ACR would be subject to review and approval by HCFA. When the organization submits its ACR calculation, it would have to include adequate supporting data, including copies of any annual premium reports submitted to other government agencies (for example, Office of Personnel Management, Office of Health Maintenance Organizations in the Public Health Service, and State Medicaid agencies).

Section 114 of Pub. L. 97-248 made very few changes in the provisions relating to reimbursement of organizations with a reasonable cost contract. Therefore, the proposed regulations for these organizations were similar to the principles of reimbursement of cost-basis HMOs found in the current regulations at 42 CFR Part 405, Subpart T (§§ 405.2040 through 405.2047). However, we did state in the NPRM that we are reviewing several payment issues, including using an organization's AAPCC as an overall limit on reasonable costs and the existing provisions that allow exceptions to Medicare's usual payment methods.

The following two provisions that are currently included in the Subpart T regulations were not included in the proposed regulations:

- The exception to the Medicare rule set forth in § 405.455 on payments at the lower of costs or charges.
- The exception to payment of reasonable charges, as defined in Subpart E of 42 CFR Part 405, in the case of emergency services, urgently needed services, and other services for which the organization assumes financial responsibility.

In addition, reinsurance costs would not be allowable in any situation.

The NPRM also required that an organization reimbursed on a reasonable cost basis would have to submit to HCFA the following reports for each contract period:

- A budget and enrollment forecast submitted at least 90 days before the start of the contract period.
- Quarterly interim cost reports (less frequently for experienced organizations).
- A final cost report submitted to us not later than 180 days after the end of the contract period.

G. Appeals

The NPRM included provisions dealing with the rights of both beneficiaries and eligible organizations to appeal adverse initial determinations, which we defined in the proposed rule.

III. Discussion of Comments

As noted above, we received over 30,000 items of correspondence on the proposed rule. All but 75 of these items were comments from chiropractors and their patients regarding the availability of chiropractic services from eligible organizations. The remaining 75 letters cover a broad range of issues and represent the views of national, State, and local health associations; providers and suppliers of health care services; potential eligible organizations; Federal and State government agencies; actuaries; members of Congress; a State governor; a beneficiary organization; and a HCFA regional office.

The comments received and our responses to those comments are grouped by subject area and are as follows:

A. Definitions (§ 417.401)

Comment: Several commenters objected to the term "geographic area" that is described as the area within which the organization furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees (§ 417.401). Most of these commenters prefer that these regulations adopt instead the terms "service area" and "enrollment area", as are used in the current Subpart T regulations. The commenters believe that the term geographic area is too broad, inexact, and confusing and implies inclusion of enrollees whose residences may be located outside the organization's service area.

Response: The Subpart T regulations make a distinction between the terms "service area" (defined as the area in which the organization offers its full range of covered Medicare items and services to its Medicare enrollees) and "enrollment area" (defined as the geographic area encompassing the residences of its enrollees, which may include locations outside the organization's service area where it offers less than the full range of covered Medicare items and services). Section 1876(c)(2) of the Act requires the organization to provide to enrollees the full range of covered Medicare services "which are available to individuals residing in the geographic area served by the organization." We have adopted the term "geographic area" because it is used exclusively in the statute and because it eliminates the obsolete distinction between service and enrollment areas. We have specified in the definition in § 417.401, and in the discussion of services in §§ 417.414 and 417.416, that organizations must furnish the full range of services to all Medicare enrollees. These services must be made available and accessible to each of these enrollees. While the terms "service area" and "enrollment area" are obsolete for purposes of contracts under Subpart C of Part 417, they will continue to apply to contracts under Subpart T of Part 405.

Comment: One commenter suggested that the definition of "urgently needed services" as set forth in § 417.401 should be modified to require that these services are necessary because of an unforeseen health problem or one that is not reasonably postponable. The commenter believes that these changes would preclude coverage when individuals who need surgery or other treatment voluntarily leave the organization's geographic area to obtain services from out-of-plan providers.

Response: We have revised the definition of "urgently needed services" to include the commenter's suggested change.

Comment: Several commenters requested clarification of the definition of "urgently needed services" when an enrollee who is "locked-in" to the organization for services is temporarily absent from the organization's geographic area or when the enrollee temporarily changes residence. The commenters were concerned that some organizations would encourage their Medicare enrollees to disenroll so that these organizations would not incur liability for emergency or urgently needed services furnished outside of the plan.

Response: As stated in § 417.414(c), an organization is financially responsible for emergency and urgently needed

services furnished out-of-plan, even if furnished without the organization's approval. Furthermore, the organization must not in any way encourage a Medicare enrollee to disenroll except in very limited circumstances as set forth in § 417.460 (for example, when the enrollee permanently moves out of the organization's geographic area). If the enrollee expresses intent to return within 90 days to his or her permanent residence within the organization's area, the move cannot be considered to be permanent. The organization, in this situation, would be responsible for emergency and urgently needed services provided outside the organization's geographic area.

Of course, an enrollee may choose to disenroll from the organization rather than to limit his or her entitlement of out-of-plan services to those that are emergency or urgently needed. In this case, the disenrollment would be effective no later than the first day of the month following a full calendar month after the notice of disenrollment is signed, and all restrictions on the use of Medicare services would cease on that date.

Comment: Some commenters asked whether the term "current nonrisk Medicare enrollee" includes those Medicare beneficiaries that purchase, on a fee-for-service basis, supplemental services from an organization or those beneficiaries who disenroll from an organization prior to the effective date of these regulations.

Response: The definition of "current nonrisk Medicare enrollee" includes only those Medicare beneficiaries who are enrolled in an organization under an existing cost contract under either section 1876 of the Act as it existed prior to Pub. L. 97–248 or section 1833(a)(1)(A) of the Act. (The latter applies to health care prepayment plans under Medicare Part B.) The definition includes Medicare enrollees who disenroll and later reenroll in the same organization, regardless of the timing of the disenrollment.

B. Eligibility and Contracting Requirements and Conditions (§§ 417.404 Through 417.418)

Comment: Several commenters wanted to know which agency or individual in the Department will have ongoing responsibility for determining a CMP's continuing compliance with the applicable requirements contained in these regulations.

Response: We have revised § 417.406 to clarify that the Assistant Secretary for Health has the ongoing responsibility for monitoring entities that have contracted with HCFA to assure that they continue to meet the definition of an eligible organization.

Comment: Many commenters asked for clarification of the definition of a CMP, including whether a preferred provider organization (PPO) or other types of organizations may be determined to qualify as eligible organizations under the CMP definition.

Response: Any entity that meets the definition in § 417.407 may be found to be an eligible organization. There is nothing in the statute or these regulations that prohibitis a PPO, a medical service corporation, or any similar organization from being a CMP, if it is organized in a manner that enables it to meet the definition in the statute and the regulations. For example, a CMP must assume full financial risk on a fixed prospective prepaid basis in exchange for services that must be provided without regard to frequency, extent, or kind. In addition, physician services must be provided primarily by physicians who are employees or partners of the organization or who are under contract to the organization. CMPs must also be organized under State law and have adequately provided against the risk of insolvency.

Comment: One commenter requested that we specify timeframes for the contract application process described in § 417.408, especially a time limit on HCFA's notice of approval or disapproval.

Response: We expect that the contract application process will encompass much exchange of information and negotiation between the parties. In some cases, this will be a relatively quick procedure; in others, the negotiation process may become prolonged. Therefore, we do not believe that we should set specific timeframes for this applications process. We also note that it is not HCFA's policy to set timeframes for the approval process of contract or provider participation agreements. In any case, we will try to review applications as expeditiously as possible.

Comment: A commenter protested our policy of allowing CMPs to contract on a reasonable cost basis even though they offer less than all covered Medicare services available in their geographic area (§ 417.410(f)(3)). However, an HMO is required to offer all these services even if it is seeking a reasonable cost contract.

The commenter believes that there is no statutory basis for this distinction and that the requirements should be the same for HMOs and CMPs.

Response: We agree with the commenter's arguments and have deleted the exception for CMPs that offer less than the full package of Medicare covered services in the area.

Comment: A large number of commenters objected to our waiver criteria for eligible organizations whose enrolled population consists of over 50 percent Medicare and Medicaid beneficiaries. We specified in the NPRM (49 FR 22201) that we would consider waiving the composition of enrollment standard for an organization that is attempting to enroll non-Medicare and non-Medicaid beneficiaries and whose geographic area is composed of over 50 percent Medicare and Medicaid beneficiaries. However, if a waiver is granted, an organization may not be composed of more than 75 percent Medicare and Medicaid beneficiaries and in no case may the percentage of those beneficiaries in the organization exceed their percentage in the organization's geographic area.

Some of these commenters believe that HCFA does not have the authority to set a limit on the percentage of Medicare and Medicaid enrollees under the waiver. Other commenters stated that such a limit is inconsistent with Medicaid regulations (42 CFR 434.26, 48 FR 54013 (November 30, 1983)), which exempt certain organization from the composition requirement and permit waivers for certain other organizations with no limit on the percentage of Medicare and Medicaid enrollees. Commenters also stated that placing a limit on composition percentages is contrary to the statute's intent because it unnecessarily limits the number of organizations that could qualify to contract. Other commenters indicated that this requirement would force organizations that currently serve Medicare enrollees (for example, organizations participating in HCFA demonstration projects) to withdraw service from Medicare enrollees in order to reduce their Medicare population and, thus, meet the HCFA contract standards.

Response: The statute (section 1876(f)(1) of the Act) specifies that no more than 50 percent of an organization's enrollees may be Medicare and Medicaid enrollees. In recognition of the fact that there may occasionally be extenuating circumstances that make it desirable to waive this requirement, as part of Pub. L. 97–248, Congress added section 1876(f)(2) to the Act, which allows modification or waiver of this requirement if special circumstances warrant and if the organization has taken and is making reasonable effort to enroll individuals other than Medicare and Medicaid beneficiaries.

We agree with the commenters that the provisions of the NPRM were overly restrictive. Therefore, we have revised § 417.413 to remove the 75 percent limit on Medicare and Medicaid beneficiaries. However, we are retaining the requirement that HCFA will not grant a waiver that would permit the percentage of Medicare and Medicaid enrollees in an organization to exceed the percentage of those beneficiaries in the organization's geographic area.

However, we are concerned that otherwise qualified eligible organizations currently participating in HCFA demonstration projects may not be able to qualify for a contract under these regulations on the basis of their failure to meet the requirements for a waiver, and that failure to qualify could disrupt service to Medicare beneficiaries. Therefore, we are including in these final regulations a new paragraph (e)(3) to § 417.413 that permits us, on a case-by-case basis, to grant exceptions to this standard for eligible organization applicants that are participating in operational demonstration projects currently funded by HCFA, even though the organizations do not meet the waiver criteria described above.

Requests for exceptions under this special provision will be evaluated, in part, on the magnitude and substance of the organization's effort to enroll members who are not Medicare or Medicaid beneficiaries. It is expected that an organization will not require an exception for more than three years from the date the organization operating the demonstration project enters into a contract under these final regulations. However, HCFA may extend the exception for more than this three-year period if certain special circumstances continue to exist and it is in the best interest of the Medicare program to do so. For example, HCFA may grant an extension if the organization services a population that is medically underserved or if the termination of the exception would leave a majority of the organization's Medicare enrollees without access to prepaid care.

Comment: Some of the commenters objected to the requirements set forth in the proposed operating experience and enrollment standard for risk organizations (§ 417.413(b)). Specifically, these commenters believe that these requirements would prohibit newly established organizations from qualifying for contracts and that the minimum requirements should be subject to waiver or some sort of phase-in period during which the organization could solicit new enrollments.

Response: As explained in the NPRM (49 FR 22201), the enrollment requirement of 5,000 enrollees for urban risk organizations in § 417.413(b)(1) is specified in the statute (section 1876(g)(1) of the Act). The minimum Medicare enrollment for these organizations (75 members) set forth in that section of the regulations is the least number of Medicare enrollees we believe is necessary to assure an adequate base for calculating an organization's ACR and to justify our administrative costs for entering into a contract with an organization.

With regard to rural organizations with risk contracts, although the statute did not specify nor give any direction concerning the determination of the minimum numer of enrollees necessary, we believe that the enrollment must be sufficient to permit calculation of an ACR and to justify our administrative costs for entering into a contract. Therefore, we specified in the NPRM that these organizations must have 1,500 enrollees, at least 75 of whom must be Medicare enrollees.

Contrary to the commenters' expectation, we believe that these minimum requirements will permit many more organizations to qualify for risk contracts because they are much less stringent than the requirements contained in the current Subpart T regulations. Therefore, we have not changed these minimum enrollment requirements.

Comment: A commenter observed that § 417.413(c)(2) requires that an eligible organization must have at least 75 Medicare enrollees before it could qualify to contract with HCFA on a reasonable cost basis. The commenter believes that the unintended result of this requirement is to prevent any newly established organization from contracting with HCFA.

Response: We have revised that section to permit contracting on a cost basis if the organization either has at least 75 Medicare enrollees or a plan acceptable to us for achieving this minimum enrollment within two years of the beginning of its initial contract period.

Comment: One commenter suggested that the language of § 417.414(c)(2), which states that an organization is financially responsible for services furnished outside its delivery system if upon appeal it is found that the enrollee was entitled to have the services furnished by the eligible organization, is troublesome and needs clarification. The commenter is concerned that this provision could be interpreted to mean that any time an enrollee obtains services outside of the organization he or she would be entitled to reimbursement for those services if they are services that the organization is required to furnish. The commenter would prefer that the regulations specifically state that an enrollee must at least attempt to receive the services from the organization and that the organization must refuse to furnish the services before the enrollee goes out of plan.

Response: We agree with this comment and have made a clarifying change to § 417.414(c)(2).

Comment: As mentioned earlier, we received over 30,000 pieces of correspondence (the overwhelming majority of which were letters from individual patients) concerning eligible organization and the provision of chiropractic services. These commenters suggested that the regulations be revised to ensure that Medicare enrollees of these organizations receive chiropractic services from a chiropractor. We received similar letters from representatives of other types of practitioners including dentists, psychologists, and others urging that the choice of practitioners not be left to the organization.

Response: The proposed regulations (§ 417.414(b)(3)) stated that if more than one type of practitioner is qualified to perform a service, the eligible organization may select the type of practitioner to be used. Under the law (section 1861(r)(5) of the Act), Medicare covered chiropractic services are limited to treatment, by manual manipulation of the spine, of subluxations of the spine that are demonstrated by x-ray to exist. An organization may hire or make arrangements with a chiropractor to treat subluxation of the spine, or may choose any other practitioner who is qualified under State law to perform this service.

We believe that eligible organizations should be free to organize their service delivery in the most efficient manner possible. It is important that they have the option of choosing which practitioner they will use to furnish a given service, as long as all Medicare covered services are available to the enrollee and high quality service is furnished. Therefore, we have made no revision in the regulations to require that organizations hire or contract with specific types of practitioners, including chiropractors, psychologists, dentists, and others.

Comment: One commenter suggested that the definition of physicians who supervise other health care professionals directly involved in

patient care is too broad. The commenter suggested that the word "physician" be replaced with "doctors of medicine and osteopathy."

Response: We do not believe that it is necessary to limit the definition of physician to doctors of medicine and osteopathy for purposes of supervising the health care services furnished by nonphysicians. Section 1861(r) of the Act defines the word "physician" as any number of professionals, including doctors of medicine or osteopathy, doctors of dentistry, podiatrists, chiropractors, and optometrists (with limitations as specified in sections 1861(r) (3), (4), and (5) of the Act, respectively). The qualifications of the physician providing supervision should be governed by the nature of the services being furnished. For example, the provision of covered foot care services could be supervised by a podiatrist (if podiatrists are legally authorized in the State to perform the services). Also, we believe an organization should be free to organize the delivery of services in any manner it sees fit, consistent with law and regulations.

Comment: One commenter is of the opinion that the quality assurance requirements (§417.418) that organizations must meet are too weak and fail to mention quality of care.

Response: We believe that firm quality assurance standards are vital once this innovative program for Medicare beneficiaries is established. Therefore, the quality assurance standards include a requirement that action must be taken to remedy inappropriate or substandard services or services inappropriately denied. In addition, the enrollee has access to grievance and appeal procedures both within and outside the organization, in accordance with §§ 417.600 through 417.638 Also, we have chosen to implement review by utilization and quality control peer review organizations (PROs) under § 417.478 for organizations in these regulations. We believe that the quality assurance provisions in these regulations are adequate if they are fully enforced. We intend to do this and, if experience indicates a need for additional standards, they will be added to the regulations.

Comment: Several commenters suggested that the Assistant Secretary for Health should have responsibility for assuring CMP, as well as HMO, compliance with the quality assurance requirements.

Response: The quality assurance requirements under Medicare and title XIII of the Public Health Service Act are basically the same. The Assistant Secretary for Health is responsible for determining whether an HMO or CMP meets the qualifications necessary to be an eligible organization. However, we believe that HCFA should have responsibility for assuring that quality assurance requirements continue to be met by these organizations. The provision of quality health care to beneficiaries enrolling in eligible organization is of paramount interest to HCFA. The number of beneficiaries enrolling in these organizations is expected to increase significantly under these regulations, and we intend to devote considerable energy to the review and assessment of all eligible organizations' quality assurance programs.

Comment: Several commenters requested that the regulations include a discussion of the provision of hospice care to Medicare enrollees of eligible organizations. The commenters believe that some sort of special arrangements are necessary because the hospice regulations (42 CFR Part 418, Hospice Care, published in the **Federal Register** on December 16, 1983 (48 FR 56008)) specify that Medicare beneficiaries who elect hospice benefits must waive (with certain exceptions) their right to receive medical services that are related to the terminal condition or a related condition from any supplier or provider except the designated hospice. The commenters maintained that the NPRM does not clearly state how this benefit would be managed for an enrollee of an organization.

Response: The statute (section 1812(d)(2) of the Act) requires that an enrollee who elects care from a hospice must waive his or her right to receive services related to the enrollee's terminal condition from the eligible organization in which he or she is enrolled. The individual may continue to receive services that are not subject to the hospice election from the organization; that is, any service, whether related to the terminal condition or not, from his or her attending physician if the physician is an employee or contractor of the organization and is not employed or under contract to the hospice, and any services not related to the terminal condition. See 42 CFR 418.24(e) (48 FR 56008, December 16, 1983). These services will be reimbursed by Medicare on a fee-for-service basis. If the individual revokes the election of hospice benefits as described in § 418.28 or the hospice benefits are exhausted, the individual may again seek all services from the organization. These services will also be reimbursed on a fee-for-service basis until the capitation payment resumes.

However, these regulations provide that Medicare beneficiaries cannot enroll in an eligible organization while they are receiving hospice care. This is because the nonhospice services furnished to a Medicare enrollee who has elected the hospice benefit are so limited that it is not practical for an organization to enroll an individual already receiving hospice care on a capitation basis. Of course, an individual who revokes or exhausts his or her hospice benefit would be eligible to enroll in an organization during the next open enrollment period.

We have revised these regulations by adding new §§ 417.414(b)(3), 417.422(c), and 417.440(c) to include clearly the policy described above. See the comments and responses contained in section III. F. below for a discussion of payment to an eligible organization for a Medicare enrollee who elects hospice benefits.

C. Enrollment, Disenrollment, and Reenrollment

Comment: In the NPRM, we requested comments on the idea of requiring that all the eligible organizations in a single geographic area hold a coordinated open enrollment period. We received numerous comments on this issue. Many of the commenters believe such a requirement would be overly intrusive and would create many operational problems for organizations. Other commenters were in favor of this requirement since it would be beneficial to both Medicare beneficiaries and organizations. In addition, since there were no details of how such a coordinated period would be implemented, several commenters requested that a separate NPRM be published concerning this issue.

Response: Section 2350(a) of Pub. L. 98–369, enacted on July 18, 1984, amended section 1876(c)(3)(A) of the act to require that we establish, for each geographic area served by more than one eligible organization, a single 30-day period each year during which all the organizations must allow open enrollment. The statute permits us to phase in this requirement over a period of three years. The variety of comments we received reflects the complexity of implementing this provision. Therefore, we are not including this new requirement in these final regulations, but rather will publish it in a separate rulemaking document. (See section IV. of this preamble for a further discussion of Pub. L. 98–369.)

Comment: One commenter suggested that, in addition to requiring coordinated open enrollment periods, HCFA should contract with a health "broker" to assist beneficiaries in comparing plans offered in the same geographic area and to help them make the best personal choice among the competing organizations. Alternatively, the commenter suggested that the Federal government could serve as the "broker."

Response: HCFA is currently conducting a demonstration project to test the health broker concept. Depending upon the results of this study, we will consider ways to increase the efficiency of consumer choice among eligible organizations. Concerning the alternative, we believe that it is inappropriate for Federal personnel to intervene in a Medicare beneficiary's choice of plan.

Comment: One commenter objected to the fact that organizations are required to enroll beneficiaries who are entitled only to Medicare Part B.

Response: Section 1876(d) of the Act states that every individual entitled to benefits under Medicare Part A and enrolled under Medicare Part B or enrolled under Medicare Part B only is eligible to enroll with any eligible organization. Therefore, organization may not deny enrollment to Part B-only enrollees and, under section 1876(c)(2)(B) of the Act, must furnish all Part B services that are available in the organization's geographic area to these enrollees.

Comment: Several commenters suggested that enrollees of a risk organization who later become entitled to Medicare should be permitted to choose whether they wish to convert under the risk or cost portions of the contract.

Response: Enrollees who later become entitled to Medicare must be converted under the risk contract, just as new enrollees must be enrolled only under the risk contract. The law (section 114(c)(1)(A) of Pub. L. 97–248) permits only current nonrisk Medicare enrollees as defined in § 417.401 to choose whether to convert under the risk contract (except if HCFA decides that all current nonrisk enrollees should convert as specified in § 417.444).

Comment: Several commenters stated that we should not require organizations to enroll individuals who have used all their inpatient hospital days under Medicare Part A, or, if this is required, special capitation rates should apply to these individuals.

Response: As stated above, section 1876(d) of the Act requires that organizations enroll persons entitled to Medicare Part A and enrolled in Part B, or enrolled in Part B only, regardless of health status. Failure to enroll individuals who have exhausted Part A benefits could be considered an attempt by the organization to screen for health status. However, organizations need not offer benefits in excess of those covered under Part A or Part B, as applicable, unless additional benefits are furnished according to § 417.440(b)(4) or supplemental services are elected by the beneficiary or required by the organization according to §§ 417.440 (b)(2) and (b)(3). There is no authority in the law for us to pay an organization special capitation rates for services not covered by Medicare.

Comment: Several commenters suggested that we clarify that if an individual enrolls in an eligible organization before becoming entitled to Medicare Part B, the organization cannot disenroll that enrollee when he or she becomes entitled to Medicare unless one of the specified criteria for disenrollment in § 417.460 is met.

Response: We agree with this comment and have revised § 417.432 to specify that no enrollee who becomes entitled to Medicare Part A or B, or both, may be disenrolled unless one of the circumstances described in § 417.460 is applicable.

Comment: Some commenters contended that the provisions of § 417.426(c) should be expanded to allow organizations to reserve vacancies for new members of existing group contracts as well as reserving vacancies for anticipated new groups.

Response: We agree with the commenters and have revised § 417.426(c) accordingly.

Comment: A few commenters believe that the requirement that unused vacancies be made available to enrollees who are not Medicare beneficiaries goes beyond the scope of the law.

Response: We disagree with the commenters. It would be beyond HCFA's authority under the statute, as well as unreasonable, to require that vacancies that are not filled within a reasonable period of time be made available only to Medicare beneficiaries.

Comment: We received many comments regarding the requirement that an organization submit marketing materials to HCFA for approval prior to their use. The comments covered many issues including—

- A desire for careful and strict Federal control, including specific guidelines;
- The establishment of broad parameters for advertising and marketing rather than review of an individual organization's marketing plan;
- A reduction of the 60-day time period HCFA has to review and approve marketing material;
- A "sunset" provision that would allow an organization that has completed a reasonable and satisfactory trial period to be exempt from the approval requirement; and
- The belief that marketing constraints of any kind are intrusive and paternalistic.

Response: We agree with the commenters that a blanket preclearance requirement such as that proposed in § 417.428(a)(2) is overly restrictive; therefore, we have deleted this requirement. We believe that the provisions set forth in § 417.428(b) adequately describe what we believe to be deceptive marketing activities and it is not necessary for us to prereview each organization's material to ascertain that it is in compliance with the regulations.

Comment: Commenters requested that the regulations specifically include door-to-door soliciting among the prohibited marketing activities. They noted that this marketing technique is nearly impossible to control or monitor, and, as an example, one commenter cited the problems that arose in California in the early 1970's with prepaid health plans that practiced this technique.

Response: We agree with this comment and have revised § 417.428 accordingly.

Comment: One commenter believes that the regulations are not strict enough and allow organizations to enroll Medicare beneficiaries without giving them adequate notice of their benefits and limitations, charges, and other information. Additionally, we were urged to require that enrollees be informed of changes in an organization's rules.

Response: Section § 417.428(a) states that, as a part of the required marketing materials, organizations must provide adequate written description of rules, procedures, benefits, fees, services, and other information necessary for beneficiaries to make an informed decision about their enrollment in the organization. Upon enrollment, each member must be given a copy of the organization's rules, including how and where to obtain services, as specified in § 417.436. We believe that these requirements are restrictive enough to protect beneficiaries.

We agree that Medicare enrollees should be informed promptly of changes in an organization's rules, and we have amended § 417.436 to include a

requirement that an organization must notify its Medicare enrollees of rule changes 30 days prior to making the changes. We will monitor contractor compliance with these rules.

Comment: One commenter questioned whether rebates could be advertised by an organization as an enrollment inducement to Medicare beneficiaries.

Response: In considering amendments to section 1876 of the Act in 1982, the Senate proposed rebates as one method by which a risk organization could return to the beneficiary the difference between its AAPCC and ACR. However, the Conference agreement specifically deleted the language permitting rebates (H.R. Rep. No. 97–760, 97th Congress, 2d Session 426–427 (1982)). Therefore, we are not allowing risk organizations to provide rebates.

Comment: Some commenters criticized our use of the word "unethical" in describing prohibited marketing practices or activities in § 417.428(b)(1) as vague and troublesome because it was too easily subject to misinterpretation.

Response: We agree with the commenters that the word "unethical" is not necessary, and we have deleted it from these regulations.

Comment: Commenters requested that we clarify the effective date of enrollment for individuals who are enrollees of the organization immediately prior to their entitlement to Medicare. Many of these commenters stated that the time frame for submittal of conversion information to HCFA should be reduced.

Response: An individual who is enrolled in an eligible organization when he or she becomes entitled to Medicare is converted to a Medicare enrollee on the date of that entitlement. If the organization is participating on a risk basis, these enrollees are not subject to the two-for-one rule because, by definition, only "current nonrisk Medicare enrollees" (that is, Medicare enrollees who are enrolled with an organization that has an existing cost contract on the effective date of these regulations) are subject to the two-for-one rule. They may be immediately converted to risk reimbursement membership. However, these individuals are not counted as "new Medicare enrollees" for the purposes of satisfying the two-for-one rule because, by definition, "a new Medicare enrollee" cannot be an individual who enrolled in the organization prior to entitlement to Medicare benefits. The 90-day period required in § 417.432(b) that specified how soon an organization must notify HCFA of an enrollee's conversion to Medicare enrollee was based on the earliest possible time an individual could apply for Medicare entitlement. We agree that this is an unrealistic time frame; however, some lead time is needed to allow HCFA to process the Medicare enrollment. Therefore, we have reduced the 90-day requirement to 30 days.

Comment: One commenter stated that the regulations should include standards for the grievance procedures mentioned in § 417.436(a)(2) to be followed by organizations, and that the regulations do not specifically mention dissatisfaction with the quality of care as a legitimate reason for a grievance.

Response: Standards for grievance procedures will be included in HCFA instructions to eligible organizations. Dissatisfaction with the quality of care is a legitimate reason for grievance and the instructions we issue will deal with this problem.

Comment: One commenter stated that the grievance procedures should require organizations to forward grievances to HCFA.

Response: Procedures for handling grievances will be included in our instructions to eligible organizations. However, the instructions do not include procedures for forwarding grievances to HCFA for resolution. Only initial determinations (see § 417.606) may be reviewed by HCFA under Medicare appeals procedures. Grievances, such as a patient complaint about waiting too long before seeing the physician for a scheduled appointment, allegations that a nurse behaved rudely, or complaints that an organization's telephones are not answered promptly, are handled by internal grievance procedures.

Comment: Many commenters expressed concern about enrollees of risk organizations who move out of the geographic area served by the organization, but who do not voluntarily disenroll. Under the proposed regulations at § 417.448, the "lock-in" would be removed and an organization would be liable for all Medicare services for these enrollees starting with the month after they have permanently left the area. Some of the commenters noted that the enrollee is not required to notify an organization of his or her intention to move, and that the organization would be, under the proposed regulations, responsible for whatever costs for Medicare services the beneficiary incurred elsewhere. Commenters generally wanted the regulations to be fair to both organizations and enrollees.

Response: We recognize the concerns of these commenters and our regulations have been revised. An enrollee is required to advise the organization if he or she is moving out of the area permanently, and an organization's liability would be limited to emergency and urgently needed services until disenrollment occurs. Retroactive disenrollment is not permitted. After the organization sends the required notice to the enrollee, disenrollment may occur no earlier than one month after, but no later than the third month after, we receive a disenrollment notice from the organization.

The lock-in under § 417.448(b)(2) would not end in the case of an enrollee who failed to notify the organization that he or she had moved permanently. We are defining "permanently moved" as at least an uninterrupted absence of more than 90 days from the area. However, if an enrollee "permanently moves" but intends to return to his or her home after the 90-day limit, an organization would have the option of disenrolling the enrollee or retaining him or her as a member without the lock-in restriction. This would make the provision consistent with our liability to make monthly payments for an enrollee and the organization's obligation to pay for all services required by the enrollee in these situations.

Comment: Some commenters proposed that certain Medicare enrollees who regularly leave their home residence to reside in another part of the country for several months of the year should be permitted to disenroll if they are leaving the area for at least three months but be able to reenroll automaticallly when they return to their home residences, without being subject to the first-come, first-served rule on applications.

Response: We believe that adding this type of exception to our enrollment rules would create problems in the administration of enrollment of beneficiaries in a fair and equitable manner. We would be particularly concerned about—

- The acceptance of applicants in the order in which they apply;
- An organization potentially operating beyond its contracted capacity; and
- Ensuring that these "automatic" reenrollment applicants would not be discriminated against if a change in health status occurs.

Of course, this category of beneficiary could disenroll and reenroll in these cases if—

- Its organization has a continuous open enrollment policy; and
- The organization is below its enrollment capacity.

If an organization does not meet these conditions, but wishes to keep these enrollees, it would have the option of

agreeing to pay for all covered Medicare services while the enrollee is out of the geographic area. This option would apply only to those persons who have not permanently left the area.

Comment: Many commenters urged us to revise the regulations to allow an organization to disenroll Medicare enrollees who are especially disruptive. In particular, the commenters sought the addition of regulations to permit the involuntary disenrollment of Medicare enrollees who were uncooperative, abusive, unruly, or disruptive to the extent that they interfered with the organization's ability to carry out its operations.

Response: We agree that organizations should be free to disenroll Medicare enrollees who behave in this manner. In the past, we have been concerned that disenrollment for "cause" offered too great a potential for abuse. A "cause" regulation might provide a means for an organization to rid itself of what it considers an undesirable enrollee. We were afraid that an organization might try to disenroll an enrollee because of his or her health needs or status, which is forbidden by law, by citing cause. For example, an organization might try to circumvent the regulations by claiming that an enrollee with high cost health needs failed to meet some minor rules of the organization and consequently must be disenrolled; or, rather than treat a mentally ill enrollee exhibiting some behavior outside the social norm, the organization might terminate the beneficiary for cause, claiming the individual was disrupting the practice of medicine, or upsetting other patients.

We are adding a new § 417.460(a)(6), to provide for disenrollment for cause. It is designed both to serve the needs of an organization and to protect beneficiaries from acts of personal bias or whim. The organization will need to document the enrollee's behavior, demonstrate its unsuccessful attempts (including internal grievance procedures) to resolve the problems, and submit evidence that the enrollee's problem behavior is not due to the use, including overutilization, of medical services. Documentation shall be submitted to us for review to determine whether the organization has met the requirements for disenrollment for cause. If our review results in the finding that there is insufficient evidence to justify such a disenrollment, the organization will be advised of that finding. We will make its decision within 20 working days after receipt of the documentation. After the organization is notified of our finding, the organization may disenroll the beneficiary.

We expect that the cause provision will be used rarely. However, for the exceptional cases that may occur, the organization will have a means available to resolve the situation.

Comment: A commenter stated that although an organization is required under § 417.460(b) to submit a disenrollment notice within 30 days of the enrollee's request, there is no provision describing what HCFA will do if an organization does not submit the notice timely. The commenter noted that a risk organization could receive payment from HCFA for the individual without being required to pay for services furnished outside the plan that are not emergency or urgently needed services.

Response: We are revising the regulations to indicate that we will be reimbursed by the organization for any capitation payments made after the date payments would have ceased if the organization had notified us on a timely basis as § 417.460(b) requires.

Comment: One commenter suggested that enrollments and disenrollments be processed by Social Security Administration personnel, rather than by the eligible organization, since these personnel are "unbiased." This commenter was afraid that organizations may not process disenrollment requests promptly.

Response: Enrollments and disenrollments are a two-step process. First, the eligible organization must amend its records. Since these organizations are private enterprises, the use of Federal personnel to perform that function would be inappropriate. Second, we must also maintain an accurate and current Federal record of Medicare enrollees in each organization.

We believe that beneficiaries are protected adequately from disenrollment initiated inappropriately by eligible organizations. An organization may not disenroll beneficiaries except for well-defined purposes, and only after specified procedural requirements are met (§ 417.460). Enrollees who believe that their rights regarding enrollment and disenrollment have been violated may complain directly to any HCFA office. Beneficiaries may consult any social security office or any Federal Information Center for the address and telephone number of HCFA's nearest regional office. Enrollees may write also to HCFA's central office at the following address:

Health Care Financing Administration, Group Health Plans Operation Staff, Room 320, Meadows East Building, 6300 Security Blvd., Baltimore, MD 21207

Comment: A commenter asked whether the minimum 30-day period that a beneficiary must wait when he or she reguests disenrollment from one organization in order to join another is necessary.

Response: The regulations reflect the requirement of present law (section 1876(b)(3)(B) of the Act).

Comment: A suggestion was made that HCFA should establish a system by which it could trigger an investigation of an HMO or CMP if beneficiary disenrollment rates exceed a certain rate. The purpose of this investigation would be to determine whether there is a pattern of discrimination against enrollees who use more services than the average enrollee.

Response: Disenrollment is an area of concern to us. Regulations are specific as to reasons and circumstances governing disenrollment. HCFA's regional offices will monitor the eligible organizations to assure that they operate within these regulations. We have decided to enhance the ability of these offices to review disenrollment activity, and we are revising § 417.482 to provide specific authority to inspect and evaluate disenrollment records.

In addition, we have added § 417.460(a)(4)(iv) to provide that when beneficiaries are disenrolled for fraudulent practices, such as permitting other persons to use their membership cards, the organization must report this abuse to the HHS Inspector General so that we may initiate our own investigation of the alleged fraud.

Comment: One commenter suggested that there be a waiting period during which a Medicare enrollee who has applied to an eligible organization for membership may withdraw his or her application, rather than having to follow disenrollment procedures.

Response: While it would be possible to build a holding period into the enrollment procedures, it would, of course, delay the effective date of enrollment. Upon receipt of an application from an eligible organization, we must add certain information to our systems in order to begin a monthly capitation payment and to annotate the enrollee's records so that Medicare services may not be reimbursed in the usual manner. Our experience, to date, has not demonstrated a need for such a delay. Indeed, the procedure might confuse rather than help potential Medicare enrollees.

D. Entitlement to Services

Comment: A number of commenters objected to the two-for-one enrollment conversion rule because the rule penalizes existing cost contract organizations that do not have a pool from which to draw new enrollees and will encourage organizations to delay enrollment of new Medicare beneficiaries until these regulations become effective. Other commenters stated that this rule discriminates against risk enrollees because current nonrisk enrollees of risk organizations are afforded special supplemental benefits under § 417.444. Conversely, current nonrisk enrollees will be discriminated against because they are denied the extra benefits that accrue from risk contracts under § 417.440(b)(4).

Response: The two-for-one enrollment rule is mandatory under the provisions of section 114(c)(2)(A) of Pub. L. 97–248. Through the provisions of these regulations, we have attempted to ensure that the two-for-one conversion criteria will be applied in an unbiased manner, and we intend to monitor closely the implementation of this rule. It is true that section 114(c)(2)(B) of Pub. L. 97–248 permits risk organizations to offer current nonrisk members a special supplemental benefits package; however, in exchange for these benefits, nonrisk enrollee must agree to the "lock-in" provisions of § 417.444(b)(6).

Comment: Several commenters indicated that cost and risk organizations should be allowed to screen applicants on the basis of health status for voluntary supplemental benefit plans that include services not covered by Medicare (for example, outpatient prescription drugs, eyeglasses, or hearing aids).

Response: We disagree. Preliminary results from demonstration projects that were permitted to screen applicants for optional supplemental benefit packages indicate that such screening has an effect on enrollment for the basic benefit plan as well. Data from these demonstrations indicate that when health screening is permitted for any plan, there may be biased selection of relatively healthier applicants. Therefore, in order to assure that Medicare beneficiaries are accepted without restriction by organizations on a first-come, first-served basis as required by section 1876(c)(3)(A) of the Act (except when denial of enrollment is permitted under § 417.424), we are prohibiting health screening for any plan offered to Medicare beneficiaries.

Comment: One commenter stated that organizations that contract on a risk basis should be required to offer a benefit package that includes only covered Medicare services.

Response: Section 1876(c)(2)(B)(ii) of the Act permits risk organizations to require that Medicare enrollees must purchase a mandatory package of supplemental health services, if these services are approved by HCFA. Supplemental services are evaluated on the basis of whether they will substantially discourage Medicare enrollment in the organization (§ 417.440(b)(3)).

Comment: Several commenters stated that organizations should be allowed to charge for special supplemental benefits offered to current nonrisk Medicare enrollees of an organization under a risk contract.

Response: These organizations are prohibited from charging current nonrisk enrollees for these benefits because, as described in §§ 417.442 and 417.444(c)(7), these benefits must be reimbursed from the savings the organization achieves from an ACR that is lower than the average of the per capita rates of payment made by HCFA.

Comment: One commenter suggested that we consider annotating a beneficiary's Medicare card upon his or her enrollment in a risk organization, so that other providers and suppliers of care would be aware that restrictions apply to the reimbursement for Medicare services received outside the organization.

Response: At the present time, it is not practical to modify the Medicare card to notify providers that a beneficiary is an enrollee of an eligible organization. We are aware that some organizations presently provide enrollees with peelable stickers to place on their Medicare cards, and we suggest that this procedure be considered by other organizations experiencing a problem.

Comment: One commenter was concerned with the provisions of § 417.460(a)(1)(iii), which permit a Medicare enrollee of a cost organization to terminate his or her participation in an optional supplemental benefit package merely by nonpayment of the premium while remaining enrolled in the rest of the program. The commenter believes that this policy is unfair to organizations and aggravates the problem of adverse selection. A Medicare enrollee could elect the optional benefits, use it to its maximum, and then drop it by nonpayment. The commenter would prefer that enrollees who elect an optional package be locked into these benefits (and payment of the premium) for a minimum of one year. Allowing them to opt in and out of the program at will creates an untenable rating and adverse selection problem.

Response: While an organization may lose money on an individual enrollee who disenrolls from an optional supplemental benefit package, it is just as likely that a beneficiary will pay premiums for optional supplemental benefits for a year or two, and seldom, if ever, use these services. These regulations are designed to protect from disenrollment by the organization those Medicare enrollees in cost organizations who decide to terminate an optional supplemental plan. We wish to stress that the services at issue are optional, and we are not aware of any optional supplemental health insurance programs where the purchaser loses the right to disenroll. We do not believe that these regulations will cause an adverse selection problem, and they are not being revised.

Comment: One commenter inquired if an enrollee of a risk organization could be disenrolled for failure to pay premiums for supplemental benefits that are part of a separate or integrated premium. This commenter noted that under § 417.460(a)(1)(iii) enrollees of reasonable cost organizations are protected from disenrollment for failure to pay the premium on an optional supplemental plan they wish to terminate.

Response: Enrollee of risk organizations are protected to the same extent as enrollees of cost organizations from disenrollment for failure to pay a premium for an optional supplemental package of benefits. We are revising § 417.460(a)(1)(iii) to make this policy clear.

Comment: A few commenters asked us to clarify when an organization must make refunds for enrollees who have died or cannot be located. Specifically, they questioned why the provisions set forth in the NPRM applied only to risk organizations and whether we intended that organizations refund all incorrectly collected amounts when the beneficiary dies or cannot be located.

Response: Section 417.456, as proposed in the NPRM, incorrectly specified that only risk organizations must refund amounts incorrectly collected when the beneficiary has died or cannot be located. We have corrected this provision to apply to all organizations. It is our intention that organizations must refund all incorrectly collected amounts when the beneficiary has died or cannot be located. If amounts were incorrectly collected from a third party on the beneficiary's behalf, refunds may be made to the third party.

Comment: One commenter stated that the proposed regulations require organizations to refund amounts

collected from beneficiaries when an enrollee was believed not entitled to Medicare benefits, if the enrollee is later determined to have been entitled to Medicare benefits during that time. The commenter stated that, as presently specified in the regulations, these refunds would be due regardless of whether or not HCFA was liable, according to the provisions of § 417.450, for payments during this period.

Response: We have amended § 417.456 to indicate that refunds are due only if HCFA was liable for payments during the period in question.

E. Contract Requirements

Comment: We received several comments that wanted to know which entity has the responsibility for monitoring the performance of contracts between HCFA and eligible organizations.

Response: The HCFA regional offices will have this responsibility. Complaints regarding an organization's compliance with these regulations may be directed to the appropriate HCFA regional office (the address and telephone numbers of which can be obtained from any social security office or any Federal information center), or interested parties may address their written comments to the following address:

Health Care Financing Administration, Group Health Plans Operations Staff, Room 320, Meadows East Building, 6300 Security Boulevard, Baltimore, MD 21207

We wish to state that, if we believe that it would be administratively feasible and cost effective, we may enter into independent contractual arrangements with national organizations that have established arrangements with health care delivery systems in a substantial number of States in order to expedite eligibility determinations and contract administration.

Comment: One commenter believes that organizations that contract with HCFA should be required to prove they furnish high quality service before they are permitted to increase enrollment in their geographic area.

Response: In order to qualify for a contract, eligible organizations are required to demonstrate their ability to furnish high quality services to enrollees. HCFA regional offices will monitor this requirement once the contract is in effect. Enrollees who believe that the services furnished by an organization are substandard should consider notifying us as directed in the immediately preceeding response.

Comment: One commenter suggested that the Assistant Secretary for Health oversee compliance with sections 1301(c)(8) and 1318 (a) and (c) of the PHS Act, which relate to conflict-of-interest and liability arrangements (§§ 417.478 (b) and (c)).

Response: The Assistant Secretary for Health is responsible for overseeing that HMOs comply with these requirements and, as a part of their responsibility in determining CMP eligibility, the Assistant Secretary will review compliance for CMPs.

Comment: One commenter stated that organizations with effective utilization review requirements should be exempt from review by PROs, which is required by § 417.478(a).

Response: The law requires review of hospital inpatient services.

Comment: One commenter stated that § 417.492(b)(4) implies that, if an organization is dissatisfied with HCFA's decision not to renew its contract, that this decision is appealable under the procedures of §§ 417.640 through 417.682. However, § 417.642 states that, unless this decision to not renew is based on one of the reasons stated in § 417.640(c) (that is, the organization failed to carry out the terms of the contract, is carrying it out in a manner inconsistent with the efficient and effective administration of section 1876 of the Act, or the organization no longer meets the qualifying conditions of an eligible organization), then these determinations are administrative actions, which are not appealable. The commenter suggested that all decisions not to renew a contract should be appealable.

Response: While we would not anticipate failure to renew a contract for other than the reasons stated in § 417.640(c), we do not agree that nonrenewals should be appealable in any given situation. Since the nature of contracts are that both parties agree on terms, we prefer to reserve the right to decline to renew the contract as a matter of administrative choice. Also, section 1876(i)(1) of the Act specifically permits either party to terminate the contract at the end of the current term as long as notice has been given as required under § 417.492. We have clarified § 417.492(b)(4) to make this policy clear.

Comment: One commenter said that an organization should have a right to terminate its contract if HCFA fails to substantially carry out the terms of the contracts.

Response: We agree and have made a corresponding change to § 417.494.

Comment: One commenter stated that, if HCFA decides not to renew an organization's contract, that HCFA should notify the organization's Medicare enrollees at least 90 days before the termination date, rather than the 30 days specified in § 417.494. The commenter believes that a Medicare enrollee will need more than 30 days to become enrolled in another organization.

Response: Where practical, HCFA has required risk organizations to provide a 60-day notice to beneficiaries when the organization's contract is not renewed. HCFA will also notify affected Medicare enrollees of the termination at least 30 days before the termination date. When HCFA terminates an organization's contract for cause, we believe that the interests of the beneficiaries are better served by a speedy termination date. Therefore, we are not revising the 30-day notice requirement in § 417.494.

Comment: One commenter requested that § 417.520(b)(3) be revised so that organizations must notify HCFA only 30 days before an anticipated change of ownership instead of the 60 days now required. Some organizations may be unable to meet the 60-day requirement because these transactions may occur rapidly depending on the type of organization and action by stockholders.

Response: We believe 60 days is the minimum time necessary for us to assure that continuation of the contract after the pending change in ownership is in the best interest of the Medicare program.

F. General Reimbursement Rules

Comment: One commenter asked whether it is permissible under § 417.528 for organizations to require an enrollee to sign a lien against benefits from any other health plan to which Medicare is secondary payor.

Response: As stated in the regulations, organizations may charge another plan or the Medicare beneficiary for services when Medicare is not the primary payor. Organizations may require the enrollee to sign a lien against the reimbursement for those benefits. Regulations have not been amended since such liens fall within the definition of the word "charge."

Comment: Several commenters supported the application of the prompt payment provisions of 31 U.S.C. 3901–3906 to the monthly capitation payments made to eligible organizations. These provisions are concerned with the time frames within which the Federal government must make payment for the goods and services it has purchased and interest penalties that accrue when the payment dates are not met.

Response: Although these provisions do not apply to benefit payments made under the Medicare program, we intend

to apply, to the extent possible, the financial management principles set forth in these provisions in our operation of contracts under section 1876 of the Act. However, under section 1876(a)(1)(D) of the Act, we must make our monthly payment to an eligible organization in advance.

Comment: Numerous commenters requested a clear statement of our reimbursement policy for Medicare enrollees who elect hospice care under 42 CFR Part 418, noted above.

Response: For reasonable cost organizations, we have added § 417.531 to provide that for the period a Medicare enrollee has elected hospice care services, reimbursement for those services will be made to the Medicare-participating hospice that furnishes the services. While the enrollee's hospice election is in effect, the organization may receive reimbursement on a reasonable cost basis for only those services that are not waived under § 418.24(e).

For risk organizations, no payment is made to the organization on behalf of an enrollee who has elected hospice care for the period the hospice election is in effect except for the portion of the payment applicable to the additional benefits that are described in § 417.442. During the time the election is in effect, the organization may bill HCFA on a fee-for-service basis, subject to the usual Medicare payment rules, for the services not waived by the enrollee. Full capitated payment resumes in the month following the month in which the hospice benefit terminates or is exhausted. This policy is set forth at § 417.585.

Comment: A commenter wished to know how organizations that are receiving payment for physicians' services will be affected by the physician fee freeze provisions of section 2306 of Pub. L. 98–369.

Response: Section 2306 amended section 1842 of the Act to establish a freeze on Medicare reimbursement for physicians' services, to create a participating physician program and to prohibit certain physicians (those who do not participate) from raising their charges to Medicare beneficiaries after June 30, 1984.

The charge screens used by Medicare carriers to determine the reasonable charges for physician services will be frozen to the limits that were in effect June 30, 1984 (that is, customary and prevailing limits that were established on 1982 charge data). These screens will not be updated until October 1, 1985 using charges made by all physicians for services furnished during the period April 1, 1984 through March 31, 1985.

Those physicians that elect to participate (that is, accept assignment for all Medicare claims) may raise their charges to Medicare beneficiaries and those charges will be recognized in calculating their customary charges effective with the October 1, 1984 update of physician charge screens. Until September 30, 1985, those physicians who do not elect to participate cannot charge a Medicare beneficiary more than the customary pattern that was charged for that service during the period March 1, 1984 through June 30, 1984. Any physician who knowingly and willfully makes a higher charge would be in violation of the law, and subject to civil penalty as well as exclusion from the Medicare program.

An organization may obtain from the Medicare carrier serving its area information necessary to determine the amounts Medicare pays on a fee-for-service basis for covered services. This information is necessary to ensure that those existing reasonable cost organizations that obtain physician services (and other Part B supplier services) on a free-for-service basis under § 417.546(c) do not exceed the reasonable charge for those services as set forth in Subpart E of 42 CFR Part 405 for contract periods beginning before January 1, 1986. The availability of these data will also ensure that the requirements at the prudent and conscientious buyer and comparability of payment for physician services are met.

G. Reasonable Cost Reimbursement

Comment: One commenter complained that, under these regulations, home health agencies (HHAs) will not be able to contract with eligible organizations at "special rates" because of current guidelines governing Medicare payment at the lower of cost or charges to HHAs.

Response: These regulations do not contain the bill payment option that is currently available under Subpart T regulations that allows HCFA to process HHA bills for services furnished to the organization's Medicare enrollees. Both cost and risk-based organizations will be free to negotiate "special rates" with HHAs for services HHAs furnish to the organizations' Medicare enrollees. Under a risk contract, the guidelines on lower of cost or charges (and other reasonable cost rules) will not apply to services furnished to Medicare enrollees by an HHA because, under a risk-capitation system, there are no retroactive adjustments to the capitation rates for these services. Organizations with cost contracts are subject to reasonable cost limits.

Comment: A local medical society believes that allowing organizations to claim as allowable costs those bad debts attributable to deductibles and coinsurance gives these organizations an unfair advantage over physicians who are not allowed to claim bad debts as a cost.

Response: By bad debts we refer only to Medicare deductible and coinsurance amounts that beneficiaries fail to pay. Physicians are paid on a charge basis and their charges may reflect losses that result from the failure of beneficiaries to pay deductibles and coinsurance. In addition, organizations with cost contracts can only claim bad debts for the period reasonably related to the period they need to disenroll a beneficiary who does not pay deductibles and coinsurance (that is, three months). In contrast, a fee-for-service physician may stop furnishing services immediately to beneficiaries who do not pay their deductibles and coinsurance.

Comment: The same commenter is also concerned about the advantages that eligible organizations have over private practitioners in that they can claim reimbursement for enrollment and marketing costs. The commenter believes that this is an unfair competitive edge because private practitioners cannot claim these costs, and the amounts that the organizations can claim and receive are in addition to their regular monthly payment, which is based on 95 percent of the AAPCC.

Response: Organizations with cost contracts are paid a monthly advance payment equivalent to the organization's interim per capita rate for each Medicare enrollee of the organization. However, at the end of a contract period, the organization submits a cost report, and the payments made to the organization are adjusted to equal the reasonable costs of the covered services the organization furnished to its Medicare enrollees. Therefore, the organization does not receive payment for enrollment and marketing costs claimed in addition to its monthly payment. Rather, the monthly payment is adjusted after all these and other costs are considered.

We believe that enrollment and marketing costs are a normal business cost to the organization and we have recognized these as allowable costs for many years. Also, we expect fee-for-service practitioners to take advertising and other overhead expenses into account when they set their charges.

Comment: Many commenters wrote to protest our suggested policy that an organization with a cost contract could

not receive total payment during a contract period that would be in excess of its AAPCC. These commenters believe that this policy—

- Would put the cost contractors on the same basis as the risk contractors without any of the benefits allowed to risk contractors;
- Would discourage organizations from participating in this program; and
- Is not supported by the statute.

We did receive one comment from a potential eligible organization that supported this policy. In addition, one commenter had no objection to using the AAPCC as a limit in the case of reasonable cost payments for current, nonrisk enrollees in a risk organization.

Response: First, it should be noted that we have used a cost HMO's AAPCC as a general guideline of the reasonableness of the organization's costs since we started contracting with HMOs under section 1876 of the Act (see § 405.2041(b)). In addition, section 1861(v)(1)(A) of the Act limits reimbursement on a reasonable cost basis by excluding those costs that are found to be unnecessary in the efficient delivery of health services. With regard to paying HMOs and CMPs on a reasonable cost basis, we believe we are required to consider the principles of reimbursement that are generally applied to established prepayment organizations regardless of whether they are cost or risk organizations. Except within the Medicare program, where we lacked sufficient experience, these organizations have been paid on a risk basis with respect to their enrollees.

Since the purpose of purchasing services from an HMO or CMP is to furnish care more efficiently than is available in the fee-for-service system, it is reasonable to expect that, in the aggregate, an eligible organization operating on a cost basis should be more efficient than the aggregate costs of suppliers and providers of services in its community. Previously, HCFA's lack of experience in this area prevented us from establishing clear standards for comparison. However, some recent studies by HCFA indicate that existing cost HMOs are already operating significantly below the average per capita costs of their community.

Therefore, we believe it is reasonable and consistent with the law that we establish the cost organization's AAPCC as an overall payment limit. The actual limit will be the weighted average of the AAPCCs for each class of the organization's Medicare enrollees. In order to provide existing participating cost organizations time to adjust to this new standard, we will delay the effective date of this change to the regulations until contract periods beginning on or after January 1, 1986. however, the limit will be applied immediately for all new organizations that begin contracting under these provisions.

Comment: Numerous commenters objected to our statement in the NPRM (49 FR 22210) that we were considering eliminating bad debts attributable to uncollected deductibles and coinsurance as an allowable cost. The commenters believe that these costs are part of the usual cost of doing business and that not allowing them as part of the organization's reasonable cost could discriminate against those organizations with a large number of lower income Medicare beneficiaries, who would probably have higher bad debt losses. In addition, they contend that eliminating these costs is inconsistent with usual Medicare policy toward providers.

Response: We agree with the commenters and have decided not to implement this provision. Therefore, we are retaining § 417.536(f).

Comment: In the NPRM (49 FR 22210), we stated that we were reviewing the various exceptions to the usual Medicare principles of reimbursement to see if these exceptions are justified. We specifically requested comments on this issue, and received only limited comments.

One commenter stated that the exception to the reasonable charge screens provided in § 417.546(c)(2) concerning payment to a physician group organized on an individual practice (IPA) basis should be revised because the Assistant Secretary for Health no longer requires a separate IPA entity. Therefore, the exception should state that payment to physicians organized on an individual practice basis is not subject to the reasonable charge screens if the eligible organization pays its physicians (either directly or through a group entity) on a fee-for-service basis and has procedures under which the physicians accept effective incentives.

One potential eligible organization wrote to suggest that we should include in § 417.560(c) and (d) an exception to the reasonable charge limit for emergency and urgently needed services and medical services furnished under an arrangement on a fee-for-service basis if these services are furnished infrequently, the charges for these services represent an insignificant amount of the organization's total reimbursement, and the charges do not exceed the amounts charged by the physician or supplier to other patients. This exception is allowed in the Subpart T regulations and the commenter believes it is justifiable because it is not reasonable to expect organizations to determine reasonable charge rates for services that are infrequently furnished and are an insignificant part of total reimbursement.

Response: Since, as stated above, we are applying the AAPCC as an overall limit on payments to a cost organization, we see no need to apply the reasonable charge limits set forth in 42 CFR 405, Subpart E to physician and supplier compensation. Therefore, we will not apply these limits to any new reasonable cost organizations that begin to contract with us and we will eliminate the limitations for existing cost organizations with contract periods beginning on or after January 1, 1986. Instead, for these organizations, we are applying reasonable cost rules to all physician and supplier costs an organization incurs, regardless of the payment method it uses.

Although we received no specific comments on other exceptions set forth in the proposed regulations, we have decided to make the following changes to what was proposed in the NPRM:

- We are eliminating the exception that allowed a cost organization that does not furnish services on a fee-for-service basis to nonenrollees to be free from the lower of cost or charges rule (§ 417.536(o)). We believe that this exception is no longer necessary because eligible organizations and their providers and suppliers no longer exclusively service their own enrollees.
- For contract periods beginning on or after January 1, 1986, we will be eliminating the weighting factor used in determining the reasonable costs of Part B direct professional services (§ 417.562) because this factor is inconsistent with the usual Medicare reasonable cost principles. Continuing to pay reasonable cost organizations with the added weighting factor results in their receiving more payment for Part B services than rates paid in the Medicare fee-for-service market. For example, no adjustment factor is paid to a hospital outpatient department or to a community health clinic after its reasonable costs are determined, yet, if the services are furnished by an organization's ambulatory clinic under the same payment rules, it receives an additional payment amount based on the weighting factor. As mentioned above, this revision will not be effective until the beginning of contract periods beginning on or after January 1, 1986, to allow organizations time to adjust their payment procedures.

Comment: A few commenters disagreed with the provisions of

§ 417.542, which do not permit reinsurance costs to be considered an allowable cost.

Response: There is no statutory authority to include reinsurance costs as allowable costs and, since cost organizations incur no risk relative to the limits of Medicare coverage because they are paid on a reasonable costs basis, we do not believe these should be included as allowable.

Comment: A potential eligible organization commented on the provisions of § 417.576(b)(2)(i), which state that consolidated cost reports are required if an organization is related to another entity by common ownership or control. The commenter is unclear as to whether this provision applies only to organizations with cost contracts or also to those with risk contracts. In any case, this entity believes that requiring consolidated cost reports of separate entities that have separate contracts with HCFA is unreasonable.

Response: The regulations at §§ 417.530–417.576 only apply to reasonable cost reimbursement. Section 1876(h)(4)(C) of the Act requires that if an eligible organization paid by Medicare on a reasonable cost basis is related to another organization by common ownership or control, a consolidated financial statement must be filed. Therefore, the regulations must contain this requirement.

H. Risk Reimbursement

1. *Adjusted Average Per Capita Cost (AAPCC).*

Comment: One commenter believes that an organization should be notified by HCFA of its AAPCC as early as possible and that information on the manner in which the AAPCC was computed should be made available.

Response: In general, we agree with this comment. It should be noted that the regulations state that HCFA will furnish the organization with its AAPCC at least 90 days before the start of the contract period. For a further discussion of this issue, see the comments and responses in section III. H. 2. of this preamble.

Comment: A beneficiary organization suggested that HCFA should monitor a risk organization's costs closely so that HCFA may lower an organization's monthly per capita rate of payment below 95 percent of its AAPCC if it discovers that organizations are operating well below this level. A hospital trade association suggested that the final regulations should provide for a five-year transition period during which the payment rate cannot be lowered below 95 percent.

Response: The 95 percent of the AAPCC provision is mandated by the statute (section 1876(a)(1)(D) of the Act) and HCFA does not have the option of changing the percentage figure. However, HCFA will be evaluating payment rates and the ACR in terms of appropriate levels of efficiency for risk organizations.

Comment: Several commenters expressed concern about the actual method we will use to develop the AAPCC rate book and inquired whether there would be an opportunity to appeal our methodology and assumptions.

Response: Since no organization will be signing a risk contract prior to publication of the rate book, each organization will have full opportunity to review the rates and decide if they are adequate. If an organization believes that the rates are not adequate, then that organization can simply decide not to participate in a risk contract. There will be no provision for appeal of our methodology and assumptions used in determining the AAPCC. However, in the addendum to this final rule, we describe the methodology, and we welcome comments and suggestions for improvement. In addition, we will be conducting demonstrations that we hope will assist us in further refining the AAPCC methodology.

Comment: One commenter suggested that the AAPCC methodology should be guaranteed for a period of five years.

Response: We believe that this would not be practical since changes in the law, new data, or other changes may result in improvements in our AAPCC methodology.

Comment: One commenter objected to our mentioning in the NPRM (49 FR 22208) that we may, in the future, include in the AAPCC methodology a health status adjustment. The commenter believes that including this adjustment would lead to wide-spread abuse. Another commenter supported the inclusion of this adjustment factor.

Response: An independent actuarial consultant has advised us that a health status adjustment would not result in improvement in the AAPCC methodology at this time. As noted in the NPRM, we will incorporate this adjustment only if future research indicates its feasibility.

Comment: One commenter asked how we have interpreted the requirement for "actuarial equivalence" of the AAPCC and how it could be demonstrated that this requirement has been met.

Response: The law (section 114(c)(4) of Pub. L. 97–248) requires that the Secretary be reasonably certain that the methodology to make appropriate adjustments have been developed and can be implemented to assure actuarial equivalence in the estimation of the AAPCC. This requirement will be met when the Secretary notifies the Committee on Finance of the Senate and the Committees on Ways and Means and on Energy and Commerce of the House of Representatives of her certification of the AAPCC methodolgy.

Comment: One commenter inquired about the definitions of "welfare" and "institutionalized" individuals as used in the AAPCC calculation.

Response: The definitions as used in the AAPCC methodology are as follows:

"Institutionalized" means a Medicare beneficiary who has been a resident for at least 30 days of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home. "Welfare" means a Medicare beneficiary who has been determined by the Medicaid agency of the State in which he or she resides to be eligible for Medicaid. However, for purposes of clarification, we have revised the term "welfare" to "medicaid" (see the addendum to this rule).

2. *Adjusted Community Rate (ACR).*

Comment: We received a comment that suggested that prior to the effective date of these final regulations, HCFA should publish, for public comment, the guidelines on the computation of the ACR, and the details of the community rating system.

Response: We believe that the explanation of the ACR that was included in the NPRM satisfies any requirements for publishing for comment our policy concerning computation of the ACR. We do plan to provide organizations with further details in administrative issuances. However, we wish to stress that the methods used to calculate the community rate must be internally consistent with rates used for calculating premiums charged to the organization's non-Medicare enrollees. Thus, documentation of rates for each service category of the community rate must be consistent with the rates used in the premium calculations for the same services.

Comment: Numerous commenters objected to the timeframes set forth in the regulations (§ 417.592(d)) concerning HCFA's furnishing of an organization's payment rates, approval by HCFA of an organization's proposed ACR and weighted averages of the per capita rates of payment. They believe these timeframes do not allow the organization sufficient time to market its package. These commenters suggested that earlier time periods be provided for HCFA notification of per capita

payment rates; the organization's submission of its ACR; and weighted averages of per capita rates and descriptions of additional benefits; and HCFA approval of that submittal. They proposed the following timeframes:

- HCFA furnishes payment rates to organization—180 days prior to the start of the contract period. (The NPRM specified 90 days.)
- Organization submits its weighted average of its per capita rates of payment and the ACR to HCFA for approval—150 days prior to the contract period. (The NPRM specified 45 days.)
- HCFA notifies the organization of its approval or disapproval—120 days prior to the contract period. (The NPRM did not specify any time frame for this approval.)

Response: Although providing payment rates 180 days in advance of the contract period may be possible in the future, we cannot do so at this time. Therefore, we will provide the rates 90 days in advance of the contract period, as stated in the NPRM. Since the other timeframes are linked to the payment rates, they will also remain as stated in the NPRM. However, we are considering all aspects of this provision, and we may, in the future, be able to provide payment rates further in advance of the contract period.

Comment: Some commenters expressed concern about the fact that we did not explicitly state in the NPRM whether or not an organization may include in its ACR computation a reasonable contribution to its contingency reserve fund against the risk of adverse selection or overutilization.

Response: An organization is free to do so if its premium for its non-Medicare enrollee groups includes this element.

Comment: An association wrote to express its concern about what supporting documentation HCFA will require an organization to submit with its ACR.

Response: The burden of identifying and proving the basis of the community rate and the adjustments for the ACR fall to each risk organization and will depend upon a fact-finding process that is based on the individual circumstances, utilization experience, private business, and expenses of each. No standardized formula applies and, thus, proof depends upon reliable, consistent, accurate, and authentic business records that the risk organization provides to us. This means that HCFA must have access to the records of the organization to verify information. Therefore, in response to the comment and in order to provide guidance to risk organizations, we are adding a new § 417.481 to specify what kind of documentation the risk organization must maintain with regard to its ACR calculation. This includes requiring that an organization will have to maintain and make available to HCFA records of reports filed with other Federal programs and State authorities.

Comment: A commenter was confused about the ACR computation methodology. Specifically, the commenter wanted to know if an organization may use the community rate method or the aggregate premium as it chooses, or if it must use both of them.

Response: As specified in § 417.594(b), an organization must choose one method or the other; however, the choice belongs to the organization.

Comment: A few commenters objected to our decision to prohibit the use of a time factor as an adjustment to the organization's community rate except as a temporary measure in the organization's initial contract period (§ 417.594(c)(2)(ii)). They believe that the time factor adjustment is well established and has been used under cost-based contract for many years; therefore, the risk organizations should be allowed to use it.

Response: We proposed in the NPRM (see § 417.594(c)(2)(ii)) that an organization with a risk contract has the option of using a time factor in its first contract period merely to allow the organization time and experience to develop empirical evidence that demonstrates the differences in the complexity of intensity of services furnished to Medicare enrollees. We have revised this section of the regulations to allow this adjustment for the first year of this program's operation. After this date, we believe that an organization should be able to gather supporting evidence to do this.

Comment: A potential eligible organization requested that, in adjusting their initial rate to take into account the characteristics of Medicare enrollees, organizations be allowed to use what it refers to as "standard area specific age/sex experience tables" as an alternative adjustment to the volume or intensity adjustments set forth in §§ 417.594(c) (1) and (2).

Response: Since the commenter described these tables in only general terms, it is difficult for us to categorically respond to their validity in making adjustments to the initial rate calculation. However, nationally recognized tables of this type could be used if—

- The organization uses the tables in developing its initial rate; and
- The organization demonstrates to HCFA's satisfaction that the tables are valid indicators of the utilization of health services.

Comment: One commenter stated that the requirements of §§ 417.594(c)(2) (i) and (ii), as set forth in the NPRM, could be in conflict with the requirements of title XIII of the PHS Act. As written, those sections would allow an organization to adjust its community rate to reflect the difference in the complexity or intensity of services furnished to its Medicare enrollees if the adjustment is made equally to *all enrollees*. The commenter believes that the term "all enrollees" should be revised to read "all Medicare enrollees"; otherwise, organizations would be required to experience rate it non-Medicare enrollees, which is prohibited under the PHS Act.

Response: We agree with the commenter that the language of the noted sections, as proposed, was misleading. We have revised those sections of the regulations to specify that if an organization chooses to use the adjustments in §§ 417.594(c)(2) (i) and (ii), then its calculation of its initial rate must also have included the elements of the adjustment. As long as this is done for all enrollees, the organization is not experience rating.

Comment: An association of prepaid health organizations is concerned about confidentiality of data submitted to HCFA regarding ACR calculations. The commenter stated that the structuring of rates is highly confidential, because ratemaking decisions are critical to the competitive position of each organization in the marketplace. The recommendation is that this information be exempted from disclosure under the Freedom of Information Act (FOIA).

Response: These data are exempted from mandatory disclosure under the FOIA by 5 U.S.C. 552(b)(4), which deals with "trade secrets and commercial or financial information obtained from a person which is privileged or confidential." Organizations should separate their ACR calculations from their other submissions to HCFA and clearly identify them as confidential. Within HCFA, access to this information will be limited to those who have a responsibility for review and evaluation of the data.

Comment: One commenter urged us to allow organizations that have already been subject to a State rate review process to submit those data to HCFA and that HCFA would accord appropriate weight to these determinations. This would, in the commenter's opinion, avoid duplicative

and unnecessarily burdensome reviews for the organizations and avoid HCFA determinations that conflict with State regulatory requirements.

Response: We will explore the possibility of coordinating our review efforts with those of state insurance premium review agencies. However, because of major differences among the various requirements in State and the Medicare program, there may be many administrative difficulties in effective and efficient coordination.

Comment: An actuary contended that HCFA should not allow organizations to compute their own average of their per capita cost of payments, since this can be manipulated to minimize required additional benefits or reduced payments. The organization will not be penalizing itself by calculating a low average for submission to HCFA because the actual payment is based on true enrollment.

Response: We disagree with the commenter. The key element in calculating the average payment rates is the expected enrollment for the contract period. We believe that the organization is best qualified to make this estimate. We will review the organization's assumptions and calculations to ensure their validity when they are reported to us under the provisions of § 417.590.

Comment: A commenter questioned whether an organization whose ACR is less than its average of the per capita rates of payment could make up the difference by a combination of accepting a reduced payment from HCFA and furnishing additional benefits to reconcile the difference.

Response: We agree that an organization may do this, and we have revised the regulations (§ 417.442(b)) to make this policy clear.

Comment: A commenter stated that the ACR computation does not appear to take into account area differences in the distribution of an eligible organization's regular business and its Medicare business. Another commenter wanted HCFA to allow separate ACRs by county with separate premiums.

Response: By definition, a community rating system spreads the risk of health insurance costs over the broad population that an organization serves. The ACR calculations must begin by being consistent with the premium calculations used by organizations in their non-Medicare business. Since these organizations usually do not set premium rates by county, if the ACR was calculated on this basis it would artificially impose a rate setting adjustment that has not been recognized or applied uniformly by the industry.

Comment: A potential eligible organization believes that we should eliminate the requirement that an organization that is utilizing the initial rate calculation described in § 417.594(b)(3) must include a separate component for overhead. The commenter suggests that overhead should be allocated among the direct service components because that is the current common practice. Overhead is driven by and a function of the direct service component.

Response: We believe that distinguishing this element separately is necessary for proper evaluation of an organization's ACR. However, we have changed "overhead" to "general and administrative" to be more consistent with usual accounting practices.

Comment: One commenter believes that, because of the prospective payment system for inpatient hospital services, the cost per unit of furnishing those services to Medicare enrollees may be more or less than the organization's cost from a related provider or charges from an unrelated provider for non-Medicare enrollees. The commenter maintained that this cost differential should be recognized in the regulations as an appropriate measure of intensity for purposes of adjusting the initial rate in the ACR computation.

Response: Just as we no longer recognize a separate adjustment to hospital payment rates to reflect an intensity factor through the nursing differential, we will not be allowing separate adjustments for prospective payment rates compared with the rates paid by organizations to hospitals. This adjustment would artifically elevate an organization's ACR in a manner that is not related to its own purchasing arrangements for hospital services.

Comment: A few commenters believed that the ACR methodology should allow flexibility so that each organization may use adjustments that take into account its usual financial needs and risks.

Response: As long as an organization's calculation method is consistent with either of the two basis methods mandated by law (that is, community rating or aggregate weighted premium method), we will recognize circumstances unique to each organization if—

- There is an equitable financial impact on the general enrollment and the Medicare enrollment; and
- Proper supporting documentation is furnished.

Comment: A potential eligible organization asked if the costs incurred by an organization in entering into contracts with existing medical groups (network model organizations) can be included in the organization's ACR calculation.

Response: An organization may include these costs if it also includes them in the premium for non-Medicare enrollee groups.

Comment: A commenter wanted to know if HCFA will attemp to recover the difference if an organization's actual ACR for a given period falls below the budgeted or projected ACR due to the improved efficiency of the organization. The commenter believes that there should be no attempt to recover that difference and that the only action taken by HCFA should be in reflecting that difference in the ACR for the following contract period. Similarly, another commenter questioned whether an organization could retain the profit it makes if its average per capita expenses are less that its average per capita payment because its Medicare enrollees' utilization was lower than what the organization estimated in calculating its proposed ACR or the organization was able to deliver services at a lower unit cost than it estimated.

Response: We will not attempt to recover the difference between a projected ACR and actual ACR due to improved efficiency or lower utilization because there is no statutory authority for us to do so. However, if this occurs, we will take appropriate action when we review the organization's proposed ACR for the next contract period.

3. *Direct Payment Option.*

Comment: One commenter favored expanding the direct payment option allowed for inpatient hospital services (§ 417.586) to include Medicare Part B services.

Response: The direct payment option for risk organizations is limited in the statute to hospitals and, since the enactment of section 2350(c) of Pub. L. 98-369 (the Deficit Reduction Act) on July 18, 1984, to skilled nursing facilities (SNFs.). (The SNF direct payment option is discussed in detail in section IV.C. of this preamble.) In addition, we believe that eligible organizations should be providing most ambulatory services directly. Not to do so implies that the organization merely arranges for services, which is inconsistent with the definition of a risk organization.

Comment: One commenter suggested that if it is administratively feasible, an organization should be allowed to elect the direct payment to hospital option at the midpoint of its contract period as well as at the beginning of the contract period.

Response: We believe that implementing this suggestion would not be administratively feasible because our system procedures are organized on a contract period basis.

Comment: Since section 1876(g)(4) of the Act states that electing direct payment to the hospital is solely at the option of the eligible organization, one commenter believes that HCFA has no authority to require that it must approve these organizations' request for the option. The commenter suggests that this should be merely a notice, rather than approval, requirement.

Response: We agree with this comment and are removing the approval requirement from the regulations (§ 417.586).

Comment: A commenter states that the NPRM is unclear as to how HCFA will estimate administrative costs applicable to paying hospital bills under the direct payment option.

Response: The initial withholding will be based on an estimate, which includes information furnished by the organization, of the organization's expected hospital utilization. This estimate will be adjusted based on the organization's actual experience.

Comment: A commenter suggested that if an organization elects to have HCFA pay the hospital directly, then HCFA and the organization, instead of only HCFA, should decide on the amount of the withholding HCFA makes from the capitation payment.

Response: Under section 1876(g)(4) of the Act, HCFA is required to decide how much to withhold from the organization's payment rate. However, HCFA would ordinarily use the organization's estimates when calculating the withholding.

Comment: A potential eligible organization believes that there should be a mechanism to protect the organization that elects the direct hospital payment option from an intermediary that makes payment for unauthorized services.

Response: We have had a service lock-in mechanism, such as the one described, in place and operating for almost 10 years. We believe that this procedure will protect the organization.

Comment: A commenter is concerned that if an organization elects to have HCFA make payment to hospitals for Part A services, then HCFA will make that payment under the prospective payment system. The commenter believes that there is no incentive for an organization to reduce length of stay for Medicare enrollees under the prospective payment system. The commenter suggests that HCFA allow other bases for payment if an organization is willing to negotiate a special rate with its affiliated institution. This would allow HCFA to realize savings from an organization's financial incentive strategies.

Response: An organization that does not elect the HCFA payment to hospital option may negotiate any payment method it wants with the hospitals it uses to furnish services to its Medicare enrollees. However, once an organization elects to have HCFA make these payments, then under section 1876(g)(4)(A) of the Act, the payment will be made in accordance with the usual Medicare payment rules (that is, prospective payment or, for hospitals excluded from that system, reasonable cost). Therefore, we have no option to negotiate special rates for HCFA to pay.

Comment: A commenter wanted to know if payment for hospital inpatient services furnished directly by a risk organization to its current nonrisk Medicare enrollees, for whom the organization receives payment on a reasonable cost basis, will be made under the prospective payment system.

Response: Payment for these enrollees will be made under the reasonable cost contract provisions, which include payment under the prospective payment system for hospital inpatient services.

Comment: One commenter suggested that risk organizations be allowed the option of either contracting directly with hospitals or allowing direct HCFA payment to the hospital.

Response: This option is available under § 417.586.

4. *Other Risk Reimbursement Comments.*

Comment: One organization recommended that the regulations should clearly state that an organization with a risk contract may continue to receive reimbursement for its nonrisk Medicare enrollees through health care prepayment plan (HCPP) contracts under section 1833(a)(1)(A) of the Act.

Response: Section 226(b) of Pub. L. 92-603 prohibits an organization that is receiving payment from Medicare for some enrollees under section 1876 of the Act from also receiving reimbursement for other enrollees under other sections of the Act. Therefore, normally, an organization that has a contract with us under section 1876 of the Act for some Medicare enrollees connot, at the same time, be receiving payment from us as an HCPP. However, sections 114(c)(1) and (c)(2) of Pub. L. 97-248 provide exceptions in the case of existing organizations being reimbursed by Medicare on a reasonable cost basis (that is, HCPPs and HMOs) for transition periods during which Medicare may make, under certain conditions, payments on both a reasonable cost and risk basis to the same organization during the time it converts to a risk contract.

Comment: Most of the potential eligible organizations that commented favor our permitting organizations to establish a benefit stabilization fund. This fund would be used by an eligible organization to stabilize both the premium and additional benefits furnished to Medicare enrollees from year to year.

Response: Section 2350(b) of Pub. L. 98-369 specifically permits us to implement such a provision. We are including this change in these final regulations and a detailed discussion of the revisions can be found in section IV.B. of this preamble.

Comment: Another organization expressed confusion about how it will receive payment for its current nonrisk enrollees after it elects a risk contract.

Response: An organization that contracts on a risk basis will continue to be paid on a reasonable cost basis for its current nonrisk Medicare enrollees.

Comment: A physician organization wanted to know how the hospital inpatient service prospective payment system will relate to eligible organization's payment for those services.

Response: If HCFA pays the hospital bills for the eligible organization's Medicare enrollees, the payment will be based on the principles set forth in Subpart D of 42 CFR Part 405, which include payment on a prospective payment basis to hospitals not excluded from that system. If the eligible organization pays the hospital for the services furnished to its Medicare enrollees, the payment method will be negotiated between the organization and the hospital, subject to applicable State law.

Comment: A potential eligible organization is concerned about the requirements related to charging Medicare Part B-only enrollees for Part A services furnished by the organization. Section 417.452(c)(3) states "The sum of the amounts an organization charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services." If the provisions of this paragraph are applied to payment for Part A services for Medicare enrollees who are entitled to Medicare Part B only, the organization will be deprived of its full financial requirements for these members. This results from the fact that the AAPCC will usually be greater than an organization's ACR for Part A

services because an organization's major cost savings is in reduced hospitalization. The regulations should clearly address how the Part B-only Medicare enrollees pay for Part A services under a risk contract.

Response: Under the law (for example, section 1876(a) and (g) of the Act), Part B-only Medicare enrollees are entitled to a different set of benefits from those to which Part A and B enrollees are entitled. This includes both Medicare covered services and the additional benefits that a risk organization must provide its enrollees if the organization's ACR for Medicare covered services is less than Medicare's payment to the organization. This means, in the case of Part B-only enrollees, that Medicare's payment to the organization is only for Part B covered services and the organization is required to provide additional benefits without cost to the enrollee only if the organization's ACR applicable to Part B services is less than Medicare's payment (unless, of course, the organization accepts a reduced payment). These additional benefits may be different, therefore, from the additional benefits the same organization must provide its Medicare enrollees who are entitled to both part A and B services.

The policy set forth in § 417.452(c)(3) is mandated by section 1876(e)(2) of the Act and, therefore, can not be revised. If the organization furnishes services which, if the enrollee was entitled to part A services, would be covered under Part A, we do not have the authority to decide the method the organization uses to collect payment for these services. The organization may devise any method it desires so long as the amount does not exceed the ACR for the service. We have added language to § 417.452 that makes this clear.

However, in reviewing the subject comment, we believe that the regulations need to be clarified, not only with respect to Part A services furnished to a Part B-only Medicare enrollee, but also with regard to other noncovered services furnished to these enrollees if the organization wishes to standardized the benefit package of its Part B-only enrollee with that for its Parts A and B enrollees. Therefore, we have also added language to § 417.452 that provides that if Part B-only enrollees are furnished coverage for a benefits package that is identical to that furnished at no cost to Medicare enrollees who are entitled to both Parts A and B (that is, both Medicare covered services and the additional benefits), the premium (or other payment method) charged the Part B-only enrollees for those services may not exceed Medicare's payment to the organization for the enrollees entitled to both Parts A and B. (In the event that applicable deductible or coinsurance liabilities are not fully satisfied through this payment, or the Part B-only enrollees are furnished other supplementary benefits, the organization could make appropriate additional charges.)

Comment: An actuary objected to the requirement that risk organizations must either accept reduced payment for the difference between the AAPCC and the ACR or make up the difference in additional benefits. The commenter suggests instead that risk organizations should make up only a portion of the difference between the ACR and the AAPCC in additional benefits and accepting reduced payment from HCFA, thus saving HCFA money in all cases.

Response: Section 1876(g)(2) of the Act clearly gives a risk organization the right to elect between furnishing additional benefits or accepting reduced payment to reconcile the difference between its AAPCC and ACR. HCFA can share in the savings only when the organization elects to receive reduced payment in whole or in part.

I. Appeals

Comment: One commenter stated that the beneficiary appeals procedures outlined by these regulations (§§ 417.600–417.638) are too complicated for the elderly who have health problems to understand and that a central authority is necessary to coordinate the appeals process.

Response: We have attempted to construct a grievance and appeals process that affords fair treatment to beneficiaries. Enrollees may request assistance from the eligible organization in filing grievances and appeals under § 417.436. For reconsiderations, hearings, and appeals, enrollees may request assistance from any Social Security office.

Comment: One commenter asked that we verify that contract appeal procedures apply to CMPs as well as HMOs.

Response: Contract appeal procedures discussed in §§ 417.640 through 417.694 apply to all eligible organizations and those seeking to qualify as eligible organizations.

J. Other Comments

Comment: We received a number of comments regarding the procedures under which HCFA will convert current demonstrations projects to contracts under these regulations.

Response: Existing demonstration projects will be required to convert to contracts under these regulations at the earliest possible date. Each demonstration project will be contacted by HCFA's Office of Research and Demonstrations regarding the termination and transition of its project to program status.

Comment: One commenter stated that eligible organizations should be required to establish a Medicare Beneficiary Advisory Board.

Response: The statute contains no provision explicitly dealing with such boards. However, organizations qualifying as HMOs under title XIII of the PHS Act must have HMO members comprise at least one-third of its policy making body (see 42 CFR 110.108(f)). Medicare members could be part of this body.

Comment: One commenter stated that these regulations should be flexible to permit coordination with those governing the Federal employees health benefits plan (FEHBP) and certain other non-Federal programs.

Response: We have not discovered any conflict between Federal regulations governing the FEHBP and these regulations. Any organization that experiences difficulty with coordination of its Medicare contract with FEHBP or other plan contract should contact its servicing HCFA regional office for assistance.

Comment: One commenter requested that enrollment of Medicare beneficiaries in eligible organizations be coordinated with State Medicaid offices.

Response: We plan to keep State Medicaid offices informed of contracts and enrollment where beneficiaries are entitled both to Medicare and Medicaid. State Medicaid offices should contact their servicing HCFA regional office for further details.

Comment: One commenter stated that HCFA should study the differences in quality of services provided by for-profit and not-for-profit organizations.

Response: HCFA intends to monitor the quality of service provided by all organizations receiving contracts under these regulations.

IV. New Legislation

After the NPRM was published on May 25, 1984, Congress enacted, on July 18, 1984, Pub. L. 98–369 (Deficit Reduction Act of 1984). Sections 2322 and 2350 of Division B of that law further amended sections 1861 and 1876 of the Act to provide for the following:

- Organizations with risk contracts can permit the services of clinical psychologists (as defined by the

Secretary), and the services and supplies incident to their services, to be furnished without the direct personal supervision of a physician. (Section 1861(s)(2)(H)(ii) of the Act.)

• The Secretary is required to establish, for each geographic area served by more than one eligible organization, a single 30-day period each year during which all the organizations serving the area must provide for open enrollment. The Secretary must determine an organization's rate of payment in such a way that individuals who enroll during this coordinated open enrollment period will not have premium charges increased or any additional benefits decreased for 12 months after the individuals' effective dates of enrollment. (Section 1876(c)(3)(A)(ii) of the Act.)

• With the Secretary's approval and for a period of less than five years, an organization with a risk contract may have a part of the value of the additional benefits it is required to provide be withheld and reserved by the Secretary for subsequent annual contract periods. These funds would be used to stabilize and prevent undue fluctuation in the additional benefits offered in those subsequent periods. (Section 1876(g)(5) of the Act.)

• Organizations with risk contracts are permitted to elect direct reimbursement by HCFA to SNFs that furnish covered services to the organization's Medicare enrollees. (Section 1876(g)(4)(A) of the Act.)

As a part of this final rule, we are implementing all but the second provision mentioned above (that is, sections 2322 and 2350(b) and (c), respectively). We plan to implement section 2350(a) in a separate rulemaking document because of the complexity of the issues involved.

A. Services of Psychologists

As stated above, section 2322 of Pub. L. 98-369 amended section 1861(s)(2)(H) of the Act to allow the services of clinical psychologists, and the services and supplies incident to their services, to be furnished in organizations with risk contracts without the direct personal supervision of a physician. We have included this provision in § 417.416(d)(2). The statute also directs us to provide a definition of clinical psychologist. We have decided to include in these regulations a definition that is similar to the definition (contained in § 405.1038(e)(1)) of the psychologist who is the staff director of the psychology department or service in a psychiatric hospital, but that also contains language adopted from the original Senate amendment that added this provision to the law.

B. Benefit Stabilization Fund

Section 2350(b) of Pub. L. 98-369 amended section 1876(g)(2) of the Act and added section 1876(g)(5) to the Act to permit an organization with a risk contract to set aside in a benefit stabilization fund a part of the value of the additional benefits the organization must provide when its ACR is less than the average of the per capita rates of payment to be made to the organization. The establishment of such a fund must be approved by us and will not be available for use by the organization for more than four years. The fund is to be used by an organization during subsequent contract periods to the extent required to stabilize and prevent excessive fluctuation in the additional benefits offered during those subsequent periods.

The statute specifies that the monies withheld for the purpose of establishing a benefit stabilization fund are to be reserved in the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Trust Fund. Any amounts that remain in a stabilization fund after the four year period expires will revert to the Trust Funds.

In addition to these requirements, section 2350(b)(3) of Pub. L. 98-369 states that we may not approve the establishment of a benefit stabilization fund under section 1876(g)(5) of the Act for any contract period beginning after July 18, 1988. The provisions of section 2350(b) are implemented in §§ 417.596 and 417.597 of this final rule and are explained below.

1. *Limitations on amounts withheld.* Since a benefit stabilization fund is intended only to prevent excessive fluctuations in the provision of additional benefits to Medicare enrollees by risk organizations, we believe that it was the intent of Congress that a limitation should be placed on the amount an organization can request to be withheld. The Conference Committee Report accompanying Pub. L. 98-369 states that although it is the organization's option to request establishment of a fund, "... the amounts withheld would be approved and held by the Secretary. The Secretary would establish limits on the amounts withheld to assure that they do not exceed the minimum levels necessary for reasonable benefit stabilization, taking into account the requirements of individual plans." (H.R. Rep. No. 98-861, 98th Congress, 2d Session 1334 (1984).) A limit on the amounts to be set aside is necessary to protect beneficiaries in situations in which an organization might use a stabilization fund to reduce the value of the additional benefits it offers. The limit will also protect against the possibility that an organization could set aside excess amounts of money so that in a future contract period it could offer an additional benefit package of such high value that it would be unfair competition to other organizations in the area.

Accordingly, we have decided to limit the amount an organization may have withheld during any contract period to 15 percent of the difference between the ACR and the average of the per capita rates of payment made to the organization for that contract period. However, an organization will never be permitted to accumulate in its fund more than 25 percent of the difference between the ACR and the average of the per capita rates of payment for a given contract period. For example, if during an organization's first contract period, the difference between its ACR and the average of the per capita rates of payment is $100,000, then the organization may set aside $15,000. If during its second contract period, the difference is $110,000 and the organization does not withdraw any money from its fund, it will be permitted to add only another $12,500 to its fund, assuming that it has made no withdrawals, so that the total in the fund does not exceed $27,500 (25 percent of $110,000).

If an organization can demonstrate that the value of the additional benefits it provides to Medicare enrollees fluctuates substantially in excess of 15 percent demonstrates the need for an exception to the 15 percent limit for each contract period, we may grant such an exception.

2. *Use of the fund.* Since the purpose of a fund is only to stabilize additional benefits from one contract period to another, the statute does not allow an organization to use the amounts withheld in the fund to finance any losses the organization suffers in its regular business. Thus, the fund may not be used in the contract period in which the monies were withheld in order to cover reserve requirements of the organization or to prevent the organization from losing money. Similarly, an organization will not be permitted to withdraw monies from its fund to refinance prior contract period losses.

3. *Establishment of and withdrawal from the fund.* Section 417.596 specifies that the risk organization must notify us of its desire to establish a benefit stabilization fund or to add money to a

fund that was previously established at the same time it submits its ACR, that is, no later than 45 days before the beginning of the contract period. As mentioned above, the amount of the fund may not exceed 25 percent of the value of the additional benefits the organization must provide during the current contract period. We will review the organization's request and determine if it is appropriate.

The monies that are withheld for the purpose of a benefit stabilization fund will be reserved in the Medicare Trust Funds. Since the amounts withheld in the stabilization fund are reduced payments in the year in which they are withheld from the organization, recommitment of the funds to the organization in the subsequent years represents an additional amount to the payment that the organization would normally receive. Thus, during the period when the monies were held in the stabilization fund but not paid out, they are not to be treated as obligations by the Trust Funds. Therefore, no interest is earned on these monies by the organization during the period they are withheld in a benefit stabilization fund.

The organization's request for a withdrawal of monies from the stabilization fund for a subsequent contract period must be made at the same time as the organization's submittal of its ACR for that contract period. The organization must—

- Indicate how it intends to use the withdrawn amounts;
- Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;
- Document the organization's experience in fluctuations of revenue requirements relative to the additional benefits provided to Medicare enrollees; and
- Document the organization's experience during its previous contract period to assure us that any losses suffered during that period are not being refinanced through the withdrawal from the stabilization fund.

We will approve an organization's request for a withdrawal of monies from its stabilization fund for an upcoming contract period only if one of the following circumstances occurs:

- The organization's average of its per capita rates of payment for that contract period is less than that of the prior contract period.
- The organization's ACR for that contract period is significantly higher than that of the prior contract period.
- The organization's revenue requirements in that contract period for providing the additional benefits it provided during the prior contract period is significantly higher than the requirements for that previous period and the ACR for the upcoming contract period results in an additional benefits package that is less in total value than that of the prior contract period.

Payment of monies withdrawn from a benefit stabilization fund will be made in equal monthly amounts throughout the contract period. These amounts will be added to the organization's monthly per capita payment.

As specified in section 1876(g)(5) of the Act, any amounts that remain in an organization's benefit stabilization fund after the fourth year after it was established will revert to the Medicare Trust Funds. Also, as noted above, we will not approve the establishment of a benefit stabilization fund for any contract period that begins after July 18, 1988.

C. Direct Payment to SNFs

Section 2350(c) of Pub. L. 98-369 amended section 1876(g)(4)(A) of the Act to permit organizations with risk contracts to elect direct reimbursement by HCFA to SNFs that furnish services to the organizations' Medicare enrollees. We plan to implement this provision in the same way we proposed to implement the direct HCFA payment to hospitals option in the NPRM (49 FR 22208 and § 417.586).

An organization that wishes to elect direct payment to SNFs will submit a written request to us before the organization's contract period begins. The election would be binding for the entire contract period. We will pay SNFs directly for the covered Medicare services furnished to the organization's Medicare enrollees. The payment made will be equal to the amount HCFA would pay the SNF for Medicare beneficiaries not enrolled in the organization.

Each month we will deduct from the organization's per capita payment an amount we estimate we will be paying to SNFs on behalf of the organization's Medicare enrollees and administrative costs we expect to incur in making these payments to SNFs. This amount will be adjusted as necessary to allow us to retain sufficient funds with which to pay the SNF bills.

If the contract between HCFA and the organization is not renewed or is terminated, we will retain the balance of the amounts withheld from the organization's payment for three years after the expiration of the contract.

The organization must agree to accept liability for and to provide to us the additional necessary funds if—

- During the contract period or the subsequent year, we do not have sufficient funds on hand from the withheld amounts to pay the SNF bills of the organization's Medicare enrollees; or
- After we return any balance of amounts withheld to the organization, we receive additional SNF bills that cover services furnished during the organization's contract period.

V. Effective Dates

As specified in section 114(c)(1) of Pub. L. 97-248, the provisions of amended section 1876 of the Act must apply with respect to services furnished on or after the initial effective date of the statute, except in certain circumstances as explained below. Section 114(c)(4) defines the initial effective date as the later of—

—October 1, 1983, or

—The first day of the month after the month in which the Secretary notifies Congress that the Secretary is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented.

As we discussed above, the methodology is described in the addendum to this final rule. However, until the Secretary provides to Congress the required certification concerning the methodology, the initial effective date of the amended section 1876 of the Act remains undetermined. Therefore, although the regulations in the new 42 CFR Part 417, Subpart C are being issued as part of this final rule, we are unable to implement them until the first day of the first month after the month in which the certification process is complete. We note this fact in § 417.402 of the new regulations, and we plan to issue an amendment to that section in the **Federal Register** to enter a certain effective date as soon as that information is available to us.

In addition, however, we emphasize that the regulations we revised and transferred from 42 CFR Part 405, Subpart F (§ 405.692) and Subpart T (§§ 405.2093–405.2098) into the new 42 CFR Part 417, Subpart D are operative on the effective date of this final rule as indicated in the beginning of this preamble. Moreover, as explained below, special considerations apply to certain Medicare beneficiaries and organizations involved in changing circumstances because of the provisions in the amended section 1876 of the Act concerning risk contracts and existing demonstration projects.

If a beneficiary is enrolled in an eligible organization receiving reasonable cost reimbursement under either section 1876 of the Act as it existed prior to the enactment of Pub. L. 97-248 or section 1833(a)(1)(A) of the Act and that organization enters into a new risk contract, the services furnished to that beneficiary will not be subject to the amended section 1876 of the Act as implemented in these final regulations unless—

- The individual requests at any time that the amended provisions apply, or
- HCFA determines at any time that the amended section 1876 of the Act must apply to all Medicare enrollees of the organization because it is not cost effective or administrative by feasible not to include these enrollees under the new risk contract and HCFA informs, in advance, each effected member of the organization.

Also, unless the organization requests an earlier application, the amended section 1876 of the Act will not apply for five years after the initial effective date if the organization has an existing risk-basis contract under current 1876 of the Act on the initial effective date. This exception also applies to organizations that were furnishing services under a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b-1) or under section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b-1 (note)) as of the date of enactment of Pub. L. 97-248 (September 3, 1982), if the project was concluded before the initial effective date and the organization entered into an existing risk-basis contract before the initial effective date.

The provisions of amended section 1876 of the Act would also not apply to services furnished by an organization during the period of an existing demonstration project if the organization was furnishing services under that project on the initial effective date and the project concludes after that date. However, we believe that once these regulations are operative, there will no longer be a need to conduct HMO risk demonstration projects operating under provisions similar to those of section 1876 of the Act as amended by section 114 of Pub. L. 97-248. HCFA conducted several demonstration projects that tested the HMO risk model before section 114 of Pub. L. 97-248 was enacted. Now that section 1876 of the Act has been amended to include some of these tested concepts, we no longer need to continue these types of demonstrations. Therefore, after the publication date of these final regulations, we do not plan to accept any new risk demonstration projects that would operate under provisions similar to those of section 1876 of the Act as amended by section 114 of Pub. L. 97-248, nor extend any of these projects that are currently in effect.

Finally, an eligible organization that is receiving reimbursement on a reasonable cost basis under current section 1876 of the Act or section 1833(a)(1)(A) of the Act on the initial effective date and then enters into a new risk contract may receive payment under that new contract for current, nonrisk Medicare enrollees only to the extent that the organization enrolls two new Medicare enrollees for each nonrisk enrollee.

VI. Summary of Changes

We are adopting the provisions set forth in the NPRM except for the following changes.

A. Changes Resulting From Public Comment

The following are the changes we are making to the proposed regulations based on public comment. These changes are discussed in detail in section III of the preamble.

1. In § 417.401, we revised the definition of urgently needed services to clarify that the need for these services must result from an unforeseen illness or injury.

2. We added a new paragraph (b) to § 417.406 to provide that the Assistant Secretary for Health has the responsibility for overseeing the continued compliance of eligible organizations.

3. We deleted § 417.410(f)(3), which permitted CMPs that offer less than all required services to become eligible organizations.

4. We revised § 417.413(c)(2) to allow an organization to contract with us on a reasonable cost basis even though it does not have at least 75 Medicare enrollees as long as it has a plan for reaching this enrollment level within two years.

5. In § 417.413, we revised paragraph (d)(3) to delete the 75 percent limitation and added a new paragraph (e) to allow current HCFA demonstration projects a special exception to the composition of enrollment standard. Former paragraph (e) was redesignated as paragraph (f).

6. To clarify our policy on coverage of hospice care for Medicare enrollees of eligible organizations, we revised §§417.414, 417.420, 417.422, and 417.440 and added §§ 417.531 and 417.585.

7. We revised § 417.414(c)(2) to clarify when organizations are financially responsible for services furnished by other sources to a Medicare enrollee.

8. We revised § 417.426(c) to allow organizations to set aside a reasonable number of vacancies for anticipated new members of an existing group contract, as well as for an anticipated new group contract.

9. We revised § 417.428 by deleting the preapproval requirement for marketing material (paragraph (a)(2)), removing the word "unethical" from the description of prohibited marketing practices (paragraph (b)(1)), and adding door-to-door solicitation as a prohibited marketing activity.

10. In § 417.432, we added new paragraphs (b), (c), and (d), redesignated proposed paragraphs (b) and (c) as (e) and (f), and revised redesignated (e)(1) to—

- Clarify the effective date of the conversion of enrollees of an organization who became entitled to Medicare;
- State that organizations may not disenroll these converted enrollees unless one of the disenrollment conditions specified in § 417.460 is met;
- Provide that converted enrollees must sign an application form as Medicare enrollees; and
- Revise the time frame within which organizations must inform us of the impending conversion of an enrollee.

11. We revised § 417.436 to provide that an organization must inform its Medicare enrolless of any changes in its membership rules 30 days prior to making the change and that the organization must maintain written rules on enrollee obligations regarding permanent moves by enrollees out of the organization's geographic area.

12. We revised § 417.440(b)(2) to prohibit all organizations from health screening Medicare enrollees for any service offered by the organization.

13. In § 417.442, we revised paragraph (b) to allow risk organizations whose AAPCC exceeds their ACR to elect to receive partially reduced payment and to furnish Medicare enrollees with additional benefits to make up the difference.

14. We revised § 417.448 to clarify the restriction on obtaining services outside the risk organization for Medicare enrollees who move out of the organization's geographic area.

15. We revised § 417.452 to clarify our policy regarding how much an organization may charge its Medicare Part B-only enrollees for services beyond those covered under Part B.

16. We revised the definition of "amounts incorrectly collected" set forth in § 417.456(a) to clarify that it includes amounts collected when the Medicare enrollee was believed not to be entitled

to Medicare benefits and is later determined to have been entitled and Medicare is liable for the payments.

17. In § 417.456, we also revised paragraphs (b), (c), (d), and (e) to clarify that the provisions of that section apply to both reasonable cost and risk organizations. The same revision was made to § 417.458(a).

18. In § 417.460, the following changes were made:

- We revised paragraph (a)(1)(iii) to clarify that both cost and risk organizations may not disenroll a Medicare enrollee for failure to pay a premium for optional supplemental benefits.
- We added a provision to paragraph (a)(2) to allow an organization to retain an enrollee as a member even if he or she plans to permanently move out of the area and to clarify that the lock-in restriction does not apply to those enrollees.
- We added a new paragraph (a)(6) and redesignated the proposed paragraph (a)(6) as paragraph (a)(7) to allow an organization to disenroll a Medicare enrollee for cause if the organization meets certain procedural requirements.
- We added a new paragraph (b)(4) to state that an organization that does not inform HCFA on a timely basis about the disenrollment of a Medicare enrollee must reimburse HCFA for any capitation payments received after the month in which payments would have ceased if the information had been provided timely.

19. We added a new § 417.481 to describe the types of records a risk organization must maintain.

20. A new paragraph (d) was added to § 417.482 to provide that an organization must agree to allow HCFA to evaluate, through inspection or other means, an organization's enrollment and disenrollment records.

21. In § 417.492(b)(4), we revised the language to clarify that, if HCFA decides not to renew an organization's contract, the organization may appeal the decision only if the decision was based on one of the reasons specified in § 417.640(c).

22. We added a new paragraph (c) to § 417.494 to permit an organization to terminate its contract with us if we fail to carry out the terms of the contract.

23. We revised § 417.532 to provide that the total amount payable to reasonable cost organizations will be limited by the organization's AAPCC. The effective date of this change is delayed until contract periods beginning on or after January 1, 1986, for existing cost organizations.

24. We revised § 417.546 to eliminate the application of the reasonable charge limitations set forth in Subpart E of 42 CFR Part 405 to physician compensation. The effective date of this change is delayed until contract periods beginning on or after January 1, 1984 for existing cost organizations.

25. We revised § 417.562 to eliminate the weighting factor used in determining the reasonable costs of Part B direct professional services for contract periods beginning on or after January 1, 1986.

26. We changed § 417.594(b)(3)(ix) to read "general and administrative" rather than "overhead" to be consistent with usual accounting principles.

27. We revised § 417.594 to clarify how a risk organization calculates its ACR.

B. Changes Resulting From Pub. L. 98–369

1. In § 417.416, we are revising paragraph (c) and adding a new paragraph (d) to allow clinical psychologists to furnish services in risk organizations without the direct personal supervision of a physician.

2. We revised § 417.586 to allow risk organizations to elect direct HCFA payment to SNFs as well as to hospitals.

3. We added new §§ 417.596 and 417.597, redesignated the proposed § 417.596 as § 417.598, and revised §§ 417.401, 417.442(b), 417.592(c), and 417.594(b) to permit a risk organization to have a part of the value of the additional benefits it is required to provide withheld and reserved in a benefit stabilization fund to be used in subsequent contract periods to stabilize and prevent undue fluctuation in those additional benefits.

C. Miscellaneous Changes to Part 417

1. We added a definition for adjusted community rate (ACR) to § 417.401. Also in that section, we corrected the definition of a reasonable cost reimbursement contract by deleting the incorrect reference to section 1833(a)(1)(A) of the Act.

2. As mentioned above in section V. of this preamble, we added a new § 417.402 to indicate that Subpart C of Part 417 is not effective until the first day of the first month after the month in which the Secretary certifies the AAPCC methodology.

3. In § 417.416, we revised paragraph (a) and added a new paragraph (e) to implement the provisions of section 1876(c)(4)(A) of the Act, which are concerned with accessibility, availability, and continuity of care furnished by organizations to their Medicare enrollees. We inadvertently omitted this qualifying standard from the conditions proposed in the NPRM.

4. We revised § 417.424(b) by changing the phrase "ten percentage points" to "ten percent" to make it consistent with § 417.413(f)(2).

5. We deleted § 417.444(a)(1)(iii), which stated that current nonrisk Medicare enrollees must be selected to convert to risk enrollees in an unbiased manner. This provision is unnecessary because paragraph (a)(1) deals with the one-time conversion of *all* current nonrisk Medicare enrollees; therefore, there is no need to select the enrollees on any basis.

6. We added a provision to § 417.460(a)(4) that requires an organization to report to the HHS Inspector General any disenrollment of a Medicare beneficiary for fraudulent practices.

7. We revised § 417.472 by adding a new paragraph (e) to ensure an organization's compliance with civil rights laws and by adding a new paragraph (f) to implement the provisions of section 1876(i)(5) of the Act. Section 1876(i)(5) of the Act authorizes the Secretary to administer contracts with eligible organizations without regard to other laws and regulations concerning contracts if any of these laws or regulations are inconsistent with the efficient and effective administration of the Medicare program.

8. We revised § 417.474(c) to specify that the initial term of a contract can be anywhere from 12 to 23 months, but any term subsequent to that must be 12 months. We made this change to clarify exactly what is meant by "a contract period."

9. In § 417.528, we revised paragraphs (a) and (c) and added a new paragraph (d) to specify more clearly the role eligible organizations must play in identifying and collecting payment from payors that are primary to Medicare. This section now specifies that organizations must identify the primary payors, the amounts payable by them, and determine the costs associated with services furnished to Medicare enrollees for whom the primary plan or insurer is liable. Organizations reimbursed on a reasonable cost basis must provide this information to ensure that Medicare reimbursement is not made for these costs. In the case of risk organizations, this information is necessary to ensure that the ACR reflects the organization's revenue requirements.

10. We revised § 417.564 to clarify how administrative and general costs are apportioned and allocated in reasonable cost organizations.

11. In § 417.586, we revised paragraph (d) to provide that we will retain the balance of withheld funds for direct payment to hospitals and SNFs for a period of three years. Although the NPRM (49 FR 22208) proposed that these funds would be retained for only one year, we did state that we were considering retaining them for the same period of time we allow Part A claims to be submitted. We received no comments on this issue, but we have decided to make the change.

12. We have revised § 417.594(e)(2) to specify a risk organization's appeal rights with respect to our determination that the ACR submitted by the organization is not acceptable. If, as a result of a hearing conducted under the provisions of this section, our determination is revised, we will make appropriate adjustments to the ACR and, if the revised ACR is less than the organization's average of its per capita payment rate, the organization will have a new opportunity to determine what additional benefits it wants to provide or whether it wants to accept a reduced payment from us.

13. We added a new paragraph (b) to § 417.606 to describe those actions that are not initial determinations. This section was inadvertently omitted from the NPRM.

D. Redesignations and Corrections

1. In the NPRM (49 FR 22199), we stated that we intended to move the current Part 405, Subpart T regulations (which deal with the requirements for HMOs set forth in section 1876 of the Act before it was amended by Pub. L. 97–248) to Subpart B of Part 417. As part of this final rule, we are redesignating §§ 405.2001 through 405.2092 of Subpart T as a new Subpart B of Part 417. We have also redesignated §§ 405.2093 through 405.2098, which deal with reimbursement for health care prepayment plans (HCPPs), as a new Subpart D in Part 417. In addition, we have redesignated § 405.692 as a new § 417.801. A redesignation table for Subpart T of Part 405 is located at the end of this preamble.

2. We are also correcting an error that was made in FR Doc. 82–35354 (the Health Care Prepayment Plans final rule published December 30, 1982). On page 58258 of that document, in the second column, under item 4.b., we inadvertently omitted paragraph (g)(3) from § 405.2042 (redesignated as § 417.242). We have added that paragraph back in as a part of this document. In addition, we are revising paragraphs (g)(1), (g)(2), and (h) of that section to change incorrect cross-references and to make other minor technical changes.

VII. Impact Analysis

A. Introduction

A preliminary analysis of the impact of these regulations was included in the proposed rule published May 25, 1984.

The purpose of that analysis was to fulfill, in combination with the preamble, the requirements of Executive Order 12291 and the Regulatory Flexibility Act of 1980 (5 U.S.C. Chapter 6).

Executive Order 12291 requires that, for any major rule, a regulatory impact analysis be performed and made available to the public. A "major rule" is defined as one that would:

- Result in an 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 (RFA) requires us to prepare and publish a regulatory flexibility analysis for regulations for which a notice of proposed rulemaking is utilized 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, we treat all providers and suppliers participating in Medicare as small entities.

Under both the Executive Order and the Regulatory Flexibility Act, such analyses must, when prepared, examine regulatory alternatives that minimize unnecessary burden or otherwise assure that regulations are cost-effective.

In considering whether the proposed regulations required a regulatory impact analysis or regulatory flexibility analysis, we determined that they would not, in themselves, meet the criteria for a major rule under the Executive Order. However, we determined that the proposed rules would have a significant impact on a substantial number of HMOs, CMPs, and other suppliers of services. Therefore, although a regulatory impact analysis was not required, we did perform an initial regulatory flexibility analysis meeting the requirements of section 603 of the RFA.

Based on comments received on, and further study of, the proposed rules, and especially considering the recent rate of growth of prepaid plans and enrollment in those plans, we have carefully reconsidered these determinations. We believe that in combination with other developments and trends, these regulations may contribute to extensive changes in the health care marketplace that would significantly impact most providers and suppliers participating in the Medicare program. We recognize that it can be argued that the changed incentives of the system could result in economic consequences, particularly in view of economic effects beyond the immediate change in the level of program expenditures, exceeding $100 million annually in subsequent years, meeting the primary Executive Order definition of a "major rule".

For these reasons, we have chosen to prepare the analysis we would be required to prepare if these final regulations were a major rule under Executive Order 12291. In the discussion below, we discuss the expected impacts of these regulations and summarize our expectations of their net effect. This discussion, combined with the rest of this preamble, constitutes a voluntary final regulatory impact analysis and a final regulatory flexibility analysis meeting the requirements of Executive Order 12291 and the RFA.

B. Objectives of These Regulations

The purpose of these regulations is to implement section 114 of Pub. L. 97–248. We expect this to encourage the growth, participation in Medicare, and increased prepaid Medicare beneficiary enrollment of HMOs and CMPs, and believe economies and efficiencies in the delivery of health care services will result. HMOs have shown that they can reduce hospitalization and utilization of high cost medical services will result. Successful competition of HMOs and CMPs with providers and suppliers of services in the fee-for-service sector should produce changes in that sector also. Since prepayment plans have stronger incentives to control costs than the fee-for-service sector, their success and example are expected to restrain the rate of growth of health care costs generally. Our intention is to restrain health costs while continuing to maintain quality of care throughout the health care system.

Medicare has been supporting demonstrations of prepaid HMO plans throughout the country since 1978. Thousands of elderly or disabled beneficiaries have enrolled in these demonstrations. These projects have shown that prepayment plans can work for Medicare and that Medicare beneficiaries will opt for HMO-type

coverage when they understand the advantages for them. Therefore, we expect these regulations to result in a substantial increase in prepaid enrollment for Medicare beneficiaries—perhaps to as many as 800,000 beneficiaries in the next three to four years, and possibly as much as a 50 to 100 percent increase in the number of contracts between prepayment plans and Medicare.

Under these regulations, beneficiaries will be enabled to enroll in an HMO or CMP to participate in plans based on preset rates paid in advance, thus obtaining full coverage at a fixed price. Participating risk-based plans would provide coverage of all Medicare covered services for a preset amount. That means they have the incentive to deliver quality care—including preventive care—at the lowest possible cost. In the past, Medicare has not taken full advantage of those incentives. Instead, through reimbursement of the "reasonable costs" of most participating HMOs, Medicare simply paid more when needed care cost more.

Despite an expected initial increase in Medicare program costs, as discussed below, we believe it is important to implement this new program. There are several reasons. First, Congress intended that Medicare beneficiaries should be afforded a choice of alternative health plans. Section 114 of Pub. L. 97-248 and these regulations are designed to afford this choice to a larger number of beneficiaries than previous law and regulations allowed. Second, we believe that prepayment plans are more efficient than more traditional forms of health care delivery. Finally, the opportunity for a beneficiary to receive enhanced benefits if the HMO in which he or she is enrolled can operate below 95 percent of AAPCC represents a significant benefit.

We also believe that these rules will to some extent, correct perverse incentives currently affecting competition and productivity in the health care sector of the economy. In our view, the anticipated effects of these regulations will have a beneficial impact on competition and productivity by increasing both, and will also have a beneficial effect by encouraging innovative means of delivering health care services.

C. Problems of Quantifying the Impacts

We expect these rules to result in net costs to the Medicare program in the first years of their implementation. We are currently paying, and presumably would continue paying if these regulations were not implemented, significantly less than 95 percent of AAPCC for many enrollees under cost contracts, and will pay more for each of these enrollees converted to a risk basis. We believe that, in the absence of these regulations, the Medicare program initially would have saved more from beneficiaries' enrollment in HMOs under cost contracts. However, for the reasons discussed below, we have determined that quantitative estimates of costs and savings would be arguable and that a general discussion of the various changes in incentives and types of expected impacts from these rules would be more useful.

As described in the NPRM, we estimated, using United States Per Capita Cost (USPCC) figures taken from the 1983 Reports of the Trustees of the Medicare Trust Funds, that net Medicare program costs would increase by $30 million in FY 1985 and $65 million in FY 1986 as a result of the NPRM. We made certain key assumptions, concerning the number of HMOs and CMPs expected to participate, and the rate of growth in the number of Medicare enrollees. We assumed that—

- Under existing contract provisions, Medicare HMO enrollees would increase at a rate of 10 percent annually, half of which would be due to age-ins (that is, due to persons already enrolled in HMOs and CMPs becoming eligible for Medicare).
- Under the NPRM, Medicare HMO enrollees would increase at a rate of 15 percent annually; that is, five percent more per year than under existing contracts.
- HMOs and HCPPs representing half of the present Medicare HMO enrollees would elect risk contracts.
- On the basis of covered services only, risk-basis HMOs and CMPs would operate, on the average, at 80 percent of what Medicare would pay on the basis of reasonable costs and charges for those services if they were furnished to a given individual by providers and suppliers in the fee-for-service sector.
- HMOs and CMPs would enroll, age-in, and convert relatively young people who are seldom institutionalized or on welfare, compared to the total Medicare beneficiary population.
- Selective enrollment, discriminating against higher-risk, higher-cost beneficiaries, would be largely avoided through administrative protections.
- HMOs and CMPs would concentrate in urban areas with costs 15 percent above USPCC for Part A and 30 percent above USPCC for Part B.

We pointed out that we believed the cost estimates could be somewhat lower if HMOs and CMPs were assumed on the average to be operating at 85 percent rather than 80 percent of the AAPCC, if there were antiselection, and if the HMO and CMP population growth rate resulting from these regulations were 20 percent rather than 15 percent, and if half of the new growth were to occur in new HMOs and CMPs and other than existing plans where the conversion option can be exercised. We also explained that actual resulting net Medicare program expenditures could be higher than the estimates if persistent biased selection were to occur.

As is clear from the above, we were careful in the proposed rule to qualify our assumptions and estimates, and to explain that different assumptions would yield different estimates. Since then, developments have shown the vulnerability of any set of assumptions that might be chosen for purposes of making such estimates. For example, recent reports show that during 1983 the rate of growth of prepayment plans and their enrollment, including Medicare enrollment, far exceeded what we had anticipated. The market for HMO and CMP services may be much more volatile, and hence unpredictable, than it has been heretofore. Various publications have also continued the debate about the relative impact of adverse (or favorable) selection on the costs and savings experienced by prepaid plans. For example, a recent RAND Corporation report* gives support to the HMO proponents who argue that efficient HMOs achieve savings as a result of reduced hospital utilization, preventive care, and the cost-neutral and volume-neutral financial incentives for physicians in a prepaid group practice setting. However, it is not at all clear that the study results could be generalized to a growing population of Medicare enrollees, or to all types of prepaid plans.

We are also making changes from the NPRM in these final regulations that could affect the behavior of HMOs in ways not easily taken into account in the estimating process. For example, by revising the rules applicable to cost contracts, we will probably affect how strongly HMOs converting from cost to risk contracts would encourage cost enrollees to convert to a risk basis. Due to the two-for-one rule, this will also affect their marketing targets for new enrollees. For many of the provisions of these regulations, even though the direction of incentives may be known, the real degree of resulting behavior

*Manning, William G., and others, "A Controlled Trial of the Effect of a Prepaid Group Practice on Use of Services." *New England Journal of Medicine*, Vol. 310, No. 23: June 7, 1984: pages 1505 to 1510.

change is not predictable. Finally, the recent enactment of Pub. L. 98-369 has resulted in changes to the Medicare statute that will affect HMO behavior, including the provisions concerning benefit stabilization and coordinated open enrollment, the latter of which will be implemented later.

Since it is not possible to develop a reliable quantitative analysis and comparison of the costs and benefits to all the various affected parties, we have instead made an effort to explain the kinds of interactions, and the decisions that those parties will have to consider. Therefore, we believe that the approach we have taken in the specific impact discussions below is the best feasible.

D. Numbers and Types of Prepaid Plans Participating in Medicare

Many potentially eligible HMOs and CMPs have indicated their interest in participating under the amended section 1876 of the Act and these regulations. The attraction of a prospective rate, an opportunity to share risk, and significantly fewer paperwork requirements are the stated reasons for such interest. Generally increased participation of HMOs and CMPs, and increased Medicare enrollment in participating organizations can be viewed as benefiting both those organizations and the beneficiaries.

There are a number of different ways that prepaid medical services may be organized. The necessary common elements are that the organization act both as insuror and as a health care delivery system. The organization may furnish services directly, arrange to have them furnished, or both. Some eligible organizations own their own facilities, including hospitals. Others provide services primarily through the offices of physicians who may also have a fee-for-service practice. Generally, HMOs and CMPs can be classified in terms of the relationship of the organization to their physicians, as follows:

- *A staff HMO or CMP* delivers services at one or more central locations through its own physicians who are employees of the plan;
- *A group practice HMO or CMP* contracts with a group of physicians to provide care at one or more sites;
- *An individual practice association (IPA)* contracts with doctors in the community, who practice out of their own offices and see HMO or CMP members there; and
- *A network HMO or CMP* contracts with more than one medical group or IPA organization to deliver care to plan members in different geographic locations. Each medical group or IPA provides a full range of comprehensive benefits and is contractually linked to a central point of accountability. Sometimes network plans are classified among IPAs.

Currently, there are about 335 prepayment plans operating in the country, of which around 210 are Federally-qualified HMOs. Most of these prepayment plans do not currently have Medicare HMO (or HCPP) contracts. They receive Medicare payments on the same basis as physicians and other suppliers in the community.

Under existing regulations, a prepayment plan may participate in Medicare as an HMO in three ways. A Federally-qualified HMO may enter into a cost contract; a risk-sharing contract; or a risk-basis demonstration project. In each of these cases, the plan would furnish all services covered under Part A and Part B. In addition, whether or not it is a Federally-qualified HMO, a prepayment plan may participate in Medicare as an HCPP under section 1833(a)(1)(A) of the Act, furnishing Part B services only, and reimbursed on a reasonable cost basis.

As of June 1, 1984, 133 prepayment plans were participating in Medicare, with numbers and enrollment as follows:

Type of contract	Number*	Estimated number of Medicare enrollees (thousands)
Cost contract	62	100
Risk-sharing contract	1	30
Risk demonstration	26	170
HCPP	44	575
Total	133	875

*These numbers exclude four contracts not actively operating.

The risk-basis demonstration HMOs are currently paid at 95 percent of AAPCC. When these regulations are implemented, those demonstrations that operate similarly to what the provisions of section 114 of Pub. L. 97-248 provide for will convert to new risk contracts. We also expect a number of HMOs currently participating under cost contracts and as HCPPs to choose to convert to risk contracts. The one plan currently participating under a risk-sharing contract may continue for up to five years, or the organization may elect either a risk or a cost contract under these regulations.

We estimate that in the next few years, at least half and perhaps as many as two-thirds (150 to 200) of the existing potential eligible organizations will choose to participate in this program under risk contracts subject to these regulations. As a result, we expect the numbers of HMO cost contracts and cost-reimbursed HCPPs may decline. In addition, new potential eligible organizations may be formed. However, we have no basis on which to estimate how many of these there may be.

E. Enrollment

As of June 1984, there were more than 14 million people enrolled in HMOs in this country. This is roughly six percent of the population. It is unlikely that in the short run this proportion of the Medicare population will enroll. There are currently about 30 million Medicare beneficiaries, of which about 1.8 million would have to be enrolled in HMOs or CMPs to achieve a comparable percentage. Nonetheless, we do expect these rules to result in increased Medicare enrollment in HMOs.

As of June 1984, there were about 875,000 Medicare beneficiaries enrolled in HMOs and HCPPs. (Of these, about 200,000 are already paid for on a risk basis under either an existing risk-sharing contract or demonstrations.) This represents an increase of about 145,000 just in the last year. Risk demonstration HMO enrollment alone increased by more than 100,000 in the year from June 1983 to June 1984. We believe this demonstrates an increase in both marketing to the Medicare population and an increased willingness of the elderly to enroll in prepayment plans.

In the proposed rule, we projected that in the next three to four years (the time we expect it to take for this new program to become fully implemented) about 250,000 to 600,000 additional Medicare beneficiaries would enroll in HMOs and CMPs. This was not an actuarial estimate. Estimation of the total rate of growth under both risk and cost contracts is technically difficult, because we were uncertain as to the extent to which the rate of growth of risk enrollees would be at the expense of the growth of cost enrollees. Therefore, we made a projection stated in terms of a wide range.

The recent increase in the rate of growth of HMO enrollment suggests that the NPRM estimate may have been understated. Total national enrollment in HMOs increased by 9.5 percent just in the last 6 months of 1983, and Medicare enrollment in prepayment plans increased by nearly 20 percent in the year ending in June 1984. Just continuing these trends will result in an increase of over 600,000 in the next three years, equaling the upper limit of the range of the previous estimate. As a result, we now believe it is more realistic to expect Medicare enrollment in these plans to

increase by 400,000 to 800,000 over the next three to four years.

Given these estimates, a series of additional calculations can be made. Specifically, 400,000 to 800,000 new enrollees spread throughout 150 participating HMOs means each HMO would attract, on the average, 2,700 to 5,300 new Medicare enrollees. Since average HMO enrollment is approximately 47,000, this would represent roughly a 5 to 10 percent increase in enrollment for the average HMO.

We believe that an HMO's ability to attract new enrollees is dependent to some extent on the stage of development of the HMO, since size and maturity appear strongly correlated to recruitment capabilities. However, many other factors are also important. For example, size may work against an HMO that has achieved great market penetration in a locality, since a high proportion of the potential enrollees would already have been recruited. Another important factor is the marketing behavior of HMOs and CMPs. A plan that views the level of Medicare payment available as highly attractive, and that has an energetic marketing program, will probably be able to achieve significant enrollment increases. New IPA-type HMOs may be able to attract "new" enrollees by recruiting physicians who in turn enroll beneficiaries who had been their regular patients on a fee-for-service basis.

F. Effect on Other Providers and Suppliers

Since participating HMOs and CMPs must furnish or arrange for at least all Part A and Part B covered services for Medicare enrollees otherwise available in the geographic area, their expansion in any particular locality has effects on the physicians, hospitals, home health agencies, and other providers and suppliers of health care services in the area. The nature and extent of these effects are dependent on many factors that will vary from organization to organization and from area to area. Some of these factors are:

- The organizational type of the HMO or CMP;
- The relationship of the HMO or CMP to local hospitals and other providers and suppliers;
- The local market penetration of prepaid organizations, both for the general populace and the Medicare population;
- The existence or absence of competing prepayment plans;
- The marketing strategies adopted by HMOs or CMPs; and
- The type and range of supplemental benfits offered by an HMO or CMP.

Some fee-for-service physicians may lose patients to eligible HMOs. As shown above, we project they will lose, in the aggregate, about 400,000 to 800,000 Medicare patients over the first three to four years. This would represent less than three precent of total Medicare patients, and a much smaller fraction of total patients. Nonetheless, in some localities, the shift from fee-for-service to prepaid plans could be substantial.

Although the impact on affected physicians will be a fractional decrease in caseload, we expect marketplace adjustments to restrain the adverse effects of such decreases in most cases. For example, some physicians or practices will be newly hired by or make arrangements with HMOs or CMPs, and most physicians losing patients will be able to replace these patients with others. Also, these regulations permit reasonable cost contracts that might prove attractive not only to HMOs but also to fee-for-service physician groups organized as IPA-type CMPs. In response to our NPRM discussion of the potential loss of patients by physicians, one commenter pointed out that, due to the growth of such organizations, in many cases a Medicare enrollee may merely continue to see his or her previous primary and referral physician, but as a Medicare HMO or CMP enrollee rather than as a fee-for-service patient. In fact, this is common in the individual practice association-type organization, especially those located in smaller communities and rural areas where there is a limited supply of physicians.

However, we expect that the primary impact that these regulations will have on the fee-for-service sector will be more indirect. Economic behavior is the result of the expectations of the parties making individual choices. Thus, when a prepayment plan begins or expands operation, the behavior of other providers and suppliers in that area is governed initially by the effects they expect could happen, as well as by actual shifts in patients' choice of sources of services. As a result, some of the effects of these rules will include many decisions by physicians and others concerning fee levels, services offered, and so forth. For example, we expect that the number of physicians accepting assignment of their patients' Medicare claims may increase in some localities, irrespective of the incentive for assignment provided by section 2306 of Pub. L. 98–369, discussed above.

HMO and CMP growth in an area will affect the local hospitals in various ways. Those hospitals that have arrangements with the plans may be able to ensure a certain level of occupancy. A plan with high Medicare enrollment could affect the Medicare utilization of the hospitals with which it deals. Of course, there are also secondary effects on the hospitals that do not have arrangements with the HMOs or CMPs, such as reduction of Medicare utilization. In addition, if enrollee selection favored the prepayment plan in an area, then less healthy and more costly beneficiaries would be receiving proportionally more of their services from the fee-for-service sector.

Non-hospital providers and suppliers of Medicare covered services would be affected similarly to hospitals. Those having arrangements with HMOs and CMPs could experience significant benefits. Those without such arrangements may experience some reduction of Medicare utilization, if a significant number of beneficiaries choose to enroll. This possibility was clearly illustrated by the comments we received from chiropractors, psychologists, and others. The supplemental benefits offered by HMOs and CMPs could extend these effects to services not covered by Medicare, such as optical and dental practitioners. This could also affect the demand for Medigap insurance (which covers costs of medical care not paid for by Medicare, such as deductible and coinsurance amounts) in areas in which an eligible plan offered competitive benefits.

G. Impact on Beneficiaries

Participation in a prepaid plan is voluntary on the part of beneficiaries. The incentive to join will come only if the HMO or other plan can offer beneficiaries more coverage, lower personal costs, or both. The regulations do not dictate any one kind of health care for the elderly and the disabled. On the contrary, these regulations are opening a whole new range of options for their benefit and at their choice.

The elderly and the disabled, for the most part, have had long-established physician relationships, and have been less likely to change the ways in which they secure medical treatment than are younger people. Historically, prepayment plans have demonstrated limited ability to enroll Medicare beneficiaries. However, as noted above, Medicare demonstrations have been very successful in recent years in enrolling Medicare beneficiaries. IPA-type plans in particular are often able to offer a beneficiary the benefits of prepaid enrollment while continuing his

or her relationship with a particular physician.

We expect that the primary effects on beneficiaries will be beneficial. In particular, we expect that beneficiaries will, on the average, have reduced out-of-pocket expenses. Some plans may offer financial advantages as part of their supplemental benefits and marketing strategies. Many plans will offer coverage of services not covered by Medicare Part A or Part B, such as physical examinations, prescription drugs, and eyeglasses.

Of course, not all beneficiaries who choose to enroll in an HMO or CMP will be satisfied. Similarly, some beneficiaries who enroll in risk plans will seek services out of plan, and will become liable for the payment for those services. However, we believe that the opportunity for self-disenrollement will afford these beneficiaries the freedom they need to protect themselves.

H. Conclusion

In summary, we expect the following types of changes to result from these regulations in the short-term:

- Some HMOs currently participating on a cost basis will convert to a risk basis.
- Some HCPPs currently participating only for provision of Part B services will convert to HMO or CMP status.
- Some potential eligible organizations will newly enter the program as HMOs or CMPs.
- The rate of HMO enrollment increase will accelerate.
- Increased Medicare enrollment in HMOs and CMPs will result in a decline in HCPP enrollment.
- Risk-basis organizations will significantly increase their Medicare enrollment.
- Some cost-basis organizations subject to the "two-for-one" rule may limit their marketing efforts to Medicare beneficiaries while they assess their potential conversion to risk basis reimbursement.
- Many, but not all, current nonrisk enrolleers will choose to convert to risk basis, as a result of the opportunity for increased benefits.

Over the longer term, perhaps in five to ten years, we expect a number of additional consequences:

- Inpatient hospital utilization for Medicare enrollees will be significantly lower than for beneficiaries receiving services solely from the fee-for-service sector.
- To the extent that selection favorable to the prepayment plans is avoided, the total cost of care for Medicare enrollees will be lower than it would have been had we paid for all services on the basis of fee-for-service costs and charges.
- In the long run, if selection favorable to prepayment plans does not prevent it, the incentives for HMOs and CMPs to furnish care economically could result in program savings.
- The competition of prepayment plans will significantly affect the fee-for-service sector, which will:

—Attempt to demonstrate that it too can be economical and efficient; and
—Restrain its increases of costs and charges;

- Many HMOs and CMPs will develop supplemental benefit packages that will afford improved benefits to Medicare enrollees.
- The availability of Federal risk-based payments will increase the rate of growth of prepayment plans, making their services and benefits increasingly accessible to both the Medicare and non-Medicare population.

Some of these changes will result in costs, others in savings. For example, as discussed above, conversion of enrollees from cost to risk contracts will result in initial increases in program expenditures. In addition, savings will result from new enrollees only to the extent that they represent enrollment that would not have occurred in the absence of these regulations, and they are representative of the fee-for-service beneficiaries in the geographic area served. Ultimately, the increase of prepaid enrollment due to the advantages of risk-based contracts, changes in the fee-for-service sector, and effective avoidance of biased selection should result in progressive savings sufficient to offset the potential costs. Although the magnitude of these effects is inestimable, and we cannot confidently quantify either the costs or benefits expected to result from these regulations, we are confident that the benefits will substantially outweigh the costs. Thus, we believe that this document meets the objectives of Executive Order 12291 and the Regulatory Flexibility Act.

VIII. Other Required Information

A. Waiver of Proposed Rulemaking for Certain Sections

In section IV. of this preamble, we noted that sections 2322 and 2350 of Pub. L. 98-369 made four amendments to sections 1861 and 1876 of the Act. Three of the four amendments, that is, those dealing with services by clinical psychologists in risk organizations, with direct payments to SNFs, and with the establishment of benefit stabilization funds, are being implemented in this final rule in § 417.416, § 417.588, and §§ 417.401, 417.442, 417.592, and 417.594–417.597 respectively.

Generally, we issue a notice of proposed rulemaking and provide a period for public comment before implementing amendments to the law through regulations. However, we may waive this procedure if it would be impractical, unnecessary, or contrary to the public interest.

In § 417.416, we provide that clinical psychologists will be permitted to furnish services in risk organizations without the direct personal supervision of a physician. This establishes an option for risk organizations that did not exist prior to enactment of Pub. L. 98-369. In § 417.586, we specify that risk organizations may elect to have HCFA pay SNFs directly for services provided to Medicare enrollees, under the auspices of the organization, in the same manner that we directly pay hospitals for inpatient services provided to Medicare enrollees. Both of these provisions constitute beneficial options to risk organizations in terms of reduced paperwork and management practices. In view of the fact that Pub. L. 98-369 was enacted on July 18, 1984, we believe it would be advantageous to risk organizations to have regulations in place so that these provisions can be implemented as soon as the regulations in Subpart C of 42 CFR Part 417 are effective.

The remaining revisions made to these regulations concern the provisions of section 2350(b) of Pub. L. 98-369. This amendment authorizes us to allow a risk organization to have placed in a benefit stabilization fund a part of the value of the additional benefits it is required to provide to its Medicare enrollees. This fund would be used to stabilize and prevent undue fluctuation in the additional benefits afforded in subsequent contract periods. We may not approve the establishment of a benefit stabilization fund for any contract period beginning later than July 18, 1988.

This provision constitutes a beneficial option to risk organizations and their Medicare enrollees in terms of protection against having to decrease the additional benefits the organizations provide to those enrolless or increase premium changes from one contract period to the next, if the organization's original estimate of its ACR or enrollment figures for its contract period is incorrect. In addition, a benefit stabilization fund is of most use to an organization during its first contract periods, before it has gained experience in the program. Therefore, for these organizations, it would be beneficial to

have this provision included in this final rule so that the stabilization fund option is available as they begin their first contract period with us under the provisions of these new regulations.

Finally, since no stabilization fund may be established for any contract period beginning later than July 18, 1988, the earliest possible implementation of this provision will allow the longest period of time risk organizations have to take advantage of its benefits. We would also like to note that several of the potential eligible organizations that commented on the NPRM are in favor of including this provision in the final regulations. Therefore, for the above reasons, we conclude that it would be contrary to the public interest to delay implementation of these several provisions until a rulemaking proceeding is completed. However, we are providing a 30-day comment period so that interested parties may comment on the regulations issued under sections 2322 and 2350 (b) and (c) of Pub. L. 98–369.

B. Waiver of 30-Day Delay of Effective Date

As discussed previously, section 114(c) of Pub. L. 97–248 states that the provisions of section 1876 of the Act must apply with respect to services furnished on or after the first day of the month after the month in which the Secretary notifies Congress that she is reasonably certain that the methodology for determining the prospective rate based on 95 percent of the AAPCC is developed and can be implemented. Since the Secretary provided Congress with this certification during the month of January 1985, the statutory effective date of these provisions is February 1, 1985. As a practical matter, we would be unable to implement this final rule by February 1, 1985 if we were to provide the customary 30-day delay in the effective date. Therefore, we find good cause to waive the delay in the effective date.

C. Public Comments

As discussed above, we are inviting comments on certain regulations in this final rule that implement Pub. L. 98–369 and that were not proposed in the NPRM published on May 25, 1984. Because of the large number of comments we receive, we cannot acknowledge or respond to them individually. However, we will consider all comments on §§ 417.401, "Benefit stabilization fund"; 417.416(d)(2); 417.442(b)(2); 417.586; 417.592(c)(2); 417.594(b)(5); 417.596; and 417.597 that are received by the date specified in the "Dates" section of this preamble. If, as a result of these public comments, we conclude that changes in these final regulations are needed, we will respond to the comments and include the changes in a future **Federal Register** publication.

All other provisions included in these final regulations were proposed in the NPRM, and we are responding in this document to comments received on these provisions. Therefore, if another **Federal Register** publication is necessary, we expect to address only comments about the regulations that implement sections 2322 and 2350 (b) and (c) of Pub. L. 98–369, as listed above.

D. Paperwork Burden

The following sections of this rule contain information collection requirements:

417.412(b)
417.413(a)
417.414(b)(3)
417.418(c)(4)
417.424(b)
417.426
417.428(a)
417.430(b)
417.432(e)
417.436
417.444(a)(1)(iii)
417.446 (b) and (c)
417.454(b)
417.460(a(1)–(a)(4)
417.460(a)(6)(iv)
417.460 (b) and (c)
417.474
417.476
417.480
417.481
417.486(a)
417.488
417.492 (a) and (b)
417.494 (a)(2) and (a)(3)
417.494(c)
417.520 (b)(2) and (b)(3)
417.522 (a) and (b)(4)
417.532 (d) and (e)(3)
417.546
417.548(a)
417.566(b)
417.568 (a), (b), (d), and (e)
417.570 (b) and (c)
417.572 (a) and (c)
417.576(b)
417.586(a)(2)
417.592(d)
417.594
417.596
417.604 (c)
417.608 (a) and (b)
417.616 (a), (b), (c), and (e)
417.620
417.624
417.650
417.662 (a) and (b)
417.801(e)
417.808 (b) and (c)
417.810(b)

We have submitted an information collection request to the Executive Office of Management and Budget for approval of these requirements under section 3507 of the Paperwork Reduction Act of 1980 (44 U.S.C. 3507). A notice will be published in the **Federal Register** when approval is obtained.

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 417

Appeals, Competitive medical plan (CMP), Contracts, Eligible organization, Health care prepayment plan (HCPP), Health maintenance organization (HMO), Medicare.

42 CFR Chapter IV, Subchapter B is amended as set forth below:

I. The table of contents for Chapter IV is amended by adding a new Part 417 to Subchapter B to read as follows:

CHAPTER IV—HEALTH CARE FINANCING ADMINISTRATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES

* * * * *

SUBCHAPTER B—MEDICARE PROGRAMS

* * * * *

Part
417 Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans

* * * * *

II. Part 405 is amended as follows:

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

A. The table of contents of Part 405, Subpart F is amended by removing § 405.692.

B. The table of contents of Part 405, Subpart T is redesignated as the tables of contents of the new Subparts B and D in the new Part 417.

C. Part 405, Subpart B is amended as follows:

Subpart B—Supplementary Medical Insurance Benefits; Enrollment, Coverage, Exclusions, and Payment

1. The authority citation for Subpart B is revised to read as follows:

Authority: Secs. 1102, 1831–1843, 1861, 1862, 1866, 1871, 1877, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395j–1395v, 1395x, 1395y, 1395cc, 1395hh, 1395nn, and 1395rr).

2. Section 405.241 is revised to read as follows:

§ 405.241 Payment of supplementary medical insurance benefits to prepayment organizations.

A prepayment organization that has not qualified as a health care prepayment plan (HCPP), health maintenance organization (HMO), or competitive medical plan (CMP) will be paid through its Medicare carrier, for Part B services furnished to its Medicare enrollees, on the basis of reasonable charges in accordance will § 405.240 and § 405.251. These organizations will be paid 80 percent of reasonable charges after subtracting their enrollees' deductible amounts and taking the other limitations under Part B into consideration. (See 42 CFR Part 417 of this chapter for applicable definitions and regulations governing reimbursement of HCPPs, HMOs, and CMPs.)

D. Part 405, Subpart F is amended as follows:

Subpart F—Notice, Election and Agreements

1. The authority citation for Subpart F is revised to read as follows:

Authority: Secs. 1102, 1816, 1842, 1861(u), 1964, 1866, 1871, and 1881 of the Social Security Act (42 U.S.C. 1302, 1395h, 1395u, 1395x(u), 1395aa, 1395cc, 1395hh, and 1395rr), unless otherwise noted.

2. Section 405.692 is revised and redesignated as new § 417.801, as set forth below in the new Part 417, Subpart D.

E. Part 405, Subpart T is amended as follows:

Subpart T—Health Maintenance Organizations

1. The authority citation for Subpart T reads as follows:

Authority: Sec. 1102, 1833(a)(1)(A), 1871, 1874, and 1876 (42 U.S.C. 1302, 13951(a)(1)(A), 1395hh, 1395kk and 1395mm).

2. Subpart T is redesignated as new Subparts B and D of new Part 417, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans, as follows (Subpart A of new Part 417 is reserved):

(a) Sections 405.2001 through 405.2092 are redesignated as new §§ 417.201 through 417.292 in a new Subpart B of Part 417 and all internal cross-references are corrected.

(b) The uncoded internal heading immediately preceding § 405.2093 is removed; § 405.2093 and §§ 405.2094 through 405.2098 are revised and redesignated as § 417.800 and §§ 417.802 through 417.810 respectively, in the new Part 417, Subpart D as set forth below.

These redesignations are set forth in the table below:

REDESIGNATION TABLE FOR 42 CFR 405.2001 THROUGH 405.2098 (PART 405, SUBPART T)

Old section	New section
405.2001	417.201
405.2002	417.202
405.2003	417.203
405.2004	417.204
405.2005	417.205
405.2007	417.207
405.2020	417.220
405.2021	417.221
405.2022	417.222
405.2023	417.223
405.2024	417.224
405.2025	417.225
405.2028	417.228
405.2029	417.229
405.2030	417.230
405.2031	417.231
405.2032	417.232
405.2033	417.233
405.2034	417.234
405.2035	417.235
405.2036	417.236
405.2037	417.237
405.2038	417.238
405.2039	417.239
405.2040	417.240
405.2041	417.241
405.2042	417.242
405.2043	417.243
405.2044	417.244
405.2045	417.245
405.2046	417.246
405.2047	417.247
405.2049	417.249
405.2050	417.250
405.2051	417.251
405.2052	417.252
405.2053	417.253
405.2054	417.254
405.2056	417.256
405.2058	417.258
405.2059	417.259
405.2060	417.260
405.2061	417.261
405.2062	417.262
405.2063	417.263
405.2065	417.265
405.2066	417.266
405.2067	417.267
405.2068	417.268
405.2069	417.269
405.2070	417.270
405.2072	417.272
405.2073	417.273
405.2074	417.274
405.2075	417.275
405.2076	417.276
405.2077	417.277
405.2078	417.278
405.2079	417.279
405.2080	417.280
405.2081	417.281
405.2082	417.282
405.2083	417.283
405.2084	417.284
405.2085	417.285
405.2086	417.286
405.2087	417.287
405.2088	417.288
405.2089	417.289

REDESIGNATION TABLE FOR 42 CFR 405.2001 THROUGH 405.2098 (PART 405, SUBPART T)—Continued

Old section	New section
405.2090	417.290
405.2091	417.291
405.2092	417.292
405.2093	[1] 417.800
405.2094	417.802
405.2095	417.804
405.2096	417.806
405.2097	417.808
405.2098	417.810

[1] Section 417.801 was redesignated from 42 CFR 405.692.

3. Redesignated § 417.201 is amended by redesignating paragraph (b) as paragraph (c) and adding a new paragraph (b) to read as follows:

§ 417.201 Health maintenance organizations; general.

* * * * *

(b) *Other applicable regulations.* Subpart C of this part contains regulations and effective dates applicable to organizations qualifying for Medicare payments under section 1876 of the Act as amended by section 114 of Pub. L. 97–248 (Tax Equity and Fiscal Responsibility Act of 1982).

* * * * *

4. In redesignated § 417.242, paragraph (g) is amended by revising paragraphs (g)(1) and (g)(2) and corrected by adding paragraph (g)(3), and paragraph (h) is revised to read as follows:

§ 417.242 Allowable costs.

* * * * *

(g) *Physicians' services under arrangements.* (1) The amount paid by an HMO to a physician group (organized on a group-practice or individual-practice basis) for physicians' services, and for other covered Part B services, furnished under arrangements (as described in § 110.104 of this title), is an allowable expense to the extent it is reasonable.

(2) The amount paid by an HMO on a-fee-for-service basis to physicians and other suppliers and to a physician group organized on an individual-practice basis for physicians' services and other covered Part B services furnished under arrangements (as described in § 110.104 of this title) is an allowable expense to the extent it is not in excess of the reasonable charges, as defined in Subpart E of Part 405 of this chapter. Therefore, payment is limited to the amount that would otherwise be paid if the services were furnished by the physician group (or by similar physicians, practitioners, or suppliers) to Medicare beneficiaries who are not enrolled in the HMO. The same limitation also applies to the amount

paid by the HMO for such covered services furnished under arrangements with a physician, physician-directed clinic, or a supplier of services.

(3) However, an exception to the reasonable charges limitation described in paragraph (g)(2) of this section is permitted, if the HMO demonstrates to HCFA's satisfaction that the physician group organized on an individual-practice basis has an agreement that includes acceptance by the members of the physician group of effective incentives, such as risk-sharing or other financial incentives, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount of physician compensation paid by an HMO is an allowable expense to the extent it is reasonable.

(h) *Provider services through arrangements.* The cost incurred by an HMO for covered services furnished by a provider through arrangements (see § 110.104 of this title and § 405.2043(b)) are allowable to the extent that such cost would be allowable and reimbursable pursuant to Subpart D of Part 405 of this chapter unless the HMO can demonstrate to the satisfaction of HCFA that payment in excess of the reasonable cost allowed pursuant to such Subpart D of Part 405 of this chapter is justified on the basis of advantages gained by the HMO. For example, if an HMO has an arrangement with a provider of services located outside the HMO's enrollment area that is not related to the HMO by common ownership or control, payment for the provider's charges to the HMO for covered services (rather than the provider's reasonable cost as determined under Subpart D of Part 405 of this chapter) may be justified if: The provider furnishes services to enrollees of the HMO on an infrequent basis; the charges represent an insignificant amount of total reimbursement to the HMO by the program; and the charges do not exceed the customary charges by the provider to its other patients for similar services. The advantages gained under this arrangement include a more timely final settlement with the HMO and the elimination of administrative costs necessary to determine the provider's reasonable cost for these services. An advantage gained represents a real and tangible benefit received by the HMO for the excess cost incurred. Any such excess payment is also subject to other applicable requirements of Part 405 of this chapter, including tests of reasonableness.

* * * * *

5. Subpart C is added to new Part 417 and Subpart D (as redesignated and revised above) is set forth to read:

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Authority: Secs. 1102, 1833(a)(1)(A), 1861(s)(2)(H), 1871, 1874, and 1876 of the Social Security Act as amended (42 U.S.C. 1302, 13951(a)(1)(A), 1395x(s)(2)(H), 1395hh, 1395kk, and 1395mm); section 114(c) of Pub. L. 97-248 (42 U.S.C. 1395mm note); and section 1301 of the Public Health Service Act (42 U.S.C. 300e).

Subpart A—[Reserved]

Subpart B—Health Maintenance Organizations

* * * * *

Subpart C—Health Maintenance Organizations and Competitive Medical Plans

§ 417.400 Basis and scope.

(a) *Statutory basis.* The regulations in this subpart implement section 1876 of the Act as amended by section 114 of Pub. L. 97-248. Section 1876 of the Act authorizes Medicare payments to HMOs and competitive medical plans (CMPs) through contracts under which the HMOs and CMPs are reimbursed for furnishing covered services to Medicare beneficiaries.

(b) *Scope.* This subpart sets forth the requirements an entity must meet in order to enter into a contract with HCFA as an HMO or CMP to be reimbursed, through capitation payments, for services furnished to Medicare beneficiaries who are enrolled with the HMO or CMP. It also specifies the principles that apply for each of the two methods for reimbursing HMOs and CMPs: reimbursement on a risk basis and reimbursement on a reasonable cost basis.

§ 417.401 Definitions.

As used in this subpart, unless the context indicates otherwise—

Adjusted average per capita cost (AAPCC) means an actuarial estimate made by HCFA in advance of an organization's contract period that represents what the average per capita cost to the Medicare program would be for each class of the organization's Medicare enrollees if they had received covered services other than through the organization in the same geographic area or in a similar area.

Adjusted community rate (ACR) is the equivalent of the premium that a risk organization would have charged to Medicare enrollees independently of Medicare payments using the same rates as charged to non-Medicare enrollees if the benefit package was limited to covered Medicare services.

Arrangement or arrangements means a written agreement executed between an eligible organization and another entity in which the other entity agrees to furnish specified services to Medicare enrollees of the organization, but the organization retains responsibility for those services. Under an arrangement, Medicare payment to the organization discharges the beneficiary's obligation to pay for the service.

Benefit stabilization fund means a fund established by HCFA at the request of an eligible organization with a new risk contract to withhold a portion of the per capita payments available to the organization for payment in a subsequent contract period for the purpose of stabilizing fluctuations in the availability of the additional benefits provided by the organization to its Medicare enrollees.

Current demonstration project Medicare enrollee means an individual who, on the effective date of these regulations, is—

(a) Enrolled with an HMO or CMP that is furnishing services pursuant to an existing demonstration project; and

(b) Entitled to benefits under part A and B of Medicare or enrolled for Part B only.

Current nonrisk Medicare enrollee means—

(a) An individual who, with respect to an eligible organization that has an existing cost contract, is enrolled with that organization on the effective date of these regulations, and is entitled to benefits under Parts A and B of Medicare or is enrolled in Part B only; and

(b) includes Medicare enrollees who disenroll and later reenroll in the same eligible organization.

Current risk Medicare enrollee means an individual who, on the effective date of these regulations, is—

(a) Enrolled with an HMO having an existing risk-sharing contract; and

(b) Entitled to benefits under Parts A and B of Medicare or enrolled in Part B only.

Eligible organization or *organization* means a public or private entity that is either an HMO or a CMP and meets all the applicable requirements of section 1876(b) of the Act. (See § 417.407.)

Emergency services means covered inpatient or outpatient services that are furnished by an appropriate source other than the organization and—

(a) Are needed immediately because of an injury or sudden illness, and

(b) The time required to reach the organization's providers or suppliers (or alternatives authorized by the organization) would have meant risk of permanent damage to the patient's health.

These services are considered to be emergency services as long as transfer of the enrollee to the organization's source of health care or designated alternative is precluded because of risk to the enrollee's health or because transfer would be unreasonable, given the distance involved in the transfer and the nature of the medical condition.

Enrollee means an individual who is enrolled in an HMO or a CMP to receive health care services on a prepaid capitation basis.

Entity with an existing cost contract means an entity that, on the effective date of these regulations, does not have in effect an existing risk contract or an existing demonstration project and—

(a) Has in effect a contract that is entered into under section 1876 of the act that was in effect prior to the effective date of these regulations (that is, a cost contract under Subpart T of Part 405 of this chapter); or

(b) is reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act.

Entity with an existing risksharing contract means an entity that, on the effective date of these regulations, has in effect a contract entered into under section 1876(i)(2)(A) of the Act as in effect prior to the effective date of these regulations (that is, a risk-sharing contract under Subpart T of Part 405 of this chapter).

Existing demonstration project means a demonstration project under section 402 of the Social Security Amendments of 1967 (42 U.S.C. 1395b–1) or section 222(a) of the Social Security Amendments of 1972 (42 U.S.C. 1395b–1 (note)), relating to the provision of services for which payment is made under Medicare on a prospectively determined basis.

Geographic area means the area found by HCFA to be the area within which the organization furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees.

Medicare enrollee means an individual who is entitled to Medicare benefits (Part A and Part B or Part B only) and who has been identified on HCFA records as an enrollee of an eligible organization that has a contract under section 1876 of the Act.

New Medicare enrollee means an individual who—

(a) Enrolls with an organization after the date on which the organization first enters into a risk contract under this subpart;

(b) Is entitled to both Part A and Part B benefits under Medicare or Part B benefits only at the time of the enrollment; and

(c) Was not enrolled with the organization at the time the individual became entitled to benefits under Part A, or eligible to enroll in Part B of Medicare.

New risk contract means a contract entered into under section 1876(g) of the Act (that is, a risk contract under this subpart).

Reasonable cost reimbursement contract means a contract entered into under section 1876(h) of the Act (that is, a cost contract under this subpart).

Urgently needed services means covered services required in order to prevent serious deterioration of an enrollee's health that results from an unforeseen illness or injury if—

(a) The enrollee is temporarily absent from the organization's geographic area; and

(b) Receipt of the health care service cannot be delayed until the enrollee's return to the organization's geographic area.

§ 417.402 Effective date.

Under section 114(c) of Pub. L. 97–248, this subpart was effective on the first day of the first month after the month in which the Secretary certified that the AAPCC methodology, as described in § 417.588, could be implemented. Based on this provision, the effective date of this subpart is February 1, 1985.

Eligibility and Contracting Requirements and Conditions

§ 417.404 Introduction.

(a) *General requirements.* In order to participate as an eligible organization under Medicare an entity must—

(1) Establish that it is an eligible organization; and

(2) Satisfy the contract requirements for an eligible organization to enter into a contract with HCFA.

(b) *Applicable regulations.* (1) Sections 417.406 and 417.407 set forth the requirements an entity must meet to be determined to be an eligible organization. These determinations are made by the Assistant Secretary for Health of the Department.

(2) Sections 417.408 through 417.418 set forth the requirements and conditions that an eligible organization must meet in order to enter into a contract with HCFA. Regulations dealing with the contents of the contract are specified in §§ 417.470 through 417.494.

§ 417.406 Eligible organization determinations.

(a) *Responsibility for making determinations.* (1) The Assistant Secretary for Health of the Department has the responsibility for determining if an entity is an eligible organization.

(2) The Assistant Secretary for Health will use the procedures set forth in § 110.605 (a) through (d) of this title in determining whether an entity meets the definition of a competitive medical plan as set forth in § 417.407(b). For purposes of this paragraph, references in those sections to "qualified HMO" are deemed references to "competitive medical plan" and references to requirements for qualification are deemed references to the requirements contained in the definition of "competitive medical plan", except that the third sentence of § 110.605(a) applies only to HMOs and not to CMPs.

(3) The Assistant Secretary for Health will, upon completion of the determination, certify in writing to HCFA whether the entity meets the definition of an eligible organization as set forth in § 417.407.

(4) HCFA will not act on any request made by an entity to contract under section 1876 of the Act until HCFA receives the certification from the Assistant Secretary for Health.

(b) *Oversight of continuing eligibility.* (1) The Assistant Secretary of Health is responsible for overseeing an entity's continuing compliance with the definition of an eligible organization as set forth in § 417.407.

(2) If the Assistant Secretary for Health notifies HCFA that an entity no longer meets the definition of an eligible organization, HCFA will terminate the entity's contract as specified in § 417.494(b)(iii).

§417.407 Definition of an eligible organization.

(a) *State law.* To qualify as an eligible organization, an entity must be organized under the laws of any State and be either an HMO or CMP under

paragraphs (b) or (c) of this section, respectively.

(b) *Health maintenance organization (HMO).* An HMO is a legal entity that is a qualified HMO as defined in section 1301(d) of the Public Health Service (PHS) Act. The PHS regulations for qualified HMOs are set forth in Subpart A of Part 110 of this title.

(c) *Competitive medical plan (CMP).* A CMP is a legal entity that meets the following requirements:

(1) Except as specified in paragraph (d) of this section, the entity provides to its enrolled members at least the following services:

(i) Physicians' services performed by physicians.

(ii) Laboratory, X-ray, emergency, and preventive services.

(iii) Out-of-area coverage.

(iv) Impatient hospital services.

(2) The entity receives compensation (except for deductibles, coinsurance, and copayments) for the health care services it provides to enrolled members on a periodic, prepaid capitation basis regardless of the frequency, extent, or kind of services provided to any member.

(3) The entity provides physicians' services primarily through—

(i) Physicians who are employees or partners of the entity; or

(ii) Physicians or groups of physicians (organized on a group or individual practice basis) under contract with the entity to provide physicians' services.

(4) The entity assumes full financial risk, under the procedures described in §110.108(b) of this title, on a prospective basis for the provision of health care services listed in paragraph (c)(1) of this section, except that the entity may—

(i) Obtain insurance or make other arrangements for the cost of providing to any enrolled member the health care services listed in paragraph (c)(1) of this section, if the aggregate value of the services exceeds $5,000 in any year;

(ii) Obtain insurance or make other arrangements for the cost of providing health care services listed in paragraph (c)(1) of this section to enrolled members other than through the entity for cases in which medical necessity required that the services be provided before they could be secured through the entity;

(iii) Obtain insurance or make other arrangements for not more than 90 percent of the amount by which the entity's costs for any of its fiscal years exceed 115 percent of its income for that fiscal year; and

(iv) Make arrangements with physicians and other health professionals, health care institutions, or any combination of these to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

(5) The entity provides adequately against the risk of insolvency by meeting the fiscal and administrative management requirements of § 110.108(a)(1)(i) through (iv) and (a)(3) of this title.

(d) *Exception for Medicaid prepayment risk contracts.* An entity that had a Medicaid prepayment risk contract before 1970 that did not include provision of inpatient hospital services does not have to meet the requirement of paragraph (b)(1)(iv) of this section.

§ 417.408 Contract application process.

(a) *Contents of application.* (1) The application for a contract must include supporting information in the form and detail required by HCFA.

(2) Whenever feasible, HCFA will exempt the organization from resubmittal of information it has already submitted to the Assistant Secretary for Health of the Department in connection with a determination made under the provisions of § 417.406.

(b) *Approval of application.* (1) If HCFA approves the application, it will give written notice to the organization, indicating that it meets the requirements for either a risk or reasonable cost contract or only for a reasonable cost contract.

(2) If the organization is dissatisfied with a determination that it meets the requirements only for a reasonable cost contract, it may request reconsideration in accordance with the procedures specified in §§ 417.640 through 417.658.

(c) *Denial of application.* If HCFA denies the application, it will give written notice to the organization indicating—

(1) That it does not meet the contract requirements under section 1876 of the Act;

(2) The reasons why the organization does not meet the contract requirements; and

(3) The organization's right to request reconsideration in accordance with the procedures specified in §§ 417.640 through 417.658.

§ 417.410 Qualifying conditions: General.

(a) In order to qualify for a contract with HCFA under this subpart, an eligible organization must demonstrate its ability to enroll members and to deliver a specified comprehensive range of high qualify services efficiently, effectively, and economically to its Medicare enrollees.

(b) An eligible organization must meet qualifying conditions that pertain to operating experience, enrollment, range of services, furnishing of services, and a quality assurance program.

(c) Generally, each qualifying condition is interpreted by a series of standards that are used in surveying an eligible organization to determine its qualifications for a Medicare contract.

(d) Application of the standards enables the surveyor to determine—

(1) The organization's activities;

(2) The extent to which the organization complies with each condition;

(3) The nature and extent of any deficiencies; and

(4) The need for improvement if HCFA should enter into a contract with the organization.

(e) An eligible organization may enter into a risk contract with HCFA if it—

(1) Meets all the applicable requirements in the statute and regulations;

(2) Has at least 5,000 enrollees or 1,500 enrollees if it serves a primarily rural area as defined in § 417.413(b)(3);

(3) Has at least 75 Medicare enrollees or has an acceptable plan to achieve this Medicare membership within 2 years;

(4) Satisfies HCFA that it can bear the potential losses of a risk contract; and

(5) Has not previously terminated or failed to renew a risk contract within the preceding 5 years, unless HCFA determines that circumstances warrant special consideration.

(f) An eligible organization may enter into a reasonable cost contract if it meets one of the following:

(1) The organization qualifies for a risk contract, but chooses a reasonable cost contract.

(2) The organization meets the conditions for entering into a risk contract specified in paragraph (e) of this section except that HCFA does not judge the organization capable of bearing the potential losses of a risk contract.

(g) Regulations on reasonable cost and risk reimbursement are set forth in §§ 417.530 through 417.596.

§ 417.412 Qualifying condition: Administration and management.

(a) HCFA will enter into or renew a contract only if it determines that that action would be consistent with the effective and efficient implementation of section 1876 of the Act.

(b) The eligible organization must demonstrate that it—

(1) Has sufficient administrative capability to carry out the requirements of the contract; and

(2) Does not have any agents or management staff or persons with ownership or control interests who have been convicted or criminal offenses related to their involvement in Medicaid, Medicare, or social service programs under title XX of the Act.

§ 417.413 Qualifying condition: Operating experience and enrollment.

(a) *Condition.* The organization must demonstrate that it has operating experience and an enrolled population sufficient to provide a reasonable basis for establishing a prospective per capita reimbursement rate or a reasonable cost reimbursement rate, as appropriate.

(b) *Standard: Enrollment and operating experience for organizations to contract on a risk basis:* (1) To be eligible to contract for Medicare reimbursement on a risk basis, a nonrural organization must currently have—

(i) At least 5,000 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within two years of the beginning of its initial contract period.

(2) To be eligible to contract for Medicare reimbursement on a risk basis, a rural organization must currently have—

(i) At least 1,500 enrollees; and

(ii) At least 75 Medicare enrollees or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within two years of the beginning of its initial contract period.

(3) For purposes of this paragraph, an organization is considered rural if at least 50 percent of its enrollees reside in nonmetropolitan areas. A nonmetropolitan area is an area—

(i) No part of which is within a metropolitan statistical area (MSA) as designated by the Executive Office of Management and Budget; and

(ii) That does not contain a city whose population exceeds 50,000 individuals.

(4) A subdivision or subsidiary of an organization that meets the requirements of paragraph (b)(1) or (b)(2) of this section need not demonstrate that it meets those requirements as an independent unit if the organization assumes responsibility for the financial risk, and adequate management and supervision of health care services furnished by its subdivision or subsidiary.

(c) *Standard: Enrollment and operating experience for organizations to contract on a reasonable cost basis.* To be eligible to contract for Medicare reimbursement on a reasonable cost basis, an organization must currently have an enrolled population sufficient to provide a reasonable basis for entering into a contract.

The organization must have—

(1) At least 1,500 enrollees;

(2) At least 75 Medicare enrollees, or a plan acceptable to HCFA for achieving a Medicare enrollment of 75 within two years of the beginning of its initial contract period; and

(3) At least 250 Medicare enrollees by the beginning of its fourth contract period.

(d) *Standard: Composition of enrollment*—(1) *Requirement.* Except as specified in paragraphs (d)(2) and (e) of this section, not more than 50 percent of an organization's enrollment may be Medicare and Medicaid beneficiaries.

(2) *Waiver of composition of enrollment standard.* Unless limited by the criteria specified in paragraph (d)(3) of this section, HCFA may waive compliance with the requirements of paragraph (d)(1) of this section if—

(i) The organization is making reasonable efforts to enroll individuals who are not Medicare or Medicaid beneficiaries; and

(ii) Medicare and Medicaid beneficiaries constitute more than 50 percent of the population of the organization's geographic area.

(3) *Limitations on waivers.* HCFA will not grant a waiver that would permit the percentage of Medicare and Medicaid enrollees to exceed the percentage of Medicare and Medicaid beneficiaries in the organization's geographic area.

(e) *Exception to composition of enrollment standard.* An organization that is an existing demonstration project on the date it applies for a contract under the provisions of this subpart and that HCFA finds is making reasonable effort to enroll individuals who are not Medicare or Medicaid beneficiaries is not subject to the composition of enrollment standard specified in paragraph (d)(1) of this section. This exception to the standard applies—

(1) For a period not to exceed three years from the start of the organization's first contract period; or

(2) For a longer period, to be determined by HCFA before the expiration of the three year period, if special circumstances indicate that it is in the best interests of the Medicare program to continue this exception.

(f) *Standard: Open enrollment.* (1) Except as specified in paragraph (f)(2) of this section, an organization must enroll Medicare beneficiaries on a first-come, first-served basis to the limit of its capacity and provide annual open enrollment periods of at least 30 days duration for Medicare beneficiaries.

(2) HCFA may waive the requirement of paragraph (f)(1) of this section if compliance would prevent compliance with the limitation on enrollment of Medicare and Medicaid beneficiaries (paragraph (d) of this section) or result in an enrollment substantially nonrepresentative of the population of the organization's geographic area. The enrollment would be "substantially nonrepresentative" if the proportion of a subgroup to the total enrollment exceeded, by 10 percent or more, its proportion of the population in the organization's geographic area, as shown by census data or other data acceptable to HCFA. For purposes of this paragraph, a subgroup means a class of Medicare enrollees as defined in § 417.582.

§ 417.414 Qualifying condition: Range of Services.

(a) *Condition.* The organization must demonstrate that it is capable of delivering to Medicare enrollees the range of services required in accordance with this section.

(b) *Standard: Range of services furnished by eligible organizations*—(1) *Basic requirement.* Except as specified in paragraph (b)(3) of this section, an organization must furnish to its Medicare enrollees (directly or through arrangements with others) all the Medicare services to which those enrollees are entitled that are available to Medicare beneficiaries who reside in the organization's geographic area but are not enrolled in the organization.

(2) *Criteria for availability.* The services are considered available if—

(i) The sources are located within the organization's geographic area; or

(ii) It is common practice to refer patients to sources outside that geographic area.

(3) *Exception for hospice care.* An organization is not required to furnish hospice care as described in Part 418 of this chapter. However, organizations must inform their Medicare enrollees about the availability of hospice care if—

(i) A hospice participating in Medicare is located within the organization's geographic area; or

(ii) It is common practice to refer patients to hospices outside the geographic area.

(4) *Choice of practitioners.* If more than one type of practitioner is qualified to furnish a particular item or service, the organization may select the type of practitioner to be used.

(c) *Standard: Financial responsibility for services furnished outside the organization.* (1) An organization must assume financial responsibility and provide reasonable reimbursement for emergency services and urgently needed services (as defined in § 417.401) that are obtained by its Medicare enrollees from providers and suppliers outside the organization even in the absence of the organization's prior approval.

(2) An organization must assume financial responsibility for services that the Medicare enrollee attempted to obtain from the organization, but that the organization failed to furnish or unreasonably denied, and that are found, upon appeal by the enrollee under §§ 417.600 through 417.638, to be services that the enrollee was entitled to have furnished to him or her by the organization.

§ 417.416 Qualifying condition: Furnishing of services.

(a) *Condition.* The organization must furnish the required services to its Medicare enrollees through providers and suppliers that meet applicable Medicare statutory definitions and implementing regulations. The organization must also ensure that the required services, additional services, and any other supplemental services for which the Medicare enrollee has contracted are available and accessible and are furnished in a manner that ensures continuity.

(b) *Standard: Conformance with conditions of participation, conditions for coverage, and conditions for certification.* (1) Hospitals, SNFs, HHAs, comprehensive outpatient rehabilitation facilities, and providers of outpatient physical therapy or speech pathology services must meet the applicable conditions of participation in Medicare, as set forth elsewhere in this chapter.

(2) Suppliers must meet the conditions for coverage or conditions for certification of their services, as set forth elsewhere in this chapter.

(c) *Standard: Physician supervision.* The organization must provide for supervision by a physician or other health care professionals who are directly involved in the provision of health care as generally authorized under section 1861 of the Act. Except as specified in paragraph (d) of this section, with respect to medical services furnished in an organization's clinic or the office of a physician with whom the organization has a service agreement, the organization must ensure that—

(1) Services furnished by paramedical, ancillary, and other nonphysician personnel are furnished under the direct supervision of a physician;

(2) A physician is present to perform medical (as opposed to administrative) services whenever the clinics or offices are open; and

(3) Each patient is under the care of a physician.

(d) *Exceptions to physician supervision.* The following services may be furnished without the direct personal supervision of a physician:

(1) The organization may permit the services of physician assistants and nurse practitioners (as defined in § 481.2 of this chapter), and the services and supplies incident to their services, to be furnished without the direct personal supervision of a physician. For purposes of this section, the definitions of physician assistants' and nurse practitioners' services and the services and supplies incident to their services for rural health clinics as specified in §§ 405.2414 and 405.2415 of this chapter are applicable.

(2) An organization that proposes to contract on a risk basis may permit the services of clinical psychologists, and the services and supplies incident to their professional services, to be furnished without the direct personal supervision of a physician. For purposes of this section, a clinical psychologist is defined as an individual who—

(i) Holds a doctoral degree in psychology from a program in clinical psychology that is approved by the American Psychological Association or an adjudged equivalent program, or has attained recognition of competency through the American Board of Examiners for Professional Psychology or through endorsement by the individual's State psychological association;

(ii) Is licensed or certified at the independent practice level of psychology in the State in which he or she practices; and

(iii) Possesses two years of supervised clinical experience at least one of which is postdegree.

(e) *Standard: Accessibility and continuity.* (1) The organization must ensure that the required services and any other services for which Medicare enrollees have contracted are accessible, with reasonable promptness, to the enrollees with respect to geographic location, hours of operation, and provision of after hours service. Medically necessary emergency services must be available twenty-four hours a day, seven days a week.

(2) The organization must maintain a health (including medical) recordkeeping system through which pertinent information relating to the health care of its Medicare enrollees is accumulated and is readily available to appropriate professionals.

§ 417.418 Qualifying condition: Quality assurance program.

(a) *Condition.* The organization must make arrangements for a quality assurance program that meets the requirements of this section.

(b) *Standard: Quality assurance program for HMOs.* An HMO must have an ongoing quality assurance program that meets the requirements set forth in § 110.108(h) of this title.

(c) *Standard: Quality assurance program for CMPs.* A CMP must have an ongoing quality assurance program for the health services it furnishes that—

(1) Stresses health outcomes to the extent consistent with the state of the art;

(2) Provides review by physicians and other health professionals of the process followed in the provision of health services;

(3) Uses systematic data collection of performance and patient results, provides interpretation of these data to its practitioners, and institutes needed changes; and

(4) Includes written procedures for taking appropriate remedial action whenever, as determined under the quality assurance program, inappropriate or substandard services have been furnished or services that should have been furnished have not been furnished.

Enrollment, Entitlement, and Disenrollment

§ 417.420 Basic rules on enrollment and entitlement.

(a) *Enrollment.* Individuals who are entitled to benefits under both Part A and Part B of Medicare or only Part B may elect to receive those benefits through an organization that has in effect a contract with HCFA under §§ 417.470 through 417.494.

(b) *Entitlement.* If a Medicare beneficiary enrolls with an organization, Medicare will make payments to the organization on his or her behalf for the services to which he or she is entitled, as described in § 417.440.

(c) *Beneficiary liability.* (1) As authorized in § 417.440, the organization may require payment, in the form of premiums or otherwise, from individuals for services not covered under Medicare, as well as deductible and coinsurance amounts attributable to Medicare covered services.

(2) As described in § 417.448, Medicare enrollees of risk organizations are liable for services that they obtain

from sources other than the organization, unless the services are—

(i) Emergency or urgently needed; or

(ii) Determined, on appeal under §§ 417.600 through 417.638, to be services that should have been furnished by the organization.

§ 417.422 Eligibility to enroll in an organization.

(a) *General criteria.* Except as specified in § 417.424 and paragraphs (b) and (c) of this section, an organization must enroll, either for an indefinite period or for a specified period of at least 12 months, any individual who—

(1) Is entitled to Medicare benefits under Parts A and B or under Part B only;

(2) Lives within the geographic area served by the organization;

(3) Is not enrolled in any other organization that has entered into a contract under this subpart or Subpart T of Part 405 of this chapter;

(4) During an enrollment period of the organization, completes and signs the organization's application form and gives whatever information is required for enrollment;

(5) Agrees to abide by the organization's rules after they are disclosed to him or her in connection with the enrollment process;

(6) Is not denied enrollment by the organization under a selection policy, if any, that has been approved by HCFA under § 417.424(b); and

(7) Is not denied enrollment by the organization on the basis of any of the administrative criteria concerning denial of enrollment in § 417.424(a).

(b) *ESRD patients.* Medicare beneficiaries who have been medically determined to have end-stage renal disease are not eligible to enroll in eligible organizations except as specified in § 417.434 concerning reenrollment.

(c) *Hospice patients.* Medicare beneficiaries who have elected hospice care under § 418.24 of this chapter are not eligible to enroll in eligible organizations as long as the hospice election remains in effect.

§ 417.424 Denial of enrollment.

(a) *Basis for denial.* An organization may deny enrollment to an individual who meets the criteria of § 417.422 if acceptance would—

(1) Cause the number of enrollees who are Medicare or Medicaid beneficiaries to exceed 50 percent of the organization's total enrollment.

(2) Prevent the organization from complying with any of the other contract qualifying conditions set forth in §§ 417.412–417.416 of this part;

(3) Require the organization to exceed its enrollment capacity; or

(4) Cause the enrollment to become substantially nonrepresentative of the general population in the organization's geographic area.

(b) *Selection policies.* Denial under paragraph (a)(4) of this section must be in accordance with written selection policies approved by HCFA. Enrollment of individuals will not be considered to make the enrollment of the organization substantially nonrepresentative of the general population in the organization's geographic area unless, as a result of the enrollment, the proportion of the subgroup (as defined in § 417.413(f)(2)) of enrollees to which the enrollee belongs as compared to the organization's total enrollment exceeds by at least ten percent its proportion to the general population in the geographic area of the organization.

§ 417.426 Open enrollment requirements.

(a) *Basic requirements.* (1) Eligible organizations must provide open enrollment for Medicare beneficiaries for at least 30 consecutive days during each contract year.

(2) During open enrollment, the organization must enroll eligible Medicare beneficiaries in the order in which their applications are received and until its enrollment capacity is reached.

(3) The organization may accept applications from Medicare beneficiaries after it has reached capacity if it places those individuals on a waiting list and enrolls them in chronological order as vacancies occur.

(b) *Capacity to accept new enrollees.* (1) If an organization chooses to limit enrollments because of its capacity, it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

(2) HCFA will evaluate the organization's submittal under paragraph (b)(1) of this section.

(3) The organization must promptly notify HCFA if there is any change in its enrollment capacity.

(c) *Reserved vacancies.* An organization may set aside a reasonable number of vacancies for an anticipated new group contract or for anticipated new members of an existing group contract that will have its enrollment period after the Medicare open enrollment period during the contract year—

(1) Subject to HCFA's approval; and

(2) On condition that any vacancies set aside that are not filled within a reasonable period of time after the beginning of the group contract enrollment period be made available to Medicare beneficiaries and other nongroup applicants under the requirements of this subpart.

§ 417.428 Marketing activities.

(a) *Required marketing activities.* An organization must meet the following requirements:

(1) Offer its plan to Medicare beneficiaries and provide to those interested in enrolling adequate written descriptions of the organization's rules, procedures, benefits, fees and other charges, services, and other information necessary for beneficiaries to make an informed decision about enrollment.

(2) Notify the general public of its enrollment period (whether time limited or continuous) in an appropriate manner through appropriate media, throughout its enrollment area.

(b) *Prohibited marketing activities—general.* In offering its plan to Medicare beneficiaries an organization may not engage in any of the following practices or activities:

(1) Practices that are discriminatory. For example, the organization may not engage in any activity intended to recruit Medicare beneficiaries from higher income areas (usually an indicator of better health) without making a comparable effort to enroll Medicare beneficiaries from lower income areas.

(2) Activities that could mislead or confuse Medicare beneficiaries, or misrepresent the organization, its marketing representatives, or HCFA. For example, the organization may not claim that it is recommended or endorsed by HCFA or that HCFA recommends that the beneficiary enroll in the organization. It may, however, explain that the entity is approved as an organization for purposes of participation in Medicare.

(3) Offers of gifts or payment as an inducement to enroll in the organization. This does not prohibit the explanation of any legitimate benefits the beneficiary might obtain as an enrollee of the organization, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance or preventive services.

(4) Door-to-door solicitation of Medicare beneficiaries.

(c) *Marketing activities of risk organizations.* In addition to the generally permitted or prohibited marketing activities described in paragraphs (a) and (b) of this section, a risk organization must provide potential Medicare enrollees with adequate written descriptions of the additional

benefits or services, or reductions in premiums, deductible or copayments that may pertain under risk reimbursement.

§ 417.430 Application procedures.

(a) *Application forms.* (1) The application form must comply with HCFA instructions regarding format and content and must include the beneficiary's signature and authorization for disclosure and exchange of necessary information between HCFA and the organization.

(2) The organization must file and retain application forms for the period specified in HCFA instructions.

(b) *Handling of applications.* An organization must have an effective system for receiving, controlling, and processing applications for Medicare beneficiaries. The system must meet the following conditions and requirements:

(1) Each application is dated as of the day it is received.

(2) Applications are processed in chronological order by date of receipt.

(3) The organization notifies the beneficiary in writing of acceptance or denial of the application promptly.

(4) The notice of acceptance—

(i) Specifies the date on which the organization will request HCFA to make the enrollment effective; or

(ii) If the organization is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur.

(5) The notice of denial explains the reason for denial.

(6) The organization transmits the information necessary for HCFA to add the beneficiary to its records of the organization's Medicare enrollees—

(i) Within 30 days from the date of application or from the date a vacancy occurs for an applicant who was accepted while the organization was enrolled to capacity; or

(ii) Within an additional period of time approved by HCFA on a showing by the organization that it needs more time.

(7) The organization promptly notifies the beneficiary of the effective month of his or her enrollment as a Medicare enrollee, when it receives that information from HCFA.

(8) If the organization accepts applications while it is enrolled to capacity, its procedures ensure that vacancies are filled in chronological order by date of application of beneficiaries who are still eligible to enroll, unless that would result in failure to comply with any of the qualifying conditions set forth in § 417.413.

§ 417.432 Conversion of enrollment.

(a) *Basic rule.* An organization must accept as a Medicare enrollee any individual who is enrolled in the organization for the month immediately before the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(b) *Effective date of conversion.* Unless the individual chooses to disenroll from the organization, the individual's conversion to a Medicare enrollee is effective the month in which he or she is entitled to both Medicare Parts A and B or Part B only.

(c) *Prohibition against disenrollment.* An organization may not disenroll an individual who is converting under the provisions of paragraph (a) of this section unless one of the conditions specified in § 417.460 is met.

(d) *Application form.* The individual who is converting must sign an application form as described in § 417.430(a).

(e) *Expedite submittal of information to HCFA.* The organization must notify HCFA, within the following time frames, of the enrollee's authorization for disclosure and exchange of information and the information necessary for HCFA to include the enrollee in its records as a Medicare enrollee of the organization:

(1) At least 30, but no earlier than 90, days before the enrollee—

(i) Attains age 65; or

(ii) Reaches his or her 25th month of entitlement to social security disability benefits under title II of the Act or railroad retirement disability benefits under section 7(d) of the Railroad Retirement Act of 1974.

(2) Within 30 days after the enrollee initiates a course of renal dialysis, or on or before the day he or she enters a hospital in anticipation of a kidney transplant.

(f) *Two-for-one rule concerning conversion of current nonrisk Medicare enrollees.* A risk organization that is receiving reimbursement for current nonrisk Medicare enrollees on a reasonable cost basis may, as provided in § 417.444, convert those enrollees to its risk reimbursement membership if it enrolls two new Medicare enrollees for each current nonrisk enrollee it converts under § 417.448. Selection of the current nonrisk Medicare enrollees to be converted must be unbiased as described in § 417.446(c).

§ 417.434 Reenrollment

If an organization requires periodic reenrollment, it must reenroll Medicare enrollees unless there is a basis for disenrollment as set forth in § 417.460.

§ 417.436 Membership rules for enrollees.

(a) *Maintaining rules.* An organization must maintain written membership rules that deal with, but need not be limited to—

(1) Procedures for paying premiums and other charges for which Medicare enrollees may be liable;

(2) Grievance and appeal procedures;

(3) Disenrollment rights;

(4) The obligation of an enrollee who is permanently moving out of the organization's geographic area; that is, expects to be absent from the area for more than 90 days, must notify the organization of the move or absence;

(5) How and where to obtain services from or through the organization; and

(6) Any other matters that HCFA may prescribe.

(b) *Availability of rules.* The organization must furnish a copy of the rules to each Medicare enrollee.

(c) *Changes in rules.* If an organization changes its rules, it must notify its Medicare enrollees of the changes at least 30 days before the effective date of the changes.

§ 417.440 Entitlement to health care services from an organization.

(a) *Basic rules.* (1) Subject to the conditions and limitations set forth in this subpart, a Medicare enrollee of an organization is entitled to receive health care services and supplies directly from, or through arrangements made by, the organization as specified in this section and §§ 417.442–417.446.

(2) A Medicare enrollee is also entitled to receive timely and reasonable payment directly (or have payment made on his or her behalf) for services he or she obtained from a provider or supplier outside the organization if those services are—

(i) Emergency services or urgently needed services as defined § 417.401;

(ii) Services denied by the organization and found (upon appeal under §§ 417.600 through 417.638) to be services the enrollee was entitled to have furnished by the organization.

(b) *Scope of services.* (1) *Part A and Part B services.* Except as specified in paragraph (c) of this section, a Medicare enrollee is entitled to receive all the services and supplies that are covered by Part A and Part B of Medicare (if he or she is entitled to benefits under both programs) or by Medicare Part B (if he or she is entitled only under that program) that are available to individuals residing in the geographical area served by the organization.

(2) *Supplemental services elected by enrollee.* A Medicare enrollee of an organization may elect to pay for

optional services that are offered by the organization in addition to the covered Part A and Part B services, and, for risk organizations, in addition to the additional benefits required under § 417.442. The organization may not set health status standards for those enrollees whom it will accept for these optional supplemental services.

(3) *Supplemental services imposed by risk reimbursement organizations.* Subject to the approval of HCFA, a risk organization may require Medicare enrollees to accept and pay for services in addition to the covered Part A and Part B services. These services must be imposed on all applicable enrollees without regard to health status. HCFA will approve the supplemental services if it determines that the requirement will not discourage enrollment in the organization by other Medicare beneficiaries.

(4) *Additional benefits from risk organizations required by statute.* Subject to the conditions stated in § 417.422, a new Medicare enrollee or a current nonrisk Medicare enrollee who converts to risk reimbursement under § 417.444 is eligible to receive, in addition to the covered Part A and Part B benefits for which he or she is eligible, benefits consisting of one or both of the following:

(i) A reduction in the organization's premium rate or in other charges for services furnished to Medicare enrollees.

(ii) Provisions of health benefits or services and supplies beyond the required Part A and Part B coverage.

(5) *Special supplemental benefits.* Under conditions described in § 417.444(c), current nonrisk Medicare enrollees who are not converted to the risk portion of the contract, may enroll in a special supplemental plan, if offered by the organization, for some or all of the additional benefits described in paragraph (b)(4) of this section.

(c) *Limitation on hospice care.—(1) Extent of the limitation.* If a Medicare enrollee elects to receive hospice care under the provisions of § 418.24 of this chapter, the enrollee waives his or her right to receive from the organization any Medicare services, including services equivalent to hospice care, that are related to the treatment of the terminal condition for which hospice care was elected or to a related condition, except for services furnished by the individual's attending physician, if that physician is an employee or contractor of the organization and is not an employee of the designated hospice or receiving compensation from the hospice for those services.

(2) *Effective date of limitation.* The limitation in paragraph (c)(1) of this section begins on the effective date of the beneficiary's election of hospice care under § 418.24 of this chapter and remains in effect until the earlier of—

(i) The effective date of the enrollee's revocation of the election of hospice care as described in § 418.28 of this chapter; or

(ii) The date the enrollee exhausts his or her hospice benefits.

(3) *Payment to organization.* For the period that the Medicare enrollee's election of hospice care is in effect, payment will be made to reasonable cost organizations only as described in § 417.531 and to risk organizations only as described in § 417.585.

§ 417.442 Risk organizations: Conditions for provision of additional benefits.

(a) *General rule.* Except as provided in paragraph (b) of this section, an organization with a risk contract must provide its Medicare enrollees with the additional benefits described in § 417.440(b)(4) during a contract period if, prior to the contract period, the organization's ACRs (calculated separately for Part A and Part B enrollees and Part B-only enrollees) are less than the average of the per capita rates of payment for those beneficiaries that HCFA will be making to the organization. The computation of the value of the additional benefits, the ACR, and the average of the per capita payment rates are described in §§ 417.592 and 417.594.

(b) *Exceptions.*—(1) *Reduced payment election.* An organization is not obligated to furnish additional services under paragraph (a) of this section if it has requested a reduction in its monthly payment from HCFA under § 417.592(e), and it—

(i) Elects to receive reduced payment so that there is no difference between the average of its per capita rates of payment and its ACR; or

(ii) Elects to receive partially reduced payment and furnish Medicare enrollees with additional benefits described in § 417.440 (b)(4) so that the combined value of benefits and reduced payment is equivalent to the difference between the average of its per capita rates of payment and its ACR.

(2) *Benefit stabilization fund.* An organization may elect to have a part of the value of the additional benefits it must provide under paragraph (a) of this section withheld in a benefit stabilization fund as described in § 417.596.

§ 417.444 Special rules for current nonrisk Medicare enrollees of an organization under a risk contract.

(a) *Condition for additional benefits.* Current nonrisk Medicare enrollees of a risk organization may retain that status indefinitely and, therefore, are not entitled to the additional benefits under § 417.442 unless HCFA determines that the enrollee's status must be changed or a change is requested by the enrollee, as follows:

(1) HCFA determines that, for administrative reasons or because there are fewer than 75 current nonrisk Medicare enrollees remaining in the organization, all current nonrisk Medicare enrollees of an organization must be covered under the risk provisions of the contract; and

(i) HCFA notifies each affected enrollee of the decision at least 90 days prior to the effective date;

(ii) The current nonrisk Medicare enrollees complete and sign forms stating that they understand and accept the new rules and benefits that will be applicable to them; and

(iii) The organization notifies each affected enrollee, in writing, at least 30 days in advance, of the date upon which his or her coverage under the risk portion of the contract takes effect.

(2) A current nonrisk Medicare enrollee requests, using the same or a similar form to that described in paragraph (a)(1)(ii) of this section, that he or she be covered under the risk portion of the contract, and—

(i) The organization has enrolled two new Medicare enrollees for each of these current nonrisk Medicare enrollees; and

(ii) In cases where there are more current nonrisk Medicare enrollees than can be accommodated due to the two-for-one rule, the selection of those to be covered under the risk portion of the contract is made in an unbiased manner, as provided in § 417.446(c).

(b) *Conditions for special supplemental benefits.* A current nonrisk Medicare enrollee of an organization with a risk contract who is precluded from enrollment under the risk portion of the contract because of the two-for-one rule in § 417.446(a) may enroll in a plan for special supplemental benefits, if one is offered by the organization. The plan may cover some or all of the additional benefits described in § 417.440(b)(4). The plan must—

(1) Be offered to all current nonrisk Medicare enrollees of the organization who meet the requirements of this paragraph;

(2) Be offered at no cost to those enrollees;

(3) Offer a uniform package of benefits to all those enrollees;

(4) Be voluntary for those enrollees;

(5) Not affect the selection of the enrollees who will be converted to coverage under the risk portion of the contract;

(6) Restrict the enrollees who accept the plan from receiving payment directly or on their behalf for covered items and services received from sources outside the organization, in the same manner and subject to the conditions described in § 417.420(c);

(7) Provide that reimbursement for the special supplemental services for such enrollees be made from the savings the organization achieves, in the manner described in § 417.442; and

(8) Be offered with full disclosure of all provisions, especially the restriction described in paragraph (c)(6) of this section.

(c) *Notification.* Current nonrisk Medicare enrollees must be informed of the availability of any special supplemental benefits at least 90 days prior to the beginning of the organization's enrollment period, or other opportunity to enroll.

§ 417.446 Two-for-one enrollment criteria.

(a) *Basic rule.* In order to receive reimbursement on a risk basis for a current nonrisk Medicare enrollee, a risk organization must enroll two new Medicare enrollees for each current nonrisk Medicare enrollee who is converting. Selection of those enrollees to be converted must be made in an unbiased manner as prescribed in paragraphs (b) and (c) of this section.

(b) *Procedure for conversion.* (1) The organization must keep an accurate count of new Medicare enrollees and, on request by HCFA, be able to demonstrate that it has done so.

(2) Unused opportunities to convert current nonrisk Medicare enrollees to the risk provisions of the contract may be carried forward indefinitely from one contract period to another regardless of the death or subsequent disenrollment of a new Medicare enrollee.

(3) The organization may convert current nonrisk Medicare enrollees continuously as vacancies occur under the two-for-one criteria or during a special period designated for this purpose at least annually.

(i) The organization need not have a special period if no conversions are possible.

(ii) If special periods are held, current nonrisk Medicare enrollees must be informed about the period 60 days before it begins.

(iii) If waiting lists are used, the organization may convert the current nonrisk Medicare enrollees as vacancies occur, or on a group basis (for example, 10 or 20 at a time) for administrative ease. In either case, the enrollees must be converted in the order in which they appear on the waiting list. Placement on a waiting list must be on an equitable basis such as first-come, first-served.

(iv) The organization may allow continuous application for conversion with applicants being placed on a waiting list and converted as vacancies occur.

(c) *Requirements for unbiased conversion.* The organization, whether it uses a waiting list, a special period or another approach such as selection by lottery, must convert current nonrisk Medicare enrollees to the risk provisions of the contract in an unbiased manner. This means that the organization must—

(1) Inform in a timely, open, and complete manner all current nonrisk Medicare enrollees of their right to convert to the risk portion of the contract and the procedures for doing so;

(2) Not discriminate among the current nonrisk Medicare enrollees on the basis of geographic location, health status, or whether or not they have enrolled in the organization's plan for special supplemental benefits, if one is offered;

(3) Not discriminate among current nonrisk Medicare enrollees who are in similar circumstances, such as length of previous enrollment; and

(4) If it uses a waiting list, place the current nonrisk Medicare enrollees on the list in an equitable manner, such as first-come, first-served during a special period, a lottery, or greatest length of time enrolled in the organization.

§ 417.448 Restrictions on obtaining services for Medicare enrollees of risk organizations.

(a) *Basic rule.* Except for emergency and urgently needed services (defined in § 417.401), certain Medicare enrollees of risk organizations may not have Medicare payments made to them or on their behalf for any services received that are not provided directly or through arrangements made by the organization. This restriction applies to—

(1) New Medicare enrollees;

(2) Current nonrisk Medicare enrollees who convert to risk reimbursement; and

(3) Current nonrisk Medicare enrollees who elect special supplemental coverage plans.

(b) *End of restriction.* The restriction on obtaining services imposed by paragraph (a) of this section does not apply to a—

(1) Disenrolled Medicare enrollee as of the first day of the month in which termination of enrollment is effective as provided under § 417.460(b)(3); or

(2) Medicare enrollee who permanently leaves the geographic area served by the risk organization as of the first day of the first month following the month in which the enrollee notifies the organization (as required in § 417.436(a)(4)) that he or she has permanently moved out of the area, unless the organization and enrollee have made arrangements for the enrollee's membership to continue as provided in § 417.460(a)(2)(v).

§ 417.450 Effective date of coverage.

(a) *Basic rules.* Except as specified in paragraph (b) of this section—

(1) Medicare's liability for payments to an organization on behalf of a Medicare beneficiary begins on the first day of the month in which he or she is—

(i) Entitled to Medicare benefits; and

(ii) Enrolled in an organization; and

(2) The effective month of coverage may not be earlier than the first month after, nor later than the third month after the month in which HCFA receives the information necessary to include the beneficiary as a Medicare enrollee of the organization in HCFA records.

(b) *Exceptions.* (1) HCFA may approve a later month if it is requested by the organization and the beneficiary.

(2) If an individual becomes an organization enrollee before becoming entitled to Medicare Part B benefits, the effective month of coverage is the first month for which he or she becomes entitled to Medicare Part B benefits.

(c) *Notice of effective date of coverage.* HCFA will promptly advise the organization of the month for which HCFA's liability for payment begins for each beneficiary added to its records as an enrollee of the organization.

§ 417.452 Liability of Medicare enrollees.

(a) *Deductibles and coinsurance.* (1) A Medicare enrollee of an organization is responsible for applicable Medicare deductible and coinsurance amounts, unless the organization's charges for these amounts are reduced under § 417.442.

(2) The deductible and coinsurance amounts may be paid by the enrollee or on his or her behalf by another individual, organization, or entity. The payments may be made in the form of a premium, membership fee, charge per unit or similar charge.

(3) The sum of the amounts the organization charges its Medicare enrollees for Medicare deductibles and coinsurance may not exceed, on the

average, the actuarial value of the deductible and coinsurance the Medicare enrollees otherwise would have been liable for had they not enrolled in the organization or in another organization.

(b) *Services not covered under Medicare.* Unless the services are provided under § 417.442 or § 417.444(b), a Medicare enrollee of an organization is liable for payment for—

(1) All services that are not covered under Medicare Part A or Part B; or

(2) If entitled only to Medicare Part B benefits, all services that are not covered under Medicare Part B.

(c) *Services for which Medicare is not primary payor.* A Medicare enrollee of an organization is liable for payments made to the enrollee for all covered services for which Medicare is not the primary payor as provided in § 417.528.

(d) *Optional supplemental benefits plan.* (1) The organization may offer its Medicare enrollees a supplemental benefit plan to cover deductible and coinsurance amounts, or services not covered under Medicare, or both.

(2) If a supplemental benefit plan premium includes charges for both noncovered services and the deductible and coinsurance amounts applicable to covered services, the portion of the premium that is for deductibles and coinsurance must be computed separately and must be disclosed to the beneficiary during the enrollment process and before he or she elects coverage options.

(3) The sum of the amounts an organization charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services.

(e) *Coverage of Part A services for Part B-only Medicare enrollees.* If an organization furnishes coverage of Medicare Part A services to a Medicare enrollee entitled to Part B only, the organization's premium (or other payment method) for these services may not exceed the ACR for these services. In addition, if a risk organization furnishes these services and supplemental services, which are the same as the additional benefits furnished Medicare enrollees of the organization who are entitled to benefits under both Parts A and B, the organization's combined premium for both these groups of services that the Part B enrollee must pay may not exceed 95 percent of the weighted average AAPCC for Part A services (or the Medicare payment for Part A services, if it is less) for the Medicare enrollees in the organization.

§ 417.454 Charges to Medicare enrollees.

(a) The organization must agree to charge its Medicare enrollees only for the—

(1) Deductible and coinsurance amounts applicable to furnished covered services;

(2) Charges for noncovered services or services for which the enrollee is liable as described in § 417.452; and

(3) Services for which Medicare is not the primary payor as provided in § 417.528.

(b) A risk organization must report, within 90 days after the end of the contract period, all premiums, enrollment fees, and other charges collected from its Medicare enrollees during that period.

§ 417.456 Refunds to Medicare enrollees.

(a) *Definitions.* As used in this section—

Amounts incorrectly collected means amounts collected that are in excess of those specified in § 417.452. It includes amounts collected when the enrollee was believed not entitled to Medicare benefits if the enrollee is later determined to have been entitled to Medicare benefits and Medicare is liable for payments as specified in § 417.450.

Other amounts due means amounts due a Medicare enrollee for services obtained outside the organization if they were—

(1) Emergency services;

(2) Urgently needed services for which the organization has assumed financial responsibility; or

(3) On appeal under §§ 417.600 through 417.638, found to be services the enrollee was entitled to have furnished by the organization.

(b) *Basic commitment.* An organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and any other amounts due the enrollees or others on their behalf.

(c) *Refund by lump sum payment.* An organization must make refunds to its current and former Medicare enrollees, or to others who have made payments on behalf of enrollees, by lump sum payment for the following:

(1) Incorrectly collected amounts that were not collected as premiums.

(2) Other amounts due.

(3) All amounts due, if the organization is going out of business.

(d) *Refund by premium adjustment or lump sum payment or both.* An organization may make refund by adjustment of future premiums, by lump sum payment, or by a combination of both methods, for amounts that were incorrectly collected in the form of premiums or through a combination of premium payments and other charges.

(e) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort by the organization, the organization must make the refund in accordance with State law.

(f) *Reduction by HCFA.* If the organization does not make refund in accordance with paragraphs (b) through (d) of this section by the end of the contract period following the contract period during which an amount was determined to be due an enrollee, HCFA will reduce its payment to the organization by the amounts incorrectly collected or otherwise due, and arrange for those amounts to be paid to the Medicare enrollee.

§ 417.458 Recoupment of uncollected deductible and coinsurance amounts.

An organization agrees to recoup deductible and coinsurance amounts for which Medicare enrollees were liable in a previous contract period only in the following circumstances:

(a) The organization failed to collect the deductible and coinsurance amounts during the contract period in which they were due because of—

(1) Underestimation of the actuarial value of the deductible and coinsurance amounts; or

(2) A billing error.

(b) The organization has identified the amounts and obtained advance HCFA approval of the recoupment and the method and timing of recoupment.

(c) The organization collects these amounts no later than the end of the contract period following the contract period during which they were found to be due.

§ 417.460 Disenrollment of beneficiaries and termination of payments to an organization.

(a) *Disenrollment of health insurance program beneficiaries.* An organization may not, orally or in writing, or by any action or inaction, request or encourage a Medicare enrollee to disenroll, except in the following circumstances:

(1) *Failure to pay premiums*—(i) *Basic rules.* Except as specified in paragraph (a)(1)(iii) of this section, an organization may disenroll a Medicare enrollee who fails to pay premiums or other charges imposed by the organization for deductible and coinsurance amounts for which the enrollee is liable, if the organization—

(A) Can demonstrate to HCFA that it made reasonable efforts to collect the unpaid amount;

(B) Gives the enrollee written notice of disenrollment, including an explanation of the enrollee's right to a hearing under the organization's grievance procedures; and

(C) Sends the notice of disenrollment to the enrollee before it notifies HCFA.

(ii) *When HCFA's liability ends.* (A) HCFA's liability to make monthly capitation payments to the organization on behalf of the enrollee ends as of the first day of the month following the month in which termination of enrollment as a Medicare enrollee is effective, as shown on HCFA records.

(B) Disenrollment will be effective no earlier than the month immediately after, and no later than the third month after, the month in which the disenrollment notice is received in acceptable form by HCFA.

(iii) *Exception.* If a Medicare enrollee of an organization fails to pay the separate premium (or the corresponding portion of a single premium) for optional supplemental benefits (that is, a package of benefits that an enrollee is not required to accept) but pays the premium for the deductible and coinsurance amounts, the organization may discontinue the optional supplemental benefits but may not disenroll the enrollee.

(2) *Enrollee moves out of the organization's geographic area*—(i) *Basic rule.* Except as provided in paragraph (a)(2)(iv) of this section, an organization must disenroll a Medicare enrollee who moves out of its geographic area and does not voluntarily disenroll under paragraph (b) of this section if the organization—

(A) Establishes, on the basis of a written statement from the enrollee or other evidence acceptable to HCFA, that the enrollee has permanently moved out of its geographic area; and

(B) Complies with the notice requirements set forth in paragraph (a)(1)(i) of this section.

(ii) *Failure to disenroll does not expand geographic area.* If the organization does not disenroll an enrollee who has moved out of its geographic area, that area is not automatically expanded to encompass the location of the enrollee's new residence.

(iii) *When HCFA's liability ends.* The provisions of paragraph (a)(1)(ii) of this section apply.

(iv) *Exception.* An organization may, if the enrollee agrees, retain as a member an enrollee who permanently moves out of the organization's geographic area. For purposes of this section, a permanent move means an uninterrupted absence of more than 90 days from the organization's geographic area. The restriction on obtaining services under § 417.448(a) does not apply to these enrollees. Organizations that choose to exercise this exception must do so for all their Medicare enrollees who permanently move out of the organization's geographic area.

(3) *Failure to convert to risk provisions of contract*—(i) *Disenrollment and notice.* A risk organization must disenroll a current, nonrisk Medicare enrollee if the enrollee refuses to convert to the risk provisions of the organization's contract after HCFA has determined under § 417.444(a)(1) that all of the organization's current nonrisk Medicare enrollees must be converted. The organization must notify the enrollee that failure to convert will result in disenrollment. The notice must be sent at least 30 days before the organization notifies HCFA of the disenrollment.

(ii) *When HCFA's liability ends.* The provisions of paragraph (a)(1)(ii) of this section apply.

(4) *Enrollee commits fraud or permits abuse of organization membership card.* (i) A Medicare beneficiary may be disenrolled by the organization if the beneficiary knowingly provides, on the application form, fraudulent information upon which an organization relies and which materially affects his or her eligibility to enroll in the organization, or if the beneficiary intentionally permits others to use his or her membership card to receive services from the organization. (ii) In either case, the organization must give the beneficiary a written notice of termination of enrollment. The notice must be mailed to the enrollee prior to the submission of the disenrollment notice to HCFA. The notice must include an explanation of the enrollee's right to have the disenrollment heard under the grievance procedures established under § 417.436.

(iii) The liability of HCFA to make monthly capitation payments to the organization on behalf of the beneficiary terminates as of the first day of the month in which the termination of the membership in the organization is made effective, as shown on HCFA records. In no event may that month be earlier than the month immediately following, or later than the third month following the month in which the disenrollment notice is received in acceptable form by HCFA.

(iv) The organization must report any disenrollment made under the provisions of this paragraph (a)(4) to the Inspector General of the Department.

(5) *Enrollee's entitlement to benefits under the supplementary medical insurance program ends.* (i) The liability of HCFA to make monthly capitation payments to the organization on behalf of the beneficiary ends with the month immediately following the last month of entitlement to benefits under Part B of Medicare. The beneficiary may be continued as an enrollee other than as a Medicare enrollee by the organization under its regular plan if the organization and the enrollee so choose.

(ii) If an enrollee loses entitlement to benefits under Part A of Medicare but remains entitled to benefits under Part B, the enrollee automatically continues as a Medicare enrollee of the organization and is entitled to receive and have payment made for Part B services beginning with the month immediately following the last month of his or her entitlement of Part A benefits.

(6) *Disenrollment for cause.*—(i) *When cause may be cited.* An organization may disenroll a Medicare enrollee for cause if the enrollee's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continuing membership in the organization seriously impairs the organization's ability to furnish services to either the enrollee or other members.

(ii) *Effort to resolve the problem.* The organization must make a serious effort to resolve the problem presented by the enrollee, including the use (or attempted use) of internal grievance procedures.

(iii) *Consideration of extenuating circumstances.* The organization must ascertain that the enrollee's behavior is not related to the use of medical services or mental illness.

(iv) *Documentation.* The organization must document the problems, efforts, and medical conditions as described in paragraphs (a)(6) (i), (ii), and (iii) of this section.

(v) *HCFA review of an organization's proposed disenrollment.* HCFA will decide, based on a review of the documentation submitted by the organization, whether disenrollment requirements have been met. HCFA will make this decision within 20 working days of receipt of the documentation material, and notify the organization within five working days after its decision is made.

(vi) *Effective date of disenrollment.* If HCFA permits an organization to disenroll an enrollee for cause, the disenrollment takes effect on the first day of the calendar month after the month in which the organization complies with the notice requirements in paragraphs (a)(1)(i) (B) and (C) of this section (other than the right to a hearing as described in paragraph (a)(1)(i)(B) of this section).

(vii) *When HCFA's liability ends.* The provisions of paragraph (a)(1)(ii)(A) of this section apply.

(7) *Death of the enrollee.* The liability of HCFA for payments to the organization on behalf of a Medicare enrollee who dies ends as of the first day of the month following the month of death.

(b) *Disenrollment by the enrollee.* (1) A Medicare enrollee may disenroll at any time by giving the organization a signed, dated request in the form and manner prescribed by the organization. The enrollee may request a certain disenrollment date but it may be no earlier than the first day of the second month following the month in which the organization receives the request.

(2) The organization must submit a disenrollment notice to HCFA within 30 days of receipt of the enrollee's request.

(3) HCFA's responsibility for payments to the organization ends with the close of the month of termination requested by the enrollee and approved by the organization.

(4) If the organization fails to submit the notice required in paragraph (b)(2) of this section on a timely basis, the organization must reimburse HCFA for any capitation payments received after the month in which payments would have ceased if the requirement had been met timely.

(c) *Effect of termination or default of contract*—(1) *Termination of contract.* If the contract between HCFA and the organization is terminated by mutual consent or by unilateral action of either party, HCFA's liability for payments ends as of the first day of the month after the last month for which the contract is in effect.

(2) *Default of contract.* If the organization defaults on the contract before the end of the contract year because of bankruptcy or other reasons, HCFA will—

(i) Determine the month in which its liability for payments ends; and

(ii) Notify the organization and all affected Medicare enrollees as soon as practicable.

Contract Requirements

§ 417.470 Basis and scope.

(a) *Basis.* Sections 417.472 through 417.494 implement those portions of section 1876(c), (g), (h), and (i) of the Act that pertain to the contract between HCFA and an organization for participation in the Medicare program.

(b) *Scope.* Sections 417.472 through 417.494 set forth—

(1) Specific contract requirements; and

(2) Procedures for renewal, nonrenewal, or termination of a contract.

§ 417.472 Basic contract requirements.

(a) *Submittal of contract.* In order for an eligible organization to participate in the Medicare program, an authorized official of the organization must sign and submit a contract that meets the requirements of this subpart and any other provisions required by HCFA.

(b) *Contract provisions for all eligible organizations.* The contract must provide that the organization agrees to comply with all the applicable requirements and conditions set forth in this subpart and general instructions of HCFA.

(c) *Other contract provisions.* In addition to the requirements set forth in §§ 417.474 through 417.488, the contract must contain any other terms and conditions that HCFA requires to implement section 1876 of the Act.

(d) *Exemption from Federal procurement regulations.* The Federal Acquisition Regulations and HHS Acquisition Regulations contained in Title 48 of the Code of Federal Regulations do not apply to Medicare contracts under section 1876 of the Act.

(e) *Compliance with civil rights laws.* The organization must comply with title VI of the Civil Rights Act of 1964 (regulations at 45 CFR Part 80), section 504 of the Rehabilitation Act of 1973 (regulations at 45 CFR Part 84), and the Age Discrimination Act of 1975 (regulations of 45 CFR Part 91).

(f) *Authority to waive conflicting contract requirements.* Under section 1876(l)(5) of the Act, the Secretary is authorized to administer the terms of this subpart without regard to provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if he or she determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

§ 417.474 Effective date and term of contract.

(a) The contract must specify its effective date.

(b) The effective date may not be earlier than the date it is signed by both HCFA and the organization.

(c) The contract must specify the duration of its term. However, the initial term of the contract must be at least 12 months, but not more than 23 months; and any subsequent term must be for a period of 12 months.

§ 417.476 Waived conditions.

The contract must specify the following information for each of the qualifying conditions required under §§ 417.410 through 417.418 that is waived by HCFA:

(a) The specific terms of the waiver.

(b) The expiration date of the waiver.

(c) Any other information required by HCFA.

§ 417.478 Requirements of other laws and regulations.

The contract must provide that the organization agrees to comply with—

(a) The requirements for PRO review of services furnished to Medicare enrollees as set forth in Subchapter D of this chapter;

(b) Sections 1318(a) and (c) of the PHS Act, which pertain to disclosure of certain financial information;

(c) Section 1301(c)(8) of the PHS Act, which relates to liability arrangements to protect members of the organization; and

(d) The reporting requirements in § 110.108(j)(i) of this title, which pertain to the monitoring of an organization's continued compliance. For purposes of this paragraph, references in that section to "HMO" are also deemed references to "CMP".

§ 417.480 Maintenance of records: Reasonable cost organizations.

A contract with a reasonable cost organization must provide that the organization agrees to maintain books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to—

(1) Ensure an audit trial; and

(2) Properly reflect all direct and indirect costs claimed to have been incurred under the contract; and

(b) Include at least records of the following:

(1) Ownership, organization, and operation of the organization's financial, medical, and other recordkeeping systems.

(2) Financial statements for the current contract period and three prior periods.

(3) Federal income tax or information returns for the current contract period and three prior periods.

(4) Assets acquisition, lease, sale, or other action.

(5) Agreements, contracts, and subcontracts.

(6) Franchise, marketing, and management agreements.

(7) Schedules of charges for the organization's fee-for-service patients.

(8) Matters pertaining to costs of operations;

(9) Amounts of income received by source and payment.

(10) Cash flow statements.

(11) Any financial reports filed with other Federal programs or State authorities.

§ 417.481 Maintenance of records: Risk organizations.

A contract with a risk organization must provide that the organization agrees to maintain, and make available to HCFA upon request, books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to—

(1) Establish component rates of the ACR for determining additional and supplementary benefits; and

(2) Determine the rates utilized in setting premiums for State insurance agency purposes; and

(b) Include at least any records or financial reports filed with other Federal agencies or State authorities.

§ 417.482 Access to facilities and records.

The contract must provide that the organization agrees to the following:

(a) HHS may evaluate, through inspection or other means, the quality, appropriateness, and timeliness of services furnished under the contract to its Medicare enrollees.

(b) HHS may evaluate, through inspection or other means, the facilities of the organization when there is reasonable evidence of some need for that inspection.

(c) HHS, the Comptroller General, or their designees may audit or inspect any books and records of the organization or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract.

(d) HHS may evaluate, through inspection or other means, the enrollment and disenrollment records for the current contract period and three prior periods, when there is reasonable evidence of some need for that inspection.

(e) In the case of a reasonable cost organization, to make available for the purposes specified in paragraphs (a), (b), (c), and (d) of this section, its premises, physical facilities, and equipment, its records relating to its Medicare enrollees, the records specified in § 417.480 and any additional relevant information that HCFA may require.

(f) That the right to inspect, evaluate, and audit, will extend through three years from the date of the final settlement for any contract period unless—

(1) HCFA determines there is a special need to retain a particular record or group of records for a longer period and notifies the organization at least 30 days before the normal disposition date;

(2) There has been a termination, dispute, fraud, or similar fault by the organization, in which case the retention may be extended to three years from the date of any resulting final settlement; or

(3) HCFA determines that there is a reasonable possibility of fraud, in which case it may reopen a final settlement at any time.

§ 417.484 Requirement applicable to related entities.

(a) *Definition.* As used in this section, "related entity" means any entity that is related to the organization by common ownership or control and—

(1) Performs some of the organization's management functions under contract or delegation;

(2) Furnishes services to Medicare enrollees under an oral or written agreement; or

(3) Leases real property or sells materials to the organization at a cost of more than $2,500 during a contract period.

(b) *Requirement.* The contract must provide that the organization agrees to require all related entities to agree that—

(1) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent books, documents, papers, and records of the subcontractor involving transactions related to the subcontract; and

(2) The right under paragraph (b)(1) of this section to information for any particular contract period will exist for a period equivalent to that specified in § 417.482(f).

§ 417.486 Disclosure of information and confidentiality.

The contract must provide that the organization agrees—

(a) To submit to HCFA—

(1) All financial information required under §§ 417.530 through 417.576 and for final settlement; and

(2) Any other information necessary for the administration or evaluation of the Medicare program.

(b) To comply with the requirements set forth in Part 420, Subpart C, of this chapter pertaining to the disclosure of ownership and control information;

(c) To comply with the requirements of the Privacy Act, as implemented by 45 CFR Part 5b and Subpart B of Part 401 of this chapter, with respect to any system of records developed in performing carrier or intermediary functions under §§ 417.532 and 417.533; and

(d) To meet the confidentially requirements of § 405.1026(a) of this chapter for medical records and for all other information on enrollees, not covered under paragraph (c) of this section, that is contained in its records or obtained from HCFA or others.

§ 417.488 Written notice of termination.

A risk contract must provide that if the contract is terminated, the organization agrees to give to its Medicare enrollees, and to be responsible for the cost of, the following notices.

(a) A written notice of the termination at least 60 days before the termination date.

(b) A written description of alternatives available for obtaining Medicare services after termination.

§ 417.490 Renewal contract.

A contract with an organization is renewed automatically for the next 12-month period unless HCFA or the organization decides not to renew, in accordance with § 417.492.

417.492 Nonrenewal of contract.

(a) *Nonrenewal by the organization.* (1) If an organization does not intend to renew its contract, it must—

(i) Give written notice to HCFA at least 90 days before the end of the current contract period;

(ii) Notify each Medicare enrollee by mail at least 60 days before the end of the contract period; and

(iii) Notify the general public at least 30 days before the end of the contract period, by publishing a notice in one or more newspapers of general circulation in each community or county located in the organization's geographic area.

(2) HCFA may accept a nonrenewal notice submitted less than 90 days before the end of a contract period if—

(i) The organization notifies its Medicare enrollees and the public in accordance with paragraph (a)(1) of this section; and

(ii) Acceptance would not otherwise jeopardize the effective and efficient administation of the Medicare program.

(b) *Nonrenewal by HCFA.* If HCFA decides not to renew a contract, it will notify interested parties of certain information, as follows:

(1) The organization at least 90 days before the end of the contract peiod;

(2) the organization's Medicare enrollees at least 60 days before the end of the contract period;

(3) The general public at least 30 days before the end of the contract period; and

(4) The organization that if the organization is dissatisfied with the decision, and HCFA's decision was based on one of the reasons specified in § 417.640(c), the organization may appeal that decision in accordance with procedures specified in §§ 417.640 through 417.682.

§ 417.494 Modification or termination of contract.

(a) *Modification or termination by mutual consent.* (1) HCFA and an organization may modify or terminate a contract at any time by written mutual consent.

(2) If the contract is modified, the organization must notify its Medicare enrollees of any changes that HCFA determines are appropriate for notification.

(3) If the contract is terminated, the organization must notify its Medicare enrollees, and HCFA will notify the general public, at least 30 days before the termination date.

(b) *Termination by HCFA.* (1) HCFA may terminate a contract for any of the following reasons:

(i) The organization has failed substantially to carry out the terms of the contract.

(ii) The organization is carrying out the contract in a manner that is inconsistent with the effective and efficient implementation of section 1876 of the Act.

(iii) PHS determines that the organization no longer meets the applicable conditions necessary to qualify as an eligible organization under section 1876 of the Act and this subpart.

(2) If HCFA determines that a contract will be terminated, it will send written notice to the organization and indicate the organization's right to appeal that determination in accordance with the procedures specified in §§ 417.640 through 417.682.

(3) An organization with a risk contract must notify its Medicare enrollees of the termination as described in § 417.488.

(4) HCFA will notify the organization's Medicare enrollees and the general public of the termination at least 30 days before the termination date.

(c) *Termination by the organization.* The organization may terminate the contract if HCFA has failed substantially to carry out the terms of the contract.

(1) The organization must notify HCFA at least 90 days before the effective date of the termination and must include in its notice the reasons for the termination.

(2) The organization must notify its Medicare enrollees of the termination at least 60 days before the termination date. Risk organizations must also provide a written description of alternatives available for obtaining Medicare services after termination of the contract. The organization is responsible for the cost of these notices.

(3) The organization must notify the general public of the termination at least 30 days before the termination date.

(4) The contract will be terminated effective 60 days after the notice to Medicare enrollees is mailed, as required in paragraph (c)(2) of this section.

(5) HCFA's liability for payment ends as specified in § 417.460(c).

Change of Ownership and Leasing of Facilities.

§ 417.520 General provisions.

(a) *Definitions.* As used in this subpart—

Lessee means the entity to which an organization leases all or part of its facilities.

Lessor means the organization that leases all or part of its facilities to another entity.

Novation agreement means a document executed and signed by the current owner of the organization, the proposed new owner, and HCFA, under which HCFA recognizes the new owner as the successor in interest to the current owner's Medicare contract.

(b) *Basic rules*—(1) *Change of ownership.* Except as provided in paragraph (b)(3)(ii) of this section, a change of ownership of an organization makes its Medicare contract invalid with respect to the period following the change of ownership, unless there is a novation agreement.

(2) *Effect of change without novation agreement.* If the new owner wishes to participate in the Medicare program, it must notify HCFA of the change of ownership and apply for and enter into a contract in accordance with §§ 417.472 through 417.488.

(3) *Advance notice of HCFA.* (i) An organization with a contract under this subpart that is considering or negotiating a change of ownership must notify HCFA at least 60 days before the anticipated change.

(ii) If the organization fails to provide the required notice to HCFA timely, it will continue to be liable for capitation payments HCFA makes to it on behalf of Medicare enrollees after the date of change of ownership.

§ 417.521 What constitutes change of ownership.

(a) *Partnership.* The removal, addition, or substitution of a partner, unless the partners expressly agree otherwise as permitted by applicable State law, constitutes a change ownership.

(b) *Unincorporated sole proprietorship.* Transfer of title and property to another party constitutes change of ownership.

(c) *Corporation.* (1) The merger of the organization's corporation into another corporation or the consolidation of the organization with one or more other corporations, resulting in a new corporate body, constitutes a change of ownership.

(2) Transfer of corporate stock or the merger of another corporation into the organization's corporation with the organization surviving, does not ordinarily constitute change of ownership.

§ 417.522 Novation agreement requirements.

(a) *Conditions for HCFA approval of a novation agreement.* HFCA will approve a novation agreement if the following conditions are met:

(1) *Advance notification.* The organization notifies HCFA at least 60 days before the date of the proposed change of ownership.

(2) *Advance submittal of agreement.* The organization submits to HCFA, at least 30 days before the proposed change of ownership date, three signed copies of the novation agreement containing the provisions specified in paragraph (b) of this section, and one copy of other relevant documents required by HCFA.

(3) *HCFA's determination.* HCFA determines that—

(i) The proposed new owner is in fact a successor in interest to the contract;

(ii) Recognition of the new owner as a successor in interest to the contract is in the best interest of the Medicare program; and

(iii) The Assistant Secretary of Health has certified that successor organization meets the PHS requirements to qualify as an eligible organization.

(b) *Provisions of a novation agreement*—(1) *Assumption of contract obligations.* The new owner must assume all obligations under the contract.

(2) *Waiver of right to reimbursement.* The previous owner must waive its rights to reimbursement for covered services furnished during the rest of the current contract period.

(3) *Guarantee of performance.*

(i) The previous owner must guarantee performance of the contract by the new owner during the contract period; or

(ii) The new owner must post a performance bond that is satisfactory to HCFA.

(4) *Records Access.* The previous owner must agree to make its books and records and other necessary information available to the new owner and to HCFA to permit an accurate determination of costs for the final settlement of the contract period.

§ 417.523 Effect of leasing of an organization's facilities.

(a) *Effect of lessee status.* If an organization leases all or part of its facilities to another entity, the lessee does not acquire eligible organization status under section 1876 of the Act.

(b) *Effect of lease of all facilities.* (1) If an organization leases all of its facilities to another entity, the contract terminates.

(2) If the lessee wishes to participate in Medicare as an eligible organization, it must apply for and enter into a contract in accordance with this subpart.

(c) *Effect of partial lease of facilities.* If the organization leases part of its facilities to another entity, its contract with HCFA remains in effect while HCFA surveys the organization to determine whether it continues to be in compliance with the requirements and qualifying conditions specified in §§ 417.410 through 417.416.

General Reimbursement Rules

§ 417.524 Payment to eligible organizations: General.

(a) *Basic rule.* The payments made to an eligible organization in accordance with the provisions of this subpart for furnishing covered Medicare services are in lieu of any payment that would otherwise be made to a beneficiary or the organization under sections 1814(b) and 1833(a) of the Act.

(b) *Basis of payment.* Reimbursement to eligible organizations is made on either a reasonable cost basis or a risk basis depending on the type of contract the organization has with HCFA. In certain cases, organizations that have contracted on a risk basis also receive reimbursement on a reasonable cost basis for certain Medicare enrollees. (See § 417.444 for a discussion of this provision.)

§ 417.526 Payment for covered services.

Sections 417.530 through 417.576 set forth the principles that HCFA follows in determining Medicare reimbursement to an eligible organization that has a reasonable cost contract. Sections 417.580 through 417.596 describe the per capita method of Medicare reimbursement to eligible organizations that contract on a risk basis.

§ 417.528 Payment for covered services—Medicare not primary payor.

(a) HCFA may not reimburse an organization for services to the extent that Medicare is not the primary payor under the provisions of section 1862(b) of the Act. The circumstances under which an organization may charge, or authorize a provider to charge, for covered Medicare services where Medicare is not the primary payor are stated in paragraphs (b) and (c) of this section.

(b) If a Medicare enrollee receives otherwise covered services from an eligible organization for which the enrollee is entitled to benefits under a State or Federal worker's compensation law or plan, an automobile medical, or no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the organization may charge, or authorize a provider that furnished the service to charge—

(1) The insurance carrier, employer, or other entity that is liable to pay for these services; or

(2) The Medicare enrollee, to the extent that he or she has been compensated under the law or policy.

(c) An eligible organization may charge an employer group health plan for covered services furnished by the organization to a Medicare enrollee and may charge the Medicare enrollee to the extent that he or she has been reimbursed by the employer group health plan for these covered services if—

(1) The Medicare enrollee is covered by the group health plan; and

(2) HCFA is not permitted to make payment for the covered services furnished under the provisions of sections 1862(b)(2) or 1862(b)(3)(A)(i) of the Act.

(d) An organization must—

(1) Identify payors that are primary to Medicare under section 1862(b) of the Act;

(2) Determine the amounts payable by these payors; and

(3) Coordinate the benefits of its Medicare enrollees with these payors.

Reasonable Cost Reimbursement

§ 417.530 Basis and scope.

Sections 417.530 through 417.576 set forth the principles that HCFA follows in determining the amount it will pay to an organization for services furnished by the organization to its Medicare enrollees for whom HCFA reimburses the organization on a reasonable cost basis (or under section 1886 of the Act, as applicable). These principles are based on sections 1861(v) and 1876 of the Act and are, for the most part, the same as those set forth in Subpart D of Part 405 of this chapter for reimbursement of provider costs on a reasonable cost basis.

§ 417.531 Hospice care services.

(a) If a Medicare enrollee of an organization with a reasonable cost contract makes an election under § 418.24 of this chapter to receive hospice care services, reimbursement for these services is made to the hospice participating in the Medicare program that furnishes the services in accordance with Part 418 of this chapter.

(b) While the enrollee's hospice election is in effect, the organization may be reimbursed on a reasonable cost basis for only the following covered Medicare services furnished to the Medicare enrollee:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

§ 417.532 General considerations.

(a) *Conditions and criteria for reimbursement.* (1) The costs incurred by the organization to furnish services covered by Medicare are reimbursable if they are—

(i) Proper and necessary;

(ii) Reasonable in amount; and

(iii) Except as provided in § 417.550, appropriately apportioned among the organization's Medicare enrollees, other enrollees, and nonenrolled patients.

(2) In determining fair and equitable reimbursement for the organizations, HCFA generally applies the cost reimbursement principles set forth in § 405.402 (a) and (b) of this chapter.

(3) Except as specified in paragraph (a)(4) of this section, in judging whether costs are reasonable, HCFA applies the weighted average to the AAPCCs of each class of the organization's Medicare enrollees (as defined in § 417.582) for the organization's geographic area as an absolute limitation on the total amount payable.

(4) For contract periods beginning before January 1, 1986, an entity with an existing cost contract is not subject to the reimbursement limitation specified in paragraph (a)(3) of this section. In judging whether costs for these organizations are reasonable, HCFA may consider the per capital costs

incurred by the organization for its Medicare enrollees in relation to the AAPCC for the organization's geographic area or a similar area. In those cases, HCFA will use the AAPCC as a general guideline for reimbursement to a reasonable cost organization rather than as a reimbursement limitation.

(b) *Method and amount of reimbursement to the organization.* (1) HCFA makes interim per capita payments each month for each Medicare enrollee, equivalent to the interim per capita cost rate determined in accordance with § 417.570.

(2) HCFA adjusts the interim per capita rate as necessary during the contract period and makes final adjustments at the end of the contract period.

(3) In determining the amount due the organization, HCFA deducts from the reasonable cost actually incurred by the organization for covered services furnished to its Medicare enrollees, an amount equal to the actuarial value of the applicable Medicare Part A and Part B deductible and coinsurance amounts that would have applied to the covered services for which payment is being made if these enrollees had not enrolled in the organization or another eligible organization.

(c) *Election by organization.* An organization must elect, on an individual provider basis, one of the following methods for reimbursement for hospital and SNF services it furnishes to Medicare enrollees:

(1) Direct payment by HCFA.

(2) Direct payment by the organization.

(d) *Notice of election.* The election must be made in writing before the beginning of the contract period and is binding for that period.

(e) *Reimbursement by organization.* If the organization elects to pay providers directly, as provided in paragraph (c) of this section, it must—

(1) Determine the eligibility of its Medicare enrollees to receive covered services through the organization;

(2) Make proper coverage decisions and appropriate payments, in accordance with §§ 421.100 and 421.200 of this chapter, for the services furnished to its Medicare enrollees;

(3) Ensure that providers maintain and furnish appropriate documentation of physician certification and recertification, to the extent required under Subpart P of Part 406 of this chapter; and

(4) Carry out any other procedures required by HCFA.

(f) *Review of organization's bill processing capabilities.* If the organization elects to pay providers directly, HCFA will determine whether the organization has the experience and capability to carry out the responsibilities specified in paragraph (e) of this section in an efficient and effective manner.

(g) *Direct reimbursement by HCFA.* Under the election specified in paragraph (c)(1) of this section, HCFA pays a provider for the covered services it furnishes to the organization's Medicare enrollees on a reasonable cost basis or on the basis of prospectively determined rates, whichever is applicable to that provider as described in Subpart D of Part 405 of this chapter. HCFA will deduct these payments and any other payments made by intermediaries or carriers on behalf of the organization (for example, payments for emergency or urgently needed services made under § 417.558(a)) in computing the payments to the organization under paragraph (b) of this section.

(h) *Reimbursement for services furnished to Medicare beneficiaries not enrolled in the organization.* HCFA reimburses the organization for services it furnishes to Medicare beneficiaries who are not its enrollees through the organization's Medicare intermediary or carrier, as appropriate.

§ 417.533 Part B carrier responsibilities.

In paying for Part B services furnished to its enrollees by suppliers, the organization is responsible for—

(a) Determining the eligibility of individuals to receive those services through the organization;

(b) Making proper coverage decisions and appropriate payment as authorized under § 421.200 of this chapter for the services for which its Medicare enrollees are eligible; and

(c) Carrying out any other procedures that HCFA may require.

§ 417.534 Allowable costs.

(a) *Definition—Allowable costs* means the direct and indirect costs, including normal standby costs incurred by the organization, that are proper and necessary for efficient delivery of needed health care services. They include the costs of furnishing services to the organization's Medicare enrollees, other enrollees, and nonenrolled patients, which are typical "provider" costs, and costs (such as marketing, enrollment, membership, and operation of the organization) that are peculiar to health care prepayment organizations.

(b) *Basic rules.* (1) The allowability of an organization's costs for furnishing services is generally determined in accordance with principles applicable to provider costs, as set forth in § 417.536.

(2) The allowability of other costs is determined in accordance with principles set forth in §§ 417.538 through 417.550.

(3) Costs for covered services for which Medicare is not the primary payor, as described in § 417.528, are not allowable.

§ 417.536 Provider cost reimbursement principles applicable to the organizations.

(a) *Applicability.* Unless otherwise specified in this subpart, the principles or reasonable cost reimbursement set forth in Subpart D of Part 405 of this chapter are applicable to the organization's costs when incurred by an organization or by providers of services and other facilities owned or operated by the organization, or related to the organization by common ownership or control. This most common examples of these costs are set forth in this section.

(b) *Depreciation.* An appropriate allowance for depreciation on buildings and equipment is an allowable cost, in accordance with §§ 405.415, 405.417, and 405.418 or this chapter.

(c) *Interest expense.* Necessary and proper interest on both current and capital indebtedness is an allowable cost, in accordance with § 405.419 of this chapter.

(d) *Cost of educational activities.* An appropriate part of the net cost of approved educational activities of a provider or other health care facility owned or operated by an organization is an allowable cost in accordance with § 405.421 of this chapter.

(e) *Compensation of owners.* An appropriate amount of compensation for services of owners is an allowable cost, if the services are actually performed and are necessary, as specified in § 405.426 of this chapter.

(f) *Bad debts.* (1) In accordance with § 405.420 of this chapter, bad debts are deductions from revenue and may be included as allowable costs only if—

(i) They are attributable to Medicare deductible and coinsurance amounts for which the Medicare enrollee is liable, and

(ii) The organization has made a reasonable, but unsuccessful, effort to collect those amounts.

(2) If all or part of the deductible and coinsurance amounts is payable through a monthly premium or other periodic payment, the amount allowed as a bad debt may not exceed three times the monthly rate for the actuarial value of the deductible and coinsurance amounts, or its equivalent, if the periodic payment is on other than a monthly basis.

(3) Any bad debt related to a service furnished to a Medicare enrollee or the organization, and claimed on a cost report submitted for reimbursement by a provider or other facility reimbursed on a cost basis, may not be claimed as a bad debt by the organization.

(g) *Charity and courtesy allowances.* As specified in § 405.420 of this chapter, charity and courtesy allowances are deductions for revenue and may not be included as allowable costs.

(h) *Research costs.* As specified in § 405.422 of this chapter, costs incurred for research purposes, over and above patient care, are not allowable costs.

(i) *Value of services of nonpaid workers.* The value of services of nonpaid workers of an organization is not an allowable cost, except as provided in § 405.425 of this chapter.

(j) *Purchase discounts and allowances and refund of expenses.* Discounts and allowances that an organization receives on purchases of goods and services and refunds of previous expense payments must be deducted from the costs to which they relate, in accordance with § 405.425 of this chapter.

(k) *Cost to related organizations.* (1) The costs of services, facilities, or supplies furnished to an organization by a related entity are allowable at the cost to the related entity in accordance with § 405.427 of this chapter.

(2) An entity is not considered related to the organization merely because—

(i) It has a risk or incentive agreement under which the organization reimburses or compensates the entity for services it furnishes to the organizations's enrollees; or

(ii) Substantially all the services the entity furnishes are furnished to the organization's enrollees.

(3) However, an entity described in paragraph (k)(2) of this section and an organization are considered related if either of them is in a position to exercise significant management or ownership influence or control over the other.

(l) *Return on equity capital of proprietary providers owned by the organization.* An allowance for a reasonable return on equity capital invested and used in providing services is allowable in addition to the reasonable cost of services furnished by a proprietary provider owned by the organization. The amount of the allowance is determined in accordance with § 405.429 of this chapter.

(m) *Limitations on reimbursement.* Medicare payment for covered services furnished by entities owned by or operated by, or related to, an organization reimbursed on a reasonable cost basis is subject to certain provisions of Subparts D and E of Part 405 of this chapter that pertain to reasonable cost and reasonable charge. Those provisions include, but are not necessarily limited to, the following:

(1) For ESRD treatment, the limitations authorized under §§ 405.439, 405.542, and 405.544 of this chapter.

(2) For services of physical, occupational, and speech therapists and other therapists and nonphysician health specialists, the limitations set forth in § 405.432 of this chapter.

(3) For drugs, the allowable cost as determined under § 405.433 of this chapter.

(4) The overall cost limits established in accordance with § 405.460 of this chapter.

(5) The limitation to the lesser of reasonable cost or customary charges, as set forth in § 405.455 of this chapter.

§ 417.538 Enrollment and marketing costs.

(a) *Principle.* Enrollment and marketing costs incurred by an organization in the course of performing the activities described in §§ 417.426 through 417.436 are allowable as provided in this section.

(b) *Definition.* Allowable enrollment and marketing costs are those necessary and proper costs incurred in offering the organization's plan to potential enrollees in accordance with this part. Those costs include selling, advertising, promotional, and other marketing costs and may not exceed an amount that would be incurred by a prudent and cost-conscious management.

(c) *Application.* Enrollment and marketing costs are allowable, whether incurred directly by organization staff or under contract with marketing specialists or other outside consultants.

(d) *Reimbursement limitation.* The relatively higher costs that an organization is likely to incur in initially offering its plan to Medicare beneficiaries are taken into account in determining whether enrollment and marketing costs are reasonable in amount. However, if such costs exceed amounts that would be paid by prudent management, the excess is not allowable.

§ 417.540 Membership costs.

(a) *Principle.* Membership costs are allowable if incurred in maintaining and servicing subscriber contracts for prepayment enrollees.

(b) *Kind of costs included.* Membership costs include, but are not limited to, reasonable costs incurred in connection with maintaining statistical, financial, and other data on enrollees.

§ 417.542 Reinsurance costs.

Reinsurance costs are not allowable.

§ 417.544 Physicians' services furnished directly by the organization.

(a) *Principles.* Conpensation paid by an organization to physicians is an allowable cost to the extent that it is commensurate with the compensation paid for similar services performed by similar physicians practicing in the same or a similar locality. Physician compensation may take various forms, but the aggregate compensation allowable must be reasonable in relation to the services personally furnished. If aggregate physician compensation costs exceed what is normally incurred, the excess is not a reasonable cost.

(b) *Application.* In determining the allowability of the costs of physicians' services, the cost of personal services (for example, expenses attributable to salaries, wages, incentive payments, fringe benefits) must be distinguished from the cost of nonpersonal services (for example, expenses attributable to facilities, equipment, support personnel, supplies). To be allowable, compensation must be reasonable in relation to the personal services furnished.

§ 417.546 Physicians' services and other Part B supplier services furnished under arrangements.

(a) *General principle.* Except as specified in paragraph (b) of this section, the amount paid by an organization for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable. Costs are considered reasonable if they—

(1) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(2) Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or a similar geographic area.

(b) *Special limitation for entities with existing cost contracts.* For entities with existing cost contracts, the provisions of this paragraph apply for contract periods beginning before January 1, 1986.

(1) If the organization pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(1)(ii) of this section, the costs incurred by the organization may be considered reasonable if they—

(A) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(B) Are comparable to costs incurred for similar services furnished by similar physicians or other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the organization makes payment compensates its physicians on a fee-for-service basis, the organization's payment to the group may not exceed the reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(1)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the organization is considered reasonable if it meets the conditions specified in paragraph (b)(1)(i) of this section.

(2) If the organization pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the organization are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter; and

(B) The amount that HCFA would pay for those services, if they were furnished to beneficiaries who are not enrolled in the organization and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the limitations specified in paragraph (b)(2)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the organization is considered reasonable if it meets the conditions specified in paragraph (b)(1)(i) of this section.

§ 417.548 Provider services through arrangements.

(a) *Principle.* The cost incurred by an organization for covered services furnished under arrangement with a provider is allowable to the extent that it would be allowable and reimbursable under Subpart D of Part 405 of this chapter, unless, upon the organization's petition to HCFA, the organization can demonstrate to HFCA's satisfaction that payment in excess of the amount authorized under Subpart D of Part 405 of this chapter is justified on the basis of advantages gained by the organization.

(b) *Application.* An advantage gained must represent a real and tangible benefit received by the organization for the excess cost incurred, and any excess payment is subject to other applicable requirements of Part 405 of this chapter, including tests of reasonableness. For example, in the case of an arrangement an organization has with a provider that is located outside the organization's geographic area and that is not related to the organization by common ownership or control, payment of the provider's charges to the organization (rather than the provider's reasonable cost as determined under Subpart D of Part 405 of this chapter) may be justified in exchange for the advantages of not having to incur the administrative costs of determining the provider's reasonable cost and of making a more timely final settlement with the organization. However, repayment of the provider's charges would be acceptable only if—

(1) The provider furnishes services to the organization's enrollees infrequently;

(2) The charges represent an insignificant portion of total Medicare reimbursement to the organization; and

(3) The charges do not exceed the customary charges by the provider to its other patients for similar services.

§ 417.550 Special Medicare program requirements.

(a) *Principle.* Except as specified in paragraph (d) of this section, Medicare reimburses the total reasonable cost incurred by an organization for activities specified in this section that are solely for Medicare purposes and unique to Medicare contracts under section 1876 of the Act.

(b) *Application.* The following costs are reimbursed in full for cost-reimbursed Medicare enrollees:

(1) The reasonable cost of reporting data concerning increases and decreases in Medicare enrollment.

(2) The reasonable cost incurred, solely for Medicare purposes, for the independent certification of the organization's cost report required under § 417.576.

(3) The total reasonable cost of special data that HCFA requires from organizations solely for program planning and evaluation purposes.

(c) *Prior approval.* Costs that are reimbursed in full under this section must be separately budgeted and approved by HCFA before the contract period begins.

(d) *Exception: Apportioned costs.* (1) Payment in full is limited to the costs specified in paragraph (b) of this section.

(2) The normal administrative costs incurred by the organization in obtaining Medicare reimbursement (such as the cost of maintaining and reporting membership statistical, and actuarial data needed to determine the amount of reimbursement to the organization, and the cost of preparing costs reports) must be apportioned in accordance with § 417.552.

§ 417.552 Cost apportionment: General provisions.

(a) *Basic rule.* Except as provided in § 417.556(c), the organization must apportion its total allowable direct and indirect costs among its Medicare enrollees, its other enrollees, and its nonenrolled patients—

(1) In accordance with §§ 417.530 through 417.576; and

(2) Using methods approved by HCFA.

(b) *Purpose of apportionment.* The purpose of apportionment is to ensure that—

(1) The cost of services furnished to Medicare enrollees is not borne by other enrollees and nonenrolled patients; and

(2) The cost of the services furnished to other enrollees and nonenrolled patients is not borne by Medicare.

§ 417.554 Apportionment: Provider services furnished directly by the organization.

The Medicare share of the cost of covered services furnished to Medicare enrollees by providers that are owned or operated by the organization or are related to the organization by common ownership or control must be determined in accordance with the apportionment methods set forth in §§ 405.452, 405.453, 405.470 through 405.477, and 405.480 of this chapter.

§ 417.556 Apportionment: Provider services furnished by the organization through arrangements with others.

The Medicare share of the cost of covered services furnished to Medicare enrollees through arrangements with providers other than those specified in § 417.554 must be determined as follows:

(a) The Medicare share must be based on the cost the organization pays the provider under their arrangement, to the extent that cost is reasonable and within the limits established by §§ 417.534 through 417.548.

(b) Except as specified in paragraph (c) of this section, apportionment must

be on the same approved basis that is used by the provider for Medicare beneficiaries who are not Medicare enrollees of the organization, subject to the conditions and limitations set forth in § 417.548.

(c) If, because of the special nature or terms of the organization's arrangement with the provider, apportionment on the basis specified in paragraph (b) of this section would result in Medicare's bearing the costs of furnishing services to individuals other than the organization's Medicare enrollees, apportionment must be on another basis that is approved by HCFA and that will ensure that Medicare does not pay any of the cost of furnishing services to individuals who are not Medicare enrollees of the organization.

(d) If the organization elects to have providers reimbursed by the organization's Medicare intermediary, the Medicare share is the amount the intermediary paid the provider.

§ 417.558 Emergency and urgently needed services, and out-of-area services for which the organization assumes financial responsibility: Source of payment.

(a) *Payment by intermediary.* An intermediary may reimburse its providers for the reasonable cost of covered emergency or urgently needed services as defined in § 417.401, and other covered out-of-area services for which the organization assumes financial responsibility.

(b) *Payment by organization*—(1) *Basic rule.* Except as specified in paragraph (b)(2) of this section, a payment by the organization to a provider for emergency or urgently needed services as defined in § 417.401 or other out-of-area services is allowable only to the extent it would be allowable under Subpart D of Part 405 of this chapter.

(2) *Exception.* Payment in excess of the reasonable cost allowed under Subpart D of Part 405 of this chapter is allowable only if the organization demonstrates to HCFA's satisfaction that it is justified on the basis of advantages gained by the organization, as set forth in § 417.548.

§ 417.560 Apportionment: Part B physician and supplier services.

(a) *Medical services furnished directly by the organization.* The total allowable cost of Part B physician and supplier services furnished by employees or partners of the organization or by a related entity of the organization must be apportioned on the basis of the ratio of covered Part B services furnished to Medicare enrollees to total services furnished to all the organization's enrollees and nonenrolled patients. The organization must use a method for reporting costs that is approved by HCFA. HCFA will base its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(b) *Medical services furnished under arrangements made by the organization.* When the organization pays for Part B physician and supplier services on some basis other than fee-for-services, the reasonable cost the organization pays under its financial arrangement with the physician or supplier must be apportioned between Medicare enrollees and others based on the ratio of covered services furnished to Medicare enrollees to the total services furnished to all enrollees and nonenrolled patients. If apportionment on this basis would result in Medicare bearing the cost of furnishing services to individuals who are not Medicare enrollees, the Medicare share must be determined on another basis (approved by HCFA) to ensure that Medicare pays only for services furnished to Medicare enrollees.

(c) *Medical services furnished under an arrangement that provides for the organization to pay on a fee-for-service basis.* The Medicare share of the cost of Part B physician and supplier services furnished to Medicare enrollees under arrangements, and paid for by the organization on a fee-for-service basis, is determined by multiplying the total amount for all such services by the ratio of charges for covered services furnished to Medicare enrollees to the total charges for all such services.

(d) *Emergency services, urgently needed services, and other covered medical services for which the organization assumes financial responsibility.* (1) Except as provided in paragraph (d)(2) of this section, the Medicare share of the cost of Part B emergency or urgently needed services or other Part B services that are not furnished by a provider and for which the organization accepts financial responsibility is determined in accordance with paragraphs (b) and (c) of this section.

(2) For contract periods beginning before January 1, 1986, in the case of entities with existing cost contracts, payment of the physician's or supplier's charges instead of the reasonable charges as defined in Subpart E of Part 405 of this chapter may be justified if the organization demonstrates to HCFA's satisfaction that—

(i) The physician or supplier furnishes services infrequently to enrollees of the organization;

(ii) The charges represent an insignificant portion of total Medicare payments to the organization; and

(iii) The charges do not exceed the amounts the physician or supplier charges other patients for similar services.

§ 417.562 Weighting of direct services furnished by physicians and other practitioners.

(a) *Basic Rule.* For contract periods beginning before January 1, 1986, an organization may adjust ("weight") the statistics it uses to compute the apportionment of the costs of the direct professional covered Part B services of physicians and other health care personnel furnished to different patient groups to reflect variations in complexity and time required to furnish the services. HCFA must approve the weighting in advance as set forth in paragraph (b) of this section.

(b) *Basis for HCFA approval.* HCFA will approve weighting if—

(1) The weighting is based on data acceptable to HCFA;

(2) All services (covered and noncovered) used in the apportionment ratio (that is, those furnished to Medicare enrollees, to other enrollees, and to nonenrolled patients) are weighted on the same basis;

(3) The organization uses only one weighting method at a time;

(4) The wighting is applied only to services furnished to Medicare enrollees—

(i) In which there is a face-to-face contact between the enrollee and the health care personnel; and

(ii) In an ambulatory health care setting that is not a provider (for example, a medical center or clinic);

(5) The payment limitations set forth in § 417.560(c) are applied to the services, if applicable; and

(6) In the case of covered Part B services furnished under arrangements, apportionment is on the basis of services as specified in § 417.560(b).

(c) *Weighting procedure.* Weighting is accomplished by adjusting the statistics in which weighting is permissible. These weighted statistics are used to compute the weighted apportionment ratio that is applied to the salaries, wages, incentive payments, fringe benefits, and other forms of compensation of those health care personnel who furnish services that involve face-to-face contact with patients. The organization may not weight—

(1) Costs related to equipment, medical records, and supplies;

(2) Other costs not related to the compensation for the direct professional services of physicians and other health care personnel; or

(3) Costs already apportioned by relative value units or some other apportionment method in which time or complexity is reflected in the apportionment statistic.

(d) *Limitations on payment for services-furnished under arrangement.* If payment is on a fee-for-service basis, time and complexity are recognized, subject to the payment limitation in § 417.560(c) but only to the extent that they are specific and reasonable elements of the amount that the organization has agreed to pay for the services.

§ 417.564 Apportionment and allocation of administrative and general costs.

(a) Enrollment, marketing, and other administrative and general costs of the organization that benefit the total enrolled population of the organization and are not directly associated with providing medical care must be apportioned on the basis of a ratio of Medicare enrollees to the total enrollment of the organization.

(b) Administrative and general costs that bear a significant relationship to the services furnished are not apportioned to Medicare directly. These costs include facility costs, interest expense, medical record costs, centralized purchasing costs, accounting and data processing costs, and the administrative and general costs that are not included in paragraph (a) of this section. These costs are allocated or distributed to the components of the organization and are then apportioned to Medicare in accordance with the rules described in §§ 417.552 through 417.560. The allocation or distribution process must be made as follows:

(1) If a separate entity or department of an organization performs administrative functions whose benefits can be quantitatively measured (such as centralized purchasing and data processing), the total allowable costs of this entity or department must be allocated or distributed to the components of the organization in reasonable proportion to the benefits received by these components.

(2) If a separate entity or department of an organization performs administrative functions whose benefits cannot be quantitatively measured (such as facility costs), the total allowable costs of this entity or department must be allocated or distributed to the components of the organization on the basis of a ratio of total incurred and distributed costs per component to the total incurred and distributed costs for all components.

§ 417.566 Other methods of allocation and apportionment.

(a) *Justification.* A method of apportionment or allocation of costs, other than the methods prescribed in this subpart may be used if it results in a more accurate and equitable apportionment of allowable costs and is justifiable from an administrative and cost standpoint.

(b) *Required approval.* (1) An organization that desires to use an alternative method must submit a written request for HCFA approval at least 90 days before the beginning of the period for which the different method is to be used.

(2) If HCFA approves use of a different method, the organization may not revert to another method without first obtaining HCFA's approval.

§ 417.568 Adequate financial records, statistical data, and cost finding.

(a) *Maintenance of records.* (1) An organization must maintain sufficient financial records and statistical data for proper determination of costs payable by Medicare for covered services the organization furnished to its Medicare enrollees, either directly or under arrangements with others. These include accurate and sufficient detail of incurred costs and enrollment data.

(2) Unless otherwise provided for in this subpart, standardized definitions and accounting, statistics, and reporting practices that are widely accepted in the health care industry must be followed.

(b) *Provision of data.* (1) The organization must provide adequate cost and statistical data, based on its financial and statistical records, that can be verified by qualified auditors.

(2) The cost data must be based on an approved method of cost finding and, except as described in this paragraph, on the accrual method of accounting.

(3) For governmental institutions that use a cash basis of accounting, cost data based on this basis will be acceptable. However, only depreciation on capital assets, rather than the expenditure for the capital asset, is allowable.

(c) *Provider services furnished directly by the organization.* If provider services are furnished directly by the organization, the provider is subject to the cost-finding and cost-reporting requirements set forth in Subpart D of Part 405 of this chapter. An approved cost-finding method described in § 405.453 of this chapter must be used to determine the actual cost of covered services furnished directly by the organization during its contract period.

(d) *Supplier services furnished directly by the organization.* If the organization furnishes Part B physician and supplier services directly, the organization must furnish statistics that indicate the frequency and type of service provided, in the form and detail prescribed by HCFA.

(e) *Part B physician and supplier services furnished through arrangement.* If the organization furnishes Part B physician and supplier services under arrangements with others, it must furnish to HCFA statistical, financial, and other information with respect to those services in the form and detail prescribed by HCFA.

§ 417.570 Interim per capita payments.

(a) *Principle of payment.* (1) HCFA makes monthly advance payments equivalent to the organization's interim per capita rate for each beneficiary who is registered in HCFA records as a Medicare enrollee of the organization.

(2) Additional lump-sum payments may be made at other times during the contract period, at HCFA's discretion, to adjust the total amounts paid during the contract period to the level of incurred costs.

(b) *Determination of rate.* The interim per capita rate of payment is equal to the estimated per capita cost of providing covered services to the organization's Medicare enrollees, based upon the types and components of costs that are reimbursable under this part. The interim per capita rate is determined annually by HCFA on the basis of the organization's annual operating and enrollment forecast (as set forth in § 417.572) and may be revised during the contract period as explained in paragraphs (c) and (d) of this section.

(c) *Adjustments of payments.* In order to maintain the interim payments at the level of current reasonable costs, HCFA will adjust the interim per capita rate, to the extent necessary, on the basis of adequate data supplied by the organization in its interim estimated cost and enrollment reports or on other evidence showing that the rate based on actual costs is more or less than the current rate. Adjustments may also be made if there is—

(1) A change in the number of Medicare enrollees that affects the per capita rate;

(2) A material variation from the costs estimated when the annual operating budget was prepared; or

(3) A significant change in the use of covered services by the organization's Medicare enrollees.

(d) *Reduction of interim payments.* If the organization does not submit, on time, the reports and other data required to determine the proper amount of payment, HCFA may reduce interim payments to the extent appropriate, or may take any other action authorized under this part. An interim payment reduction remains in effect until HCFA can make a reasonable estimate of per capita costs.

§ 417.572 Budget and enrollment forecast and interim reports.

(a) *Annual submittal.* The organization must submit an annual operating budget and enrollment forecast, in the form and detail required by HCFA, at least, 90 days before the beginning of each contract period. The forecast must be based on financial and statistical data and records that can be verified if HCFA requires a detailed review of supporting records. The data and records include, but are not limited to, all ledgers, books, records, and original evidence of costs, and statistical data used in the determination of reasonable cost.

(b) *Effect of failure to submit on time.* If the organization does not submit the budget and enrollment forecast on time, HCFA may—

(1) Establish an interim per capita rate of payment on the basis of the best available data and adjust payments on the basis of that rate until the required reports are submitted and a new interim per capita rate can be established; or

(2) If there is not enough data on which to base an interim per capita rate, inform the organization that interim payments will not be made until the required reports are submitted.

(c) *Interim cost reports.* (1) An organization must submit interim cost reports on a quarterly basis in the form and detail prescribed by HCFA. These interim cost reports must be submitted no later then 60 days after the close of each quarter of the contract period.

(2) HCFA may reduce the frequency of the reports required under paragraph (c)(1) of this section if HCFA determines that, on the basis of the organization's reporting experience, there is good cause to do so.

§ 417.574 Interim settlement.

(a) *Determination.* Within 30 days following the receipt of the organization's final interim cost and enrollment reports, HCFA will make an interim determination of the estimated amount payable to the organization for the reasonable cost of covered services furnished to its Medicare enrollees during the contract period. HCFA will base the determination on the interim cost report and enrollment data submitted by the organization, and any other relevant data HCFA finds appropriate. For this purpose, HCFA will accept costs as reported, subject to later review or audit, unless there are obvious errors or inconsistencies.

(b) *Payment.* Any difference between the total amount of interim payments and the amount found payable on the basis of the interim determination under paragraph (a) of this section, must be paid by the organization or will be paid by HCFA, whichever is appropriate, no later than 30 days after HCFA's determination.

§ 417.576 Final settlement.

(a) *General rule.* Final settlement and payment of amounts due the organization or the appropriate Medicare trust funds are made following the organization's submission and HCFA's review of an independently certified cost report and supporting documents as described in paragraph (b) of this section.

(b) *Certified cost report as basis for final settlement*—(1) *Timing of cost report.* The organization must submit to HCFA an independently certified cost report and supporting documents, in the form and detail required by HCFA, no later than 180 days after the end of each contract period, unless HCFA extends the period for good cause shown by the organization.

(2) *Content of cost report.* The cost report and supporting documents must include—

(i) The per capita costs incurred by the organization, including those of entities related to the organization by common ownership or control, in furnishing covered services to its Medicare enrollees, determined in accordance with §§ 417.532 through 417.568.

(ii) The organization's methods of apportioning cost among Medicare enrollees, other enrollees, and nonenrolled patients, in accordance with the reimbursement procedures specified in this subpart (and, as applicable, in Subpart D of Part 405 of this chapter); and

(iii) Any other information required by HCFA.

(3) *Failure to report required financial information.* If the organization fails to submit the required cost report and supporting documents within 180 days after the end of the contract period, without having requested and received an extension of time for good cause shown, HCFA may—

(i) Consider the failure to reports as evidence of likely overpayment; and

(ii) Initiate recovery of amounts previously paid, or reduce interim payments, or both.

(c) *Final determination and adjustment.* (1) After receipt of acceptable reports as specified in paragraph (b) of this section, HCFA determines the total reimbursement due the organization for providing covered services to its Medicare enrollees (which is subject to the audit provisions of this subpart) and makes a retroactive adjustment to bring interim payments into agreement with the reimbursable amount due the organization.

(2) A final settlement may be made with the organization even though a provider that is not owned or operated by the organization or related to the organization by common ownership or control and that provides services to the organization's Medicare enrollees has not had a final settlement with HCFA under Subpart D of Part 405 of this chapter for services furnished by the provider to Medicare beneficiaries who are not enrolled in the organization. In this situation—

(i) HCFA must be satisfied that the costs of covered services furnished to the organization's Medicare enrollees, as shown in the reports specified in paragraph (b) of this section, are reasonable and that the interest of the Medicare program would best be served by not delaying final settlement with the organization until there is a final settlement with the provider for services furnished to Medicare beneficiaries not enrolled in the organization; and

(ii) Prompt settlement with the organization would be in the best interest of the Medicare program if, for instance, the provider's costs represent an insignificant amount of total reimbursement due to the organization; or if HCFA is satisfied that the provider's costs, as shown in the reports specified in paragraph (b) of this section, will not be modified, to any significant extent, by the final settlement with the provider under Subpart D of Part 405 of this chapter.

(d) *Notice of amount of reimbursement.* The notice of amount of Medicare reimbursement—

(1) Explains HCFA's determination regarding total Medicare reimbursement due the organization for the contract period covered by the financial information specified in paragraph (b) of this section;

(2) Relates this determination to the organization's claimed total reimbursable cost for that period;

(3) Explains the amounts and reasons, by appropriate reference to law, regulations, and Medicare program policy and procedures, if the determined amounts differ from the organization's claim; and

(4) Informs the organization of its right to a hearing in accordance with Subpart R of part 405 of this chapter.

(e) *Basis for retroactive adjustment.* (1) HCFA's determination (as contained in the notice of amount of Medicare reimbursement) constitutes the basis for making retroactive adjustments to any Medicare payment made to the organization during the period to which the determination applies.

(2) Further payments to the organization may be withheld or offset in order to recover, or to aid in the recovery of, any overpayment identified in the determination as having been made to the organization, even if the organization requests a hearing under Subpart R of Part 405 of this chapter.

(3) Any withholding will continue until—

(i) The overpayment is liquidated;

(ii) The organization enters into an agreement with HCFA to refund the overpaid amount; or

(iii) HCFA, on the basis of subsequently acquired evidence, determines that there was no overpayment.

Risk Reimbursement

§ 417.580 Basis and scope.

(a) *Basis.* Sections 417.582 through 417.596 implement those portions of section 1876 (a), (e), and (g) of the Act that pertain to the amount HCFA reimburses an organization for its Medicare enrollees who are enrolled on a risk basis.

(b) *Scope.* Sections 417.582 through 417.596 set forth—

(1) Method of payment;

(2) Procedures for determining the organization's payment rate; and

(3) Procedures for determining the additional benefits (and their value) the organization must provide to its Medicare enrollees.

§ 417.582 Definitions applicable to risk reimbursement.

As used in §§ 417.584 through 417.596—

Actuarial factors means factors such as the age, sex, and disability level distribution of the population and any other relevant factors that HCFA determines have a significant effect on the level of utilization and cost of health services.

Class of Medicare enrollees means a group of Medicare enrollees of an organization that HCFA constructs on the basis of actuarial factors.

Similar area means an area similar to the organization's geographic area but free from special characteristics that would distort the determination of the AAPCC.

U.S. per capita incurred cost means the average per capita cost, including intermediary or carrier administrative costs, incurred by Medicare, as determined on an accrual basis, for covered services furnished to Medicare beneficiaries nationwide during the most recent period for which HCFA has complete data.

§ 417.584 Payment to organization with risk contracts.

Except as provided in §§ 417.585 and 417.586, HCFA makes payments for covered services furnished to the organization's Medicare enrollees only to the organization.

(a) *Principle of payment.* HCFA makes monthly advance payments equivalent to the organization's per capita rate of payment for each beneficiary who is registered in HCFA records as a Medicare enrollee of the organization.

(b) *Determination of rate.* (1) The annual per capita rate of payment for each class of Medicare enrollees is equal to 95 percent of the AAPCC (as determined under the provisions of § 417.588) for that class of Medicare enrollees.

(2) HCFA furnishes each organization with its per capita rate of payment for each class of Medicare enrollees not later than 90 days before the beginning of the organization's contract period.

(c) *Adjustments to payments.* If the organization's actual number of Medicare enrollees in each class differs from the number of individuals estimated to be enrolled for purposes of determining the amount of advance payment, HCFA will adjust the amount of payment made in subsequent months to take these enrollment changes into amount.

(d) *Reduction of payments.* If an organization requests a reduction in its monthly payment in accordance with § 417.592(e), HCFA will reduce the amount of payment by the appropriate amount. Reductions in the monthly payment to an organization will also be made if the organization elects the hospital or SNF payment option described in § 417.586.

§ 417.585 Exception for hospice care services.

(a) No payment is made to an organization on behalf of a Medicare enrollee who has elected hospice care under § 418.24 of this chapter except for the portion of the payment applicable to the additional benefits described in § 417.592. No payment is made effective the first day of the month following the month of election to receie hospice care, until the first day of the month following the month in which the enrollee resumes normal Medicare coverage.

(b) During the time the election is in effect, the organization may bill HCFA on a fee-for-service basis (subject to the usual Medicare rules of payment for only the following covered Medicare services:

(1) Services of the enrollee's attending physician if the physician is an employee or contractor of the organization and is not employed by or under contract to the enrollee's hospice.

(2) Services not related to the treatment of the terminal condition for which hospice care was elected or a condition related to the terminal condition.

(3) Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again.

(c) Payment for hospice care services furnished to Medicare enrolees of an organization are made to the hospice participating in Medicare elected by the enrollee.

§ 417.586 Organization option: Payment to hospitals and SNFs.

(a) *Election by organization.* (1) An organization may elect to have hospitals or SNFs that furnish inpatient services to its Medicare enrollees, or both of those types of providers, obtain payment directly from the provider's Medicare intermediary.

(2) If an organization wishes to elect either or both of these options, it must submit a written request to HCFA before the organization's contract period begins.

(3) The election of these payment options by the organization is binding for the entire contract period.

(b) *Payment by intermediary to the hospital or SNF.* (1) After an organization submits its request, HCFA pays the hospital or SNF through the provider's Medicare intermediary for the covered inpatient services furnished to the organization's Medicare enrollees.

(2) The payment made under paragraph (b)(1) of this section is equal to the payment made in accordance with the principles of reimbursement specified in Subpart D of Part 405 of this chapter.

(c) *Reduction in organization's per capita payment.* (1) Each month HCFA will deduct from the organization's per

capita payment described in § 417.584 an amount HCFA estimates it will be paying to hospitals or SNFs on behalf of the organization's Medicare enrollees and administrative costs HCFA incurs in making the payments to the hospitals or SNFs.

(2) The amount of deduction will be adjusted as necessary to allow HCFA to retain sufficient funds with which to pay the bills.

(d) *Retention of withheld funds.* If the contract between the organization and HCFA is terminated or not renewed, HCFA will retain the balance of the amounts withheld from the organization's per capita payment for three years after the expiration or termination of the contract.

(e) *Organization's liability.* In making an election under this section, the organization must agree to accept liability and to provide the additional necessary funds to HCFA if—

(1) During the contract period or in subsequent years, HCFA did not withhold sufficient funds to pay the bills of the organization's Medicare enrollees;

(2) After HCFA returns any balance of amounts withheld to the organization, HCFA receives additional bills that cover services furnished to Medicare enrollees of the organization during its contract period.

§ 417.588 Computation of adjusted average per capita cost (AAPCC).

(a) *Basic data.* In computing the (AAPCC), HCFA uses the U.S. per capita incurred cost and adjusts it by the factors specified in paragraph (c) of this section resulting in an AAPCC for each class of Medicare enrollees.

(b) *Advance notice to the organization.* Before the beginning of a contract period, HCFA informs the organization of the specific adjustment factors it will use in computing the AAPCC.

(c) *Adjustment factors*—(1) *Geographic.* HCFA makes an adjustment to reflect the relative level of Medicare expenditures for beneficiaries who reside in the organization's geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the organization's geographic area and that is available to HCFA when it makes the determination.

(2) *Enrollment.* A further adjustment is made by HCFA to remove the cost effect of all area Medicare beneficiaries who are enrolled in the organization or another eligible organization.

(3) *Age, sex, and disability status.* HCFA makes adjustments to reflect the age and sex distribution and the disability status of the organization's enrollees based on Medicare program experience and available data that indicate cost differences that result from those factors.

(4) *Other relevant factors.* If accurate data are available and appropriate, HCFA makes adjustments to reflect welfare and institutional status and other relevant factors.

§ 417.590 Computation of the average of the per capita rates of payment.

(a) *Computation by the organization.* As indicated in § 417.584(b), prior to the start of an organization's contract period, HCFA determines an organization's per capita rate of payment for each class of Medicare enrollees. For purposes of determining an organization's required additional benefits (see § 417.592), an organization must compute a weighted average of these per capita rates of payment based on the organization's anticipated enrollment distribution. This computation must be done separately for Part A and Part B enrollees and Part B-only enrollees and is subject to HCFA's review and approval.

(b) *Computation by HCFA.* If the organization claims to have insufficient enrollment experience to make the computation required by paragraph (a) of this section, and HCFA agrees with this claim, then HCFA will compute the average of the per capita rates of payment based on the best information available to HCFA, including the enrollment experience of other organizations that have contracted with HCFA to receive reimbursement on a risk basis.

§ 417.592 Determination of required additional benefits.

(a) *General consideration.* Except as provided in paragraph (e) of this section, if the organization's average of its per capita rates of payment as determined under § 417.590 is more than the organization's adjusted community rate (ACR) as determined under § 417.594, then the organization must provide its Medicare enrollees with additional benefits as described in paragraphs (b) and (c) of this section. This determination must be done separately for Part A and Part B enrollees and Part B-only enrollees.

(b) *Form of additional benefits.* The additional benefits are selected by the organization and may be—

(1) A reduction in the organization's premium or other charges made by the organization in the form of deductibles and coinsurance; or

(2) Health benefits beyond the required Part A and B services; or

(3) A combination of the benefits specified in paragraphs (b)(1) and (b)(2).

(c) *Value of additional benefits.* The additional benefits must be at least equal in value to the difference between the ACR and the average of the per capita rates of payment, unless—

(1) The organization requests a reduction in its monthly payment as provided in paragraph (e) of this section; or

(2) The organization requests that HCFA withhold in a benefit stabilization fund as provided in § 417.596, a part of the value of the additional benefits it is required to provide.

(d) *Notification to HCFA.* (1) The organization must notify HCFA not later than 45 days before the beginning of the contract period of its ACR and its weighted average of its per capita rates of payment (as computed under § 417.590) for the contract period.

(2) If the proposed ACR is less than the average of the per capita rates of payment to be made at the beginning of the contract period, the organization must provide HCFA with—

(i) A description of the additional benefits (as described in paragraph (b) of this section) the organization has elected to provide its Medicare enrollees; and

(ii) Supporting evidence to demonstrate that the selected additional benefits are at least equal in value to the difference between the organization's proposed ACR and the average of the per capita rates of payment.

(e) *Exception.* (1) If the organization's ACR is less than the average of the per capita rates of payment, the organization may request a reduction in its monthly payment from HCFA instead of offering its Medicare enrollees additional benefits.

(2) The reduction in the monthly payment must, over the course of the contract period, be equal in value to the difference between the proposed ACR and the average of the per capita rates of payment, or meet the requirements of § 417.442(b)(1)(ii).

§ 417.594 Computation of ACR.

(a) *General.* (1) Each organization must compute its own ACR. In computing the ACR, the organization calculates an initial rate (using the methods described in paragraph (b) of this section) that represents the organization's premium if it provided the Medicare covered services package to its general membership (that is, its non-Medicare enrollees). The organization then either adjusts that rate by the factors specified in paragraph (c) of this section or requests that HCFA adjust the

rate in accordance with the procedures specified in paragraph (d) of this section.

(2) The organization or HCFA further reduces this rate by the actuarial value of applicable Medicare coinsurance and deductibles.

(3) Separate ACRs must be calculated for Part A and Part B enrollees and Part B-only enrollees.

(4) In calculating its initial rate, the organization must identify and take into account anticipated revenue from health insurance payors for those services for which Medicare is not the primary payor as described in § 417.528.

(b) *Initial rate calculation.* (1) The organization's initial rate is calculated, at the organization's election, using either—

(i) A community rating system as defined in § 110.105(b) of this title; or

(ii) A system, approved by HCFA, under which the organization develops an aggregate premium for all its enrollees that is weighted by the size of the various enrolled groups that compose the organization's enrollment.

(For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers that purchase membership in the organization on a premium basis.)

(2) Regardless of which method the organization uses to calculate its initial rate, the initial rate must be equal to the premium the organization would charge its non-Medicare enrollees for the Medicare covered services.

(3) Except as provided in paragraph (b)(4) of this section, the organization must identify in its initial rate calculation, the following components whose rates must be consistent with rates used by the organization in calculating premiums for non-Medicare enrollees:

(i) Hospital services (services covered under Medicare Part A and Part B shown separately).

(ii) Physicians services.

(iii) Other medical services (for example, X-ray and laboratory services).

(iv) Home health services.

(v) Out-of-plan claims for emergency services.

(vi) Skilled nursing care services.

(vii) Ambulance services.

(viii) Other Medicare covered services.

(ix) General and administrative.

(x) Noncovered Medicare services for example, eyeglasses).

(xi) Services for which Medicare is the secondary payor

(xii) Enrollee liabilities (for example, deductibles, coinsurance, or copayments) for covered services.

(4) An organization that does not usually separate its premium components as described in paragraph (b)(3) of this section may calculate its initial rate with the methods it uses for its other enrolled groups if the organization provides HCFA with the documentation necessary to support any adjustments the organization makes to the initial rate in accordance with paragraph (e) of this section.

(5) The initial rate calculation must not carry forward any losses experienced by the organization during prior contract periods. The organization must submit supporting documentation to assure HCFA that rates do not include past losses but only premiums for the price of additional benefits and services of the upcoming contract period.

(c) *Adjustment factors.* These factors are designed to adjust on a component basis the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of the organization's Medicare enrollees. The organization may adjust the same service using more than one factor if the factors do not duplicate each other. The factors are as follows:

(1) *Unit of service.* If the organization purchases or identifies services on a unit of service basis and the unit of service is defined the same for all enrollees, the organization may make an adjustment in its initial rate to reflect the number of units of services furnished to its Medicare enrollees in comparison to those furnished to other enrollees.

(2) *Complexity or intensity of services.* (i) The organization may make an adjustment to reflect the differences in the complexity or intensity of services furnished to its Medicare enrollees if the calculation of its initial rate includes the elements of this adjustment.

(ii) If an organization cannot support an adjustment such as that described in paragraph (c)(2)(i) of this section, it may, for contract periods beginning before January 1, 1986, make an adjustment to the direct professional services of physicians and other health care personnel. This adjustment will reflect the difference in time of service furnished to the organization's Medicare enrollee if the calculation of the organization's initial rate includes the elements of this adjustment.

(3) *Supporting documentation.* All adjustments made by the organization must be accompanied by adequate supporting data. If an organization does not have sufficient enrollment experience to develop this data, it may, during its initial contract period, use documented statistics from a nationally recognized statistical source.

(d) *Adjustment by HCFA.* If the organization does not have adequate data to adjust the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of its Medicare enrollees, HCFA will, at the organization's request, adjust the initial rate. HCFA will adjust the rate on the basis of differences in the utilization characteristics of—

(1) Medicare and non-Medicare enrollees in other eligible organizations; or

(2) Medicare beneficiaries in the organization's area, State, or the United States who are eligible to enroll in an eligible organization and other individuals in that same area, State, or the United States.

(e) *HCFA review.* (1) The organization's methodology and computation of its ACR are subject to review and approval by HCFA. When the organization submits the ACR computation, it must include adequate supporting data.

(2) If the organization is dissatisfied with a HCFA determination that the organization's ACR computation is not acceptable, the organization may, within 30 days after the date of receipt of notification of this determination, file a request for a hearing with HCFA. The request must state why the determination is incorrect and must be accompanied by any supporting evidence the organization wishes to submit. The hearing will be conducted by a hearing officer designated by HCFA under the hearing procedures described in §§ 405.1819 through 405.1833 of this chapter.

§ 417.596 Establishment of a benefit stabilization fund.

(a) *General.* For contract periods beginning before July 19, 1988, if an organization is required to provide its Medicare enrollees with additional benefits as described in § 417.592, the organization may request that HCFA withhold a part of its monthly per capita payment in a benefit stabilization fund. The fund will be used to prevent excessive fluctuation in the provision of those additional benefits in subsequent contract periods.

(b) *Notification to HCFA.* An organization's request to have monies withheld in a benefit stabilization fund must be made when the organization notifies HCFA under § 417.592(d) of its ACR and the average of its per capita rates of payment in preparation for its next contract period.

(c) *Limitations on the amounts withheld.*—(1) *Limit per contract period.* Except as provided in paragraph (b)(3) of this section, HCFA will not withhold in a benefit stabilization fund more than 15 percent of the difference between an organization's ACR and the average of its per capita rates or payment for a given contract period.

(2) *Cumulative limit.* If HCFA has established a benefit stabilization fund for an organization, it will not approve a request for withholding made by that organization for a subsequent contract period that would cause the total value of the benefit stabilization fund to exceed 25 percent of the difference between the organization's ACR and the average of its per capita rates of payment for that subsequent contract period.

(3) *Exception.* HCFA may grant an exception to the limit described in paragraph (b)(1) of this section if an organization can demonstrate to HCFA's satisfaction that the value of the additional benefits it provides to its Medicare enrollees fluctuates substantially in excess of 15 percent from one contract period to another.

(d) *Financial management of benefit stabilization funds.* (1) The amounts withheld by HCFA for the purpose of establishing or maintaining a benefit stabilization fund are in the custody of the Federal Health Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

(2) The amounts withheld in a benefit stabilization fund are accounted for by HCFA in accounts in which interest does not accrue to the organization.

§ 417.597 Withdrawal from a benefit stabilization fund.

(a) *Notification to HCFA.* An organization's request to make a withdrawal from its benefit stabilization fund for use during a contract period must be made when the organization notifies HCFA of its ACR and the average of its per capita rates of payment for that contract period. In making its request, the organization must—

(1) Indicate how it intends to use the withdrawn amounts;

(2) Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;

(3) Document the organization's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(4) Document the organization's experience during the contract period previous to the one for which the withdrawal is requested to ensure that the organization will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(b) *Criteria for HCFA approval.* HCFA will approve an organization's request for a withdrawal from its benefit stabilization fund for use during the next contract period only if—

(1) The organization's average of its per capita rates of payment for the next contract period is less than that of the previous contract period;

(2) The organization's ACR for the next contract period is significantly higher than that of the previous contract period; or

(3) The organization's revenue requirements for the next contract period for providing the additional benefits it provided during the previous contract period is significantly higher than the requirements for that previous period and the ACR for the next contract period results in an additional benefits package that is less in total value than that of the previous contract period.

(c) *Basis for denial.* HCFA will not approve an organization's request for a withdrawal from its benefit stabilization fund if the withdrawal allows the organization to—

(1) Offer without charge the supplemental services it provides to its Medicare enrollees under the provisions of § 417.440 (b)(2) or (b)(3); or

(2) Refinance prior contract period losses or to avoid losses in the upcoming contract period.

(d) *Form of payment.* Payment of monies withdrawn from a benefit stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the organization under § 417.584 during the period of the contract.

(e) *Availability of a benefit stabilization fund.* (1) Amounts withheld in a benefit stabilization fund are available for use by an organization only for four years following the establishment of the fund.

(2) Any amounts remaining in a benefit stabilization fund after the period of availability described in paragraph (c)(1) of this section will revert to the Medicare Trust Funds in the proportions HCFA determines to be appropriate.

§ 417.598 Annual enrollment reconciliation.

HCFA's payment to an organization may be subject to an enrollment reconciliation at least annually. HCFA will conduct this reconciliation as necessary to assure that the payments made do not exceed or fall short of the appropriate per capita rate of payment for each Medicare enrollee of the organization during the contract period. The organization must submit any information or reports required by HCFA to conduct the reconciliation.

Beneficiary Appeals

§ 417.600 Scope.

Sections 417.600 through 417.638 establish procedures for the presentation and resolution of initial determinations, reconsiderations, hearings, Appeals Council reviews, court reviews, and finality of decisions, that are applicable in matters arising under section 1876 of the Act and this subpart. The grievance procedures established by organizations under § 417.436(a)(2) apply to all complaints that do not involve initial determinations. Those grievance procedures must provide to Medicare enrollees a thorough explanation of—

(a) The steps to follow in completing the procedure; and

(b) The time limits imposed on each step of the procedure.

§ 417.602 Definitions applicable to beneficiary appeals.

As used in §§ 417.604 through 417.638, unless the context indicates otherwise—

ALJ stands for administrative law judge.

Enrollee means a Medicare enrollee.

RRB stands for Railroad Retirement Board.

§ 417.604 General provisions.

(a) *Applicability.* (1) The appeals procedure described in §§ 417.604 through 417.638 pertain to disputes involving an initial determination, as defined in § 417.606, with which the enrollee is dissatisfied.

(2) Any determinations regarding items or services that were furnished by the organization, either directly or under arrangement, for which the enrollee has no further liability for payment are not subject to appeal.

(3) Services included in an optional supplemental plan (see § 417.440(b)(2)) are subject only to a grievance procedure under § 417.436(a)(2).

(4) Except as provided in § 417.610(b), physicians and other individuals who furnish items or services under arrangements with an organization have no right of appeal under this subpart.

(5) The provisions of Subpart R of 20 CFR Part 404 dealing with representation of parties under Title II of the Act are, unless otherwise provided in this subpart, also applicable

to matters arising under section 1876 of the Act.

(b) *Responsibility for establishing appeals procedures.* (1) Except as provided in paragraph (b)(2) of this section, the provisions of §§ 417.604 through 417.638 apply equally to all enrollees regardless of the method of claims processing adopted by the organization. The organization is responsible for establishing and maintaining the appeals procedures that are specified in these sections.

(2) If a carrier or intermediary processes the claims for an organization's enrollees, the carrier or intermediary—

(i) Is acting in the place of the organization, except with regard to initial determinations as specified in § 417.606(a)(3), and

(ii) Acts for the organization with respect to the appeals procedures specified in §§ 417.604 through 417.638, except that § 417.620(b)(2) does not apply to a carrier or intermediary.

(c) *Written description of appeals procedure.* Each organization is responsible for ensuring that all enrollees are informed in writing of the appeals procedures that are available to them.

§ 417.606 Initial determinations.

(a) *Actions that are initial determinations.* An initial determination is a determination made by an organization, or carrier or intermediary acting for the organization, concerning the rights of an enrollee with regard to services payable by Medicare that are furnished by the organization. In addition, an initial determination is also any determination made with respect to—

(1) Reimbursement for emergency or urgently needed services;

(2) Any other health services furnished by a provider or supplier other than the organization that the enrollee believes—

(i) Are covered under Medicare; and

(ii) Should have been furnished, arranged for, or reimbursed by the organization.

(3) The organization's refusal to provide services that the enrollee believes should be furnished or arranged for by the organization and the enrollee has not received the services outside the organization.

(b) *Actions that are not initial determinations.* The following are not initial determinations for purposes of this subpart:

(1) A determination regarding items or services that were furnished by the organization, either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding items or services included in an optional supplemental plan (see § 417.440(b)(2)).

(c) *Relation to grievances.* A determination that is not an initial determination is subject only to a grievance procedure under § 417.436(a)(2).

§ 417.608 Notice of adverse initial determination.

(a) If an organization, carrier, or intermediary makes an initial determination that is partially or fully adverse to the enrollee, it must notify the enrollee of the determination within 60 days of receiving the enrollee's request for payment of services.

(b) The notice must—

(1) State the specific reasons for the determination; and

(2) Inform the enrollee of his or her right to reconsideration.

(c) The failure to provide the enrollee with timely notification of an adverse initial determination constitutes an adverse initial determination and may be appealed.

§ 417.610 Parties to the initial determination.

The parties to the initial determination are—

(a) The enrollee;

(b) An assignee of the enrollee (that is, a physician or other supplier who accepts assignment for services furnished to an enrollee that are not covered by the organization's plan);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other entity determined to have an appealable interest in the proceeding.

§ 417.612 Effect of initial determinations.

The initial determination is final and binding on all parties unless it is reconsidered in accordance with § 417.614 through 417.626, or revised in accordance with § 417.638.

§ 417.614 Right to reconsideration.

Any party to an initial determination who is dissatisfied with that determination may request a reconsideration of the determination after reopening in accordance with the procedures of § 417.616.

§ 417.616 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with—

(1) The organization, carrier, or intermediary that made the initial determination;

(2) An SSA office; or

(3) In the case of a qualified railroad retirement beneficiary, an RRB office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, the request for reconsideration must be filed within 60 days from the date of the notice of the initial determination.

(c) *Extension of time to file a request.* (1) *Rule.* If good cause is shown, the organization, carrier, or intermediary that made the initial determination may extend the time for filing the request for reconsideration.

(2) *Method of requesting an extension.* If the time limit in paragraph (a) of this section has expired, a party to the initial determination may file a request to extend the time to file a request for reconsideration with the organization, carrier, intermediary, HCFA, SSA, or, in the case of a qualified railroad retirement beneficiary, an RRB office. The request to extend the time limit must—

(i) Be in writing; and

(ii) State why the request for reconsideration was not filed timely.

(d) *Parties to the reconsideration.* The parties to the reconsideration are the parties to the initial determination as described in § 417.610, and any other person or entity whose rights with respect to the initial determination may be affected by the reconsideration, as determined by the entity that conducts the reconsideration.

(e) *Withdrawal of request.* A request for reconsideration may be withdrawn by the party who filed the request. The request for withdrawal must be filed at one of the places specified in paragraph (c)(2) of this section.

§ 417.618 Opportunity to submit evidence.

The organization, carrier, or intermediary must provide the parties to the reconsideration reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing.

§ 417.620 Responsibility for reconsideration.

(a) *Basic rule.* Except as specified in paragraph (b) of this section, the entity that made the initial determination is the entity that reconsiders it.

(b) *Exception.* If the organization made the initial determination or the issue is the organization's refusal to furnish or arrange for requested services, the organization or HCFA makes the reconsidered determination, as follows:

(1) *Favorable determination by the organization.* If the organization can

make a reconsidered determination completely favorable to the enrollee, it issues a reconsidered determination.

(2) *Unfavorable recommendation by the organization.* If the organization recommends partial or complete affirmance of the initial adverse determination, the organization must prepare a written explanation and forward the entire case file to HCFA, which makes a reconsidered determination.

§ 417.622 Reconsidered determination.

A reconsidered determination is a new determination that—

(a) Is based on a review of the initial determination, the evidence and findings upon which it was based, and any other evidence submitted by the parties, or obtained by HCFA, the organization, or the carrier or intermediary; and

(b) Is made by a person or persons who were not involved in making the initial determination.

§ 417.624 Notice of reconsidered determination.

(a) *Responsibility for notice.* The entity that makes the reconsidered determination is responsible for mailing notice to the parties and, if that entity is not HCFA, for sending a copy to HCFA.

(b) *Content of notice.* The notice must—

(1) State the specific reasons for the reconsidered determination;

(2) Inform the party of his or her right to a hearing if the amount in controversy is $100 or more; and

(3) Describe the procedures that the party must follow to obtain a hearing.

§ 417.626 Effect of reconsidered determination.

A reconsidered determination is final and binding on all parties unless a request for a hearing is filed in accordance with the provisions of § 417.632, or unless it is revised in accordance with § 417.638.

§ 417.628 Hearings: General.

Unless otherwise provided in this subpart, regulations at 20 CFR 404.929 through 404.961 dealing with the conduct of hearings are also applicable to hearings arising under this subpart.

§ 417.630 Right to hearing.

Any party to the reconsideration who is dissatisfied with the reconsidered determination has a right to a hearing if the amount in controversy is $100 or more. The amount in controversy is computed in accordance with § 405.740 of this chapter for Part A services and § 405.820(b) of this chapter for Part B services. When the basis for the appeal is the refusal of services, the projected value of those services must be used in computing the amount in controversy.

§ 417.632 Request for hearing.

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed at one of the places specified in § 417.616(c)(2).

(b) *Time for filing a request.* Except when the time is extended by a presiding officer as provided in 20 CFR 404.933(c), a request for a hearing must be filed within 60 days of the date of the notice of reconsidered determination.

(c) *Parties to a hearing.* The parties to a hearing must be the parties to the reconsideration as described in § 417.616(d), and any other person or entity whose rights with respect to the reconsidered determination may be affected by the hearing, as determined by the ALJ. The organization must be made a party to the hearing; however, the organization does not have a right to request a hearing. Fees for any services provided by a representative appointed on behalf of the organization are not subject to section 206 of the Act, which governs appointment of representatives and payment of fees to representatives.

(d) *Dismissal of request for hearing when amount in controversy is less than $100.* The ALJ makes the determination as to whether the amount incontroversy is $100 or more. The ALJ will dismiss the request for a hearing if the request plainly shows that less than $100 is in controversy. If a hearing is held and the ALJ finds that the amount in controversy is less than $100, he or she will dismiss the request for hearing and will not rule on the substantive issues involved in the appeal.

§ 417.634 Appeals Council review.

Any party to the hearing, including the organization, who is dissatisfied with the hearing decision, may request the Appeals Council to review the ALJ's decision or dismissal. Provisions regarding Appeal Council review are contained in 20 CFR 404.967 through 404.981.

§ 417.636 Court review.

(a) *Review of ALJ's decision.* A party or the organization may request judicial review of an ALJ's decision if—

(1) The Appeals Council denied the party's or the organization's request for review; and

(2) The amount in controversy is $1,000 or more.

(b) *Review of Appeals Council decision.* A party or the organization may request judicial review of the Appeals Council decision if—

(1) It is the final decision of the Secretary; and

(2) The amount in controversy is $1,000 or more.

(c) *Request for review.* The civil action must be filed in a district court of the United States in accordance with section 205(g) of the Act (see 20 CFR 422.210 for a description of the procedures to follow in requesting judicial review).

§ 417.638 Reopening determinations and decisions.

An initial, reconsidered, or revised determination made by an organization, carrier, intermediary, or HCFA, or a decision or revised decision of an ALJ or the Appeals Council, may be reopened in accordance with the provisions of § 405.750 of this chapter.

Contract Appeals

§ 417.640 Determinations subject to appeal.

Sections 417.640 through 417.694 establish the procedures for making and reviewing the following initial determinations:

(a) A determination that an eligible organization is not qualified to enter into a contract with HCFA under section 1876 of the Act.

(b) A determination that an eligible organization is qualified only for a reasonable cost contract.

(c) A determination to terminate, or to refuse to renew, a contract with an organization because—

(1) The organization has failed substantially to carry out the terms of the contract;

(2) The organization is carrying out the contract in a manner that is inconsistent with the efficient and effective administration of section 1876 of the Act; or

(3) The organization no longer meets the applicable conditions necessary to qualify as an eligible organization under section 1876 of the Act and this subpart.

§ 417.642 Administrative actions that are not initial determinations.

Administrative actions that are not initial determinations under §§ 417.640 through 417.694 include, but are not limited to, HCFA's refusal to renew a contract with an organization when the refusal is not based on the causes specifed in § 417.640(c).

§ 417.644 Notice of initial determination.

(a) When HCFA makes an initial determination, it will notify the organization in writing.

(b) The notice specifies—

(1) The reasons for the determination; and

(2) The organization's right to request reconsideration.

(c) Notice of an initial determination specified in § 417.640 is mailed to the organization at least 90 days before the end of the contract period, or in the case of termination, at least 90 days before the effective date of the termination.

§ 417.646 Effect of initial determination.

The initial determination is final and binding on all parties unless—

(a) It is reconsidered in accordance with §§ 417.648 through 417.658;

(b) In the case of an initial determination described in § 417.640(c), a request for a hearing is filed; or

(c) It is revised as a result of a reopening under § 417.692.

§ 417.648 Right to request reconsideration.

An entity that is dissatisfied with an initial determination as described in § 417.640 (a) or (b) may request a reconsideration of the determination in accordance with the procedures specified in § 417.650.

§ 417.650 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with any HCFA office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, the request for reconsideration must be filed within 60 days from the date of the notice of the initial determination.

(c) *Extension of time to file a request.* HCFA may, in response to a party's written petition showing good cause, accept a request for reconsideration after the expiration of the 60 day period.

(d) *Proper party to file a request.* Only an authorized official of the entity that was a party to an initial determination may file the request for reconsideration.

(e) *Withdrawal of a request.* A request for reconsideration may be withdrawn by the party who filed the request at any time before the notice of the reconsidered determination is mailed. The request for withdrawal must be in writing and filed with HCFA. If HCFA approves, the request for reconsideration is withdrawn.

§ 417.652 Opportunity to submit evidence.

HCFA will provide the parties to the reconsideration reasonable opportunity to present as evidence any documents or written statements that are relevant and material to the matters at issue.

§ 417.654 Reconsidered determination.

A reconsidered determination is a new determination that—

(a) Is based on a review of the initial determination, the evidence and findings upon which that was based, and any other written evidence submitted before notice of the reconsidered determination is mailed, including facts relating to the status of the entity subsequent to the initial determination; and

(b) Affirms, reverses, or modifies the initial determination.

§ 417.656 Notice of reconsidered determination.

Written notice of the reconsidered determination is mailed by HCFA to the party concerned and—

(a) Contains findings with respect to the eligible organization's qualifications to enter into a contract with HCFA under section 1876 of the Act;

(b) States the specific reasons for the reconsidered determination; and

(c) Informs the party of its right to a hearing if it is dissatisfied with the determination.

§ 417.658 Effect of reconsidered determination.

A reconsidered determination is final and binding on all parties unless a request for a hearing is filed in accordance with § 417.662 or it is revised in accordance with § 417.692.

§ 417.660 Right to a hearing.

The following parties are entitled to a hearing:

(a) An entity that has been determined in a reconsidered determination to be unqualified to enter into a contract with HCFA under section 1876 of the Act.

(b) An eligible organization that has been determined in a reconsidered determination to be qualified only for a reasonable cost contract.

(c) An organization whose contract with HCFA has been terminated or has not been renewed as a result of an initial determination as provided in § 417.640(c).

§ 417.662 Request for hearing.

(a) *Method and place for filing a request.* A request for a hearing must be made in writing and filed by an authorized official of the entity or organization that was the party to the determination under appeal. The request for a hearing must be filed with any HCFA office.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, a request for a hearing must be filed within 60 days after the date of receipt of the notice of initial or reconsidered determination.

(c) *Extension of time to file a request.* If good cause is shown, the 60-day period to request a hearing may be extended by HCFA.

(d) *Parties to a hearing.* The parties to a hearing must be—

(1) The parties described in § 417.660;

(2) At the discretion of the hearing officer, any interested parties who make a showing that their rights may be prejudiced by the decision to be rendered at the hearing; and

(3) HCFA.

§ 417.664 Postponement of effective date of initial determination.

When a request for a hearing with respect to an initial determination is filed timely—

(a) The effective date of the initial determination to terminate a contract with an organization will be postponed until a hearing decision is reached; and

(b) The current contract will be extended at the end of the contract period (in the case of a determination not to renew) only—

(1) If HCFA finds that an extension of the contract will be consistent with the purpose of section 1876 of the Act; and

(2) For such period as HCFA and the organization agree.

§ 417.666 Designation of hearing officer.

HCFA will designate a hearing officer to conduct the hearing. The hearing officer need not be an ALJ.

§ 417.668 Disqualification of hearing officer.

(a) A hearing officer may not conduct a hearing in a case in which he or she is prejudiced or partial to any party or has any interest in the matter pending for decision.

(b) A party to the hearing who objects to the designated hearing officer must notify that officer in writing at the earliest opportunity.

(c) The hearing officer must consider the objection, and may, at his or her discretion, either proceed with the hearing or withdraw.

(1) If the hearing officer withdraws, HCFA will designate another hearing officer to conduct the hearing.

(2) If the hearing officer does not withdraw, the objecting party may, after the hearing, present objections and request that the officer's decision be revised or a new hearing be held before another hearing officer. The objections must be submitted to HCFA.

§ 417.670 Time and place of hearing.

(a) The hearing officer will fix a time and place for the hearing and send written notice to the parties. The notice must also inform the parties of the general and specific issues to be

resolved and information about the hearing procedure.

(b) The hearing officer may, on his or her own motion, or at the request of a party, change the time and place for the hearing. The hearing officer may adjourn or postpone the hearing.

(c) The hearing officer will give the parties reasonable notice of any change in time or place of adjournment.

§ 417.672 Appointment of representatives.

A party may appoint as its representative at the hearing anyone not disqualified or suspended from acting as a representative before the Secretary or otherwise prohibited by law.

§ 471.674 Authority of representatives.

(a) A representative appointed and qualified in accordance with § 417.672 may, on behalf of the represented party—

(1) Give or accept any notice or request pertinent to the proceedings set forth in this subpart;

(2) Present evidence and allegations as to facts and law in any proceedings affecting that party; and

(3) Obtain information to the same extent as the party.

(b) A notice or request sent to the representative has the same force and effect as if it had been sent to the party.

§ 417.676 Conduct of hearing.

(a) The hearing will be open to the parties and to the public.

(b) The hearing officer will inquire fully into all the matters at issue and must receive in evidence the testimony of witnesses and any documents that are relevant and material.

(c) The parties will be provided an opportunity to enter any objection to the inclusion of any document.

(d) The hearing officer will decide the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

§ 417.678 Evidence.

The hearing officer will rule on the admissibility of evidence and may admit evidence that would be inadmissible under rules applicable to court procedures.

§ 417.680 Witnesses.

(a) The hearing officer may examine the witnesses.

(b) The parties or their representatives will be permitted to examine their witnesses and cross-examine witnesses of other parties.

§ 417.682 Discovery.

(a) Prehearing discovery will be permitted upon timely request of a party.

(b) A request is timely if it is made before the beginning of the hearing.

(c) A reasonable time for inspection and reproduction of documents will be provided by order of the hearing officer.

(d) The hearing officer's order on all discovery matters is final.

§ 417.684 Prehearing.

The hearing officer may schedule a prehearing conference if he or she believes that a conference would more clearly define the issues.

§ 417.686 Record of hearing.

(a) A complete record of the proceedings at the hearing will be made and transcribed and made available to all parties upon request.

(b) The record may not be closed until a hearing decision has been issued.

§ 417.688 Authority of hearing officer.

In exercising his or her authority, the hearing officer must comply with the provisions of title XVIII and related provisions of the Act, the regulations issued by the Secretary, and general instructions issued by HCFA in implementing that Act.

§ 417.690 Notice and effect of hearing decision.

(a) As soon as practical after the close of the hearing, the hearing officer will issue a written decision that—

(1) Is based upon the evidence of record; and

(2) Contains separately numbered findings of fact and conclusions of law.

(b) The hearing officer will provide a copy of the hearing decision to each party.

(c) The hearing decision is final and binding unless it is reopened and revised in accordance with § 417.692.

§ 417.692 Reopening of initial or reconsidered determination and decision of a hearing officer.

(a) *Initial or reconsidered determination.* An initial or reconsidered determination may be reopened and revised by HCFA upon its own motion within one year of the date of the notice of determination.

(b) *Decision of hearing officer.* A decision of a hearing officer that is unfavorable to any party and is otherwise final may be reopened and revised by the hearing officer upon the officer's own motion within one year of the notice of the hearing decision. It may be reopened and revised by another hearing officer designated by HCFA if the hearing officer who issued the decision is unavailable.

(c) *Notices.* (1) The notice of reopening and of any revisions following the reopening will be mailed to the parties.

(2) The notice of revision will specify the reasons for revisions.

§ 417.694 Effect of revised determination.

The revision of an initial or reconsidered determination is final and binding unless a party files a written request for hearing of the revised determination in accordance with § 417.662.

Subpart D—Health Care Prepayment Plans

§ 417.800 Reimbursement of health care prepayment plans; definitions and basic rule.

(a) *Definitions.* As used in this subpart, unless the context indicates otherwise—

"Covered Part B services" means physicians' services, diagnostic X-ray tests, laboratory, other diagnostic tests, and any additional medical and other health services, that the HCPP furnishes to its Medicare enrollees.

"Health care prepayment plan" (HCPP) means an organization that—

(1) Is responsible for the organization, financing and delivery of covered Part B services to a defined population on a prepayment basis;

(2) Meets the conditions specified in paragraph (b) of this section; and

(3) Elects to be reimbursed on a reasonable cost basis.

"Medicare enrollee" means a beneficiary under Part B of Medicare who has been identified of HCFA records as an enrollee of the HCPP.

"Reporting period" means the period specified by HCFA for which an HCPP must report its costs and utilization.

(b) *Qualifying conditions.* (1) Except as provided in paragraph (b)(2) of this section, an organization wishing to participate as an HCPP must—

(i) Enter into a written agreement with HCFA as specified in § 417.801;

(ii) Furnish physicians' services through its employees or under a formal arrangement with a medical group, independent practice association or individual physicians; and

(iii) Furnish covered Part B services to its Medicare enrollees through institutions, entities, and persons that have qualified under the applicable requirements of Title XVIII of the Social Security Act.

(2) An organization that, as of January 31, 1983, was being reimbursed on a reasonable cost basis under section 1833(a)(1)(A) of the Act, and that would not otherwise meet the conditions specified in paragraph (b)(1), may receive reimbursement on a reasonable

cost basis as an HCPP, provided it files an agreement with HCFA as required by § 417.801.

(c) *Payment of reasonable cost.* (1) Except as otherwise provided in this subpart, HCFA pays an HCPP on the basis of the reasonable cost it incurs, as specified in §§ 417.530 through 417.576, for the covered Part B services furnished to its Medicare enrollees.

(2) In determining the amount due an HCPP for covered Part B services furnished its Medicare enrollees, HCFA deducts from the reasonable cost actually incurred by the HCPP an amount equal to the actuarial value of the deductible and coinsurance amount that would otherwise be applicable to those services if the Medicare enrollees who received the services had not been enrolled in the HCPP.

(d) *Covered services not reimbursed to an HCPP.* (1) Services reimbursed under Part A are not reimbursable to an HCPP. HCFA makes payment for these services directly to the hospital, or other provider of services, on a reasonable cost basis through the provider's Medicare fiscal intermediary (for more details, see Subpart D of Part 405 of this chapter).

(2) Covered Part B services furnished by a provider of services to an HCPP's Medicare enrollees are not payable to the HCPP. HCFA makes payment for these services to the provider on behalf of the Medicare enrollee through the provider's Medicare fiscal intermediary. This requirement does not affect Medicare payment to the HCPP for physicians' services furnished to its Medicare enrollees for which the physicians are compensated by the HCPP.

(e) *Payment for services to nonenrollees.* HCFA makes payment to an HCPP for covered Part B services furnished by the HCPP to a Medicare beneficiary who is not enrolled in the HCPP if the beneficiary assigns his rights to payment in accordance with § 405.1675 of this chapter. Payment is made on a reasonable charge basis through the HCPP's Medicare carrier.

§ 417.801 Agreements between HCFA and health care prepayment plans.

(a) *General requirement.* (1) In order to participate and receive payment under the Medicare program as an HCPP as defined in § 417.800, an organization must enter into a written agreement with HCFA.

(2) An existing group practice prepayment plan (GPPP) that continues as an HCPP under this Subpart D must have entered into a written agreement with HCFA within 60 days of January 31, 1983.

(b) *Terms.* The agreement must provide that the HCPP agrees to—

(1) Maintain compliance with the requirements for participation and reimbursement on a reasonable cost basis of HCPPs as specified in § 417.800;

(2) Not charge the Medicare enrollee, as defined in § 417.800, a beneficiary, or any other person for items or services for which that individual is entitled to have payment made under the provisions of this part, except for any deductible or coinsurance amounts for which the individual is liable;

(3) Refund, as promptly as possible, any money incorrectly collected as charges or premiums, or in any other way from Medicare enrollees in the HCPP in accordance with the requirements specified in § 417.456;

(4) Not impose any limitations on the acceptance of Medicare enrollees or beneficiaries for care and treatment that it does not impose on all other individuals; and

(5) Consider any additional requirements that HCFA finds necessary or desirable for efficient and effective program administration.

(c) *Duration of agreement.* Except for the term of the initial agreement, the agreement is for a term of one year and may be renewed annually by mutual consent. The term of the intitial agreement is set by HCFA.

(d) *Termination or nonrenewal of agreement by HCFA.* (1) HCFA may terminate or not renew an agreement if it determines that—

(i) The HCPP no longer meets the requirements for participation and reimbursement as an HCPP as specified in § 417.800;

(ii) The HCPP is not in substantial compliance with the provisions of the agreement, applicable HCFA regulations, or applicable provisions of the Medicare law; or

(iii) The HCPP undergoes a change in ownership as specified in §§ 417.520 through 417.523.

(2) HCFA will give notice of termination or nonrenewal to the HCPP at least 90 days before the effective date stated in the notice.

(e) *Termination or nonrenewal of agreement by HCPP.* (1) If an HCPP does not wish to renew its agreement at the end of the term, it must give written notice to HCFA at least 90 days before the end of the term of the agreement. If an HCPP wishes to terminate its agreement before the end of the term, it must file a written notice with HCFA stating the intended effective date of termination.

(2) HCFA may approve the termination date proposed by the HCPP, or set a different date no later than 6 months after that date. HCFA makes this decision based on a finding that termination on a specific date would not—

(i) Unduly disrupt the furnishing of services to the community serviced by the HCPP; or

(ii) Otherwise interfere with the efficient administration of the Medicare program.

§ 417.802 Allowable costs.

(a) *General rule.* The costs that are considered allowable for HCPP reimbursement are the same as those for reasonable cost HMOs and CMPs specified in §§ 417.530 through 417.550, except those in §§ 417.531, 417.532 (a)(3) and (c) through (g), 417.536 (l) and (m), 417.546, 417.548, and 417.550(b)(2).

(b) *Physicians' services and other Part B supplier services furnished under arrangements.*—(1) *Principle.* The amount paid by an HCPP for physicians' services and other Part B supplier services furnished under arrangements is an allowable cost to the extent it is reasonable.

(2) *Application: Payment on other than a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on other than a fee-for-service basis—

(i) Except as specified in paragraph (b)(2)(ii) of this section, the costs incurred by the HCPP may be considered reasonable if they—

(A) Do not exceed those that a prudent and cost-conscious buyer would incur to purchase those services; and

(B) Are comparable to costs incurred for similar services furnished by similar physicians of other suppliers in the same or a similar locality.

(ii)(A) If a physician group to whom the HCPP makes payment compensates its physicians on a fee-for-service basis, the HCPP's payment to the group may not exceed the reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter.

(B) Payment in excess of the limits specified in paragraph (b)(2)(ii)(A) of this section is allowable if the group has procedures under which members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In such cases, the amount paid by the HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

(3) *Application: Payment on a fee-for-service basis.* If the HCPP pays for physicians' services and other Part B supplier services on a fee-for-service basis—

(i) Except as specified in paragraph (b)(3)(ii) of this section, the costs incurred by the HCPP are considered reasonable if they do not exceed—

(A) The reasonable charges for those services, as defined in Subpart E of Part 405 of this chapter; and

(B) The amount that HCFA would pay for those services if they were furnished to beneficiaries who are not enrolled in the HCPP and who receive the services from sources other than providers of services or other entities that are reimbursed on a reasonable cost basis.

(ii) Payment to a physician group organized on an individual-practice basis is not subject to the paragraph (b)(3)(i) of this section if the group pays its physicians on a fee-for-service basis and has procedures under which the members of the group accept effective incentives, such as risk-sharing, designed to avoid unnecessary or unduly costly utilization of health services. In these cases, the amount paid by an HCPP is considered reasonable if it meets the conditions specified in paragraph (b)(2)(i) of this section.

§ 417.804 Cost apportionment.

(a) The HCPP follows the cost apportionment principles specified in §§ 417.552 through 417.566, except for provisions on provider costs and provisions on departmental apportionment.

(b) The HCPP may use a method for reporting costs that is approved by HCFA. HCFA bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

§ 417.806 Financial records, statistical data, and cost finding.

(a) The principles specified in § 417.568 will apply to HCPPs, except those in paragraph (c) of that section.

(b) The HCPP may use a method for reporting costs that is approved by HCFA. HCFA bases its approval on a finding that the method—

(1) Results in an accurate and equitable allocation of allowable costs; and

(2) Is justifiable from an administrative and cost efficiency standpoint.

(c) An HCPP must permit the Department and the Comptroller General to audit or inspect any books and records of the HCPP and of any related organization that pertain to the determination of amounts payable for covered Part B services furnished its Medicare enrollees. For purposes of this requirement, the principles specified in § 417.486 apply to HCPPs.

§ 417.808 Interim per capita payments.

The HCPP follows the principles specified in §§ 417.570 and 417.572 on interim per capita payments, except for the following:

(a) When applying these principles in to HCPPs, the term "reporting period" should be used instead of the term "contract period" contained in that section.

(b) An HCPP must submit to HCFA an annual operating budget and enrollment forecast, in the form and detail specified by HCFA, at least 60 days before the beginning of each reporting period. A reporting period must be 12 consecutive months, except that the HCPP's initial reporting period for participating in Medicare may be as short as 6 months or as long as 18 months.

(c) An HCPP must submit to HCFA an interim cost report and enrollment data applicable to the first 6-month period of the HCPP's reporting period in the form and detail specified by HCFA. The interim cost report must be submitted not later than 45 days after the close of the first 6-month period of the HCPP's reporting period.

(d) In lieu of an interim payment based on the actual monthly enrollment in an HCPP, HCFA and the HCPP may agree to a uniform monthly interim reimbursement rate for a reporting period. This interim rate is based on the HCPP's budget and enrollment forecast, if HCFA is satisified that the rate is consistent with efficiency and economy, and will not result in excessive adjustment at the end of the reporting period.

§ 417.810 Final settlement.

(a) *General requirement.* HCFA and an HCPP must make a final settlement, and payment of amounts due either to the HCPP or to HCFA, following the submission and review of the HCPP's annual cost report and the supporting documents specified in paragraph (b) of this section.

(b) *Annual cost report as basis for final settlement*—(1) *Form and due date.* An HCPP must submit to HCFA a cost report and supporting documents in the form and detail specified by HCFA, no later than 120 days following the close of a reporting period.

(2) *Contents.* The report must include—

(i) The HCPP's per capita incurred costs of providing covered Part B services to its Medicare enrollees during the reporting period, including any costs incurred by another organization related to the HCPP by common ownership or control;

(ii) The HCPP's methods of apportioning costs among its Medicare enrollees, enrollees who are not Medicare beneficiaries, and other nonenrollees, including Medicare beneficiaries receiving health care services on a fee-for-service or other basis; and

(iii) Information on enrollment and other data as specified by HCFA.

(3) *Extension of time to submit cost report.* HCFA may grant an HCPP an extension of time to submit a cost report for good cause shown.

(4) *Failure to report required financial information.* If an HCPP does not submit the required cost report and supporting documents within the time specified in paragraph (b)(1) of this section, and has not requested and received an extension of time for good cause shown, HCFA may—

(i) Regard the failure to report this information as evidence of likely overpayment and reduce or suspend interim payments to the HCPP; and

(ii) Determine that amounts previously paid are overpayments, and make appropriate recovery.

(c) *Determination of final settlement.* Following the HCPP's submission of the reports specified in paragraph (b) of this section in acceptable form, HCFA makes a determination of the total reimbursement due the HCPP for the reporting period and the difference, if any, between this amount and the total interim payments made to the HCPP. HCFA sends to the HCPP a notice of the amount of reimbursement by the Medicare program. This notice—

(1) Explains HCFA's determination of total reimbursement due the HCPP for the reporting period; and

(2) Informs the HCPP of its right to have the determination reviewed at a hearing as provided in Part 405, Subpart R of this subchapter.

(d) *Payment of amounts due.* (1) Within 30 days of HCFA's determination, HCFA or the HCPP, as appropriate, will make payment of any difference between the total amount due and the total interim payments made to the HCPP by HCFA.

(2) If the HCPP does not pay HCFA within 30 days of HCFA's determination of any amounts the HCPP owes HCFA, HCFA may offset further payments to the HCPP to recover, or to aid in the recovery of, any overpayment identified in its determination.

(3) Any offset of payments HCFA makes under paragraph (d)(2) of this section will remain in effect even if the HCPP has requested a hearing on the

determination under the provisions of Part 405, Subpart R of this chapter.

(e) *Tentative settlement.* (1) If a final settlement cannot be made within 90 days after the HCPP submits the report specified in paragraph (b) of this section, HCFA will make an interim settlement by estimating the amount payable to the HCPP.

(2) HCFA or the HCPP will make payment within 30 days of HCFA's determination under the tentative settlement of any estimated amounts due.

(3) The tentative settlement is subject to adjustment at the time of a final settlement.

(Catalog of Federal Domestic Assistance Programs No. 13.773, Medicare-Hospital Insurance Program, and No. 13.774, Medicare-Supplementary Medical Insurance Program)

Dated: October 5, 1984.

Carolyne K. Davis,

Administrator, Health Care Financing Administration.

Approved: December 7, 1984.

Margaret M. Heckler,

Secretary.

[Editorial Note.—The following addendum will not appear in the Code of Federal Regulations.]

Addendum—Adjusted Average Per Capita Cost Methodology for the Implementation of Prospective Risk Contracts

The Tax Equity and Fiscal Responsibility Act (Pub. L. 97-248) authorized prospective Medicare payment under risk contracts with eligible organizations. Eligible organizations are health maintenance organizations (HMOs) and other prepaid plans, known as competitive medical plans (CMPs), that provide health care services to their enrollees in return for fixed predetermined premium payments.

The Medicare program will pay monthly per capita payments in advance to an eligible organization with a risk contract for each Medicare eligible individual enrolled with the organization under the risk contract. In order to determine the appropriate payments, each enrollee will be assigned to a demographic class based on age, sex, Medicare entitlement status, institutionalization, and Medicaid status. The annual rate of the payment for each enrollee will then be set at 95 percent of the adjusted average per capita cost (AAPCC) for the demographic class to which that enrollee is assigned.

The AAPCC applicable to a demographic class is a prospective estimate of the average per capita amount that would be payable by Medicare in the contract year for a group of similarly classified Medicare eligibles in a geographic area if services were to be furnished by other than an eligible organization in the same or a similar geographic area. Thus, the AAPCC is a prospective estimate of Medicare cost levels by demographic category, in the fee-for-service (that is, noneligible organization) sector of the geographic area.

A set of AAPCC values is calculated at the county level for all Medicare insureds except those having end-stage renal disease (ESRD), in which case the calculation is performed at the State level because of the relatively small size of this segment of the population. The calculation of AAPCC values that are applicable to a future calendar year is developed in four conceptually basic steps:

1. Medicare national average calendar year per capita costs are projected for the future year under consideration.

2. Geographic adjustment factors that reflect the historical relationships between the county's and the nation's per capita costs are used to convert the national average per capita costs to the county level.

3. Expected Medicare per capita costs for the county are adjusted (by removing both reimbursement and enrollment attributable to Medicare beneficiaries in eligible organizations under contract with HCFA) to a fee-for-service basis.

4. The fee-for-service Medicare cost per capita is disaggregated into its demographically defined component parts to produce a set of county AAPCC values.

These steps are discussed in greater detail below.

Step 1.—The national average per capita costs to the Medicare program are projected for the future calendar year under consideration. These numbers are known as the United States per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee, loaded for carrier and intermediary expenses.

For each of Part A (hospital insurance) and Part B (supplementary medical insurance) of Medicare, the USPCCs are developed separately for the aged, the disabled, and those beneficiaries having end-stage renal disease (ESRD). The estimates that are used as the basis for the USPCCs are the most recent Medicare cost estimates prepared by the actuaries in the Office of Financial and Actuarial Analysis within HCFA.

Carrier and intermediary expense loadings are calculated separately for Part A and Part B as the ratio of cash administrative expenses to cash benefits. The administrative expense amounts are obtained from reports of HCFA's Division of Contractor Financial Management. The cash benefits amount are obtained from reports of the U.S. Treasury's Division of Financial Management. Monthly USPCCs are calculated for the future calendar year as:

$$\text{USPCC} = \frac{\text{(annual incurred benefit outlays)}}{\text{(projected enrollment)}} \times (1.0 + \text{loading factor})$$

where

$$\text{loading factor} = \frac{\text{(cash administrative expenses)}}{\text{(cash benefit outlays)}}$$

Step 2.—After the USPCCs have been determined, national costs to the Medicare program are adjusted to a county level. For each of Parts A and B, the historical relationship between the county per capita cost and the national per capita cost is established separately for the aged, the disabled, and the ESRD beneficiaries, and is used to make the adjustment. These per capita costs are developed from the entire Medicare enrollment and the aggregate amount of claims paid. No sample population is involved.

Calculations of county and national per capita costs are based on reimbursement *and* enrollment data tabulated in Medicare's statistical system along with reimbursement data provided by HCFA's Group Health Plans Operations Staff (GHPOS). The reimbursement data provided by GHPOS represents payments excluded from Medicare's statistical system that were made to health care prepayment plans (HCPPs) and HMOs dealing directly with HCFA.

The statistical system data is tabulated by county of the beneficiary's

residence as well as by coverage (Part A or Part B) and Medicare eligibility status (aged, disabled, or ESRD). The GHPOS reimbursement data is listed only by coverage and by the prepaid plan to which it was paid. Consequently, one of two approximation methods is used to allocate the GHPOS reimbursement amounts by county of residence and by Medicare eligibility status.

Since service areas and enrollment mixes are not uniform among the prepaid plans, the allocations are performed separately for each plan. The allocation is made on the basis of the distribution of the plan's Medicare membership by county of residence. If the membership by county is not available, the overall Medicare enrollment by county is used as the basis for allocation. Once a GHPOS reimbursement allocation is made to the county, the amount is added to the statistical system's reimbursement amount for that county, giving the total reimbursement for the county.

County per capita costs for each of the five most recent available years are then calculated as follows:

$$\frac{\text{(statistical system reimbursement + GHPOS reimbursement)}}{\text{(statistical system enrollment)}}$$

National per capita costs for each of the five years involved are similarly calculated using reimbursement and enrollment data applicable to the entire nation.

If CPCC, and NPCC, respectively represent the county and national per capita costs in year i, then the geographic index for year i is:

$GI_i = CPCC_i / NPCC_i$.

The adjustment factor to be applied to the USPCC is the unweighted average of the geographic indices for the five years. This factor is known as the "geographic adjustment" (GA):

$GA = (GI_1 + GI_2 + \ldots + GI_5)/5$.

Application of this factor to the contract year USPCC is used to adjust the projected national per capita cost to the county level:

Projected County Per Capita Cost = GA × USPCC.

For that portion of the population having end-stage renal disease, the relationship between the State per capita cost and the national per capita cost is used to make the geographic adjustment. State data rather than county data are used because of the relatively small size of this segment of the population.

Step 3.—At this point, six per capita cost figures have been calculated for the county. For each of Parts A and B, there is a separate cost for each of the aged, disabled, and renal disease populations. These costs are averages for the entire county (or State for the renal disease beneficiaries) and therefore include the reimbursement and enrollment totals of prepaid health plans. The third step is to remove, from the county (or state) per capita cost, the incurred cost and enrollment of any eligible organization that serves the county and is under contract with HCFA. This is accomplished by subtracting the combined total of the organization's incurred costs and enrollments from the entire county's (or State's) Medicare cost and enrollment. The per capita cost is then recalculated.

Step 4.—In the final step, the recalculated county per capita cost is converted into rates that vary according to certain demographic variables: age, sex, Medicaid status, and institutional status. (For purposes of this methodology, an institutionalized individual is a Medicare beneficiary who has been a resident for at least 30 days of a nursing home, sanatorium, rest home, convalescent home, long-term care hospital, or domiciliary home, and a Medicaid individual is a Medicare beneficiary who has been determined by the Medicaid agency of the State in which he or she resides to be eligible for Medicaid.) For each of the aged and disabled, there are thirty cells for each of Parts A and B, corresponding to different combinations of these variables (see Table 1). The factor shown in each cell is the ratio of the cost for a Medicare beneficiary having that particular demographic-cell characteristic to the average per capita cost. These relative cost factors are referred to as demographic factors, and were developed from the last three years (1974–76) of the Current Medicare Survey, incorporating roughly 20,000 Medicare beneficiary-years of observations. Through the use of these demographic factors, the county per capita cost is converted into rates. (A detailed methodology for this step is shown in the Appendix.) However, no demographic adjustment is made to the state per capita cost for those beneficiaries having end-stage renal disease.

For the county, there will be thirty rates for each of Parts A and B, for the aged and disabled populations separately. For each Medicare eligible enrolled under the risk contract, Medicare will pay the organization 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

Appendix to Addendum—Conversion of County Per Capita Costs Into Rates

The AAPCC methodology adjusts for age, sex, Medicaid status, and institutional status of the Medicare beneficiaries in a given county.[1] Table 1 shows the demographic cells used in this adjustment. The adjustment process hinges on the demographic factors (DF_i for each demographic cell i) developed from the Current Medicare Survey. Each factor relates the Medicare cost for a person in that demographic cell to the cost for the average Medicare beneficiary (factor = 1.00). Because of rounding and shifts in the demographic distribution of the Medicare population, it is possible that the average demographic factor for the entire Medicare population would not be exactly 1.00, although it should be close to that value. Demographic distributions for a given county could lead to an average demographic factor other than 1.00. The extent of institutionalization can be extremely volatile, especially for a small county. Medicaid entitlement can vary dramatically by State. Even age-sex differences can have an impact. This problem of county demographic variations is addressed by adjusting the county fee-for-service per capita costs ($PCC_{f,s}$) to the theoretical level, K, that would result if the county demographic distribution were such as to give an average demographic factor of 1.00. This is accomplished simply by dividing $PCC_{f,s}$ by the average demographic factor for the county calculated by using the actual fee-for-service county population ($_{f,s}P_i$ for each demographic cell i):

$$K = PCC_{f,s} \times \frac{(_{f,s}P_1 + \ldots + {}_{f,s}P_{30})}{(_{f,s}P_1 * DF_1 + \ldots + {}_{f,s}P_{30} * DF_{30})}$$

[1] This adjustment does not apply to those beneficiaries suffering from end-stage renal disease.

This calculation (and in fact, the entire AAPCC calculation) must be done separately for each of aged Part A, aged Part B, disabled Part A, and disabled Part B beneficiaries.

Demographic adjustments are not made for Medicare beneficiaries with end-stage renal disease because we cannot determine the significance of demographics in determining the cost for people having this rare and extremely costly condition. After the county fee-for-service per capita cost has been standardized for demographic variables, yielding a value for K as defined above, it is possible to estimate the amount that those in a given demographic cell would have cost Medicare had they not been enrolled in a prepaid health plan, simply by multiplying K by DF_i for each cell i. This procedure allows 95 percent of the AAPCC to be presented as a set of rates, $R_i = .95 * K * DF_i$, varying according to the demographic cells shown in Table 1.

Table 2 sets forth the standardized per capita rates of payment by county. These standardized per capita rates of payment represent 95 percent of the standardized county per capita cost. As mentioned above, these rates must be multiplied by the demographic cost factors shown in Table 1 to give the actual per capita rates of payment for each county. The following is an example of how the actual per capita rates of payment will be calculated for a particular county.

Sample Calculation of the Per Capita Rates of Payment for Autauga County, Alabama

For each county, there will be thirty rates of payment for each of aged Part A, disabled Part A, aged Part B, and disabled Part B. These rates vary according to the demographic cells shown in Table 1.

The rates for Autauga County, Alabama are presented below in table form. The thirty rates for each part are calculated by multiplying the county standardized per capita rates obtained from Table 2 by the corresponding demographic factors in Table 1. For example, Table 2 shows that the aged Part A standardized per capita rate is $111.81. Table 1 shows that the aged Part A demographic factors for male noninstitutionalized Medicaid enrollees range from 1.35 (ages 65–69) to 2.30 (ages 85 and over).

Age group	Demographic cost factor	Standardized per capita rate	95 pct of AAPCC rates
85 and over	2.30		$257.16
80 to 84	2.25		251.57
75 to 79	2.00	$111.81	223.62
70 to 74	1.65		184.49
65 to 69	1.35		150.94

Multiplying each of these factors by the standardized per capita rate gives the corresponding per capita rates of payment shown in the sample table set forth below.

As further example, the disabled Part B noninstitutionalized non-Medicaid rate ($55.18) for a female age 57 can be calculated by multiplying the demographic factor for her age group (1.10) by the appropriate standardized per capita rate ($50.16).

SAMPLE CALCULATION OF PER CAPITA RATES OF PAYMENT FOR CALENDAR YEAR 1985 FOR AUTAUGA COUNTY

STATE: ALABAMA COUNTY NAME	AGED PART A	AGED PART B	DISABLED PART A	DISABLED PART B
AUTAUGA (From Table 2)	$111.81	$43.60	$125.12	$50.16

AGE GROUP	MALE INSTITUTIONALIZED	MALE NONINSTITUTIONALIZED MEDICAID	MALE NONINSTITUTIONALIZED NON-MEDICAID	FEMALE INSTITUTIONALIZED	FEMALE NONINSTITUTIONALIZED MEDICAID	FEMALE NONINSTITUTIONALIZED NON-MEDICAID
AGED			PART A			
85 & OVER	251.57	257.16	134.17	223.62	206.85	122.99
80-84	251.57	251.57	128.58	223.62	190.08	117.40
75-79	251.57	223.62	117.40	223.62	162.12	95.04
70-74	251.57	184.89	95.04	212.44	128.58	78.27
65-69	223.62	150.94	78.27	190.08	100.63	67.09
DISABLED						
60-64	68.82	212.70	112.61	81.33	187.68	156.40
55-59	100.10	175.17	93.84	125.12	181.42	125.12
45-54	137.63	162.66	81.33	181.42	181.42	118.86
35-44	150.14	131.38	68.82	187.68	162.66	81.33
UNDER 35	181.42	112.61	62.56	206.45	143.89	62.56
AGED			PART B			
85 & OVER	78.48	69.76	47.96	69.76	52.32	41.42
80-84	78.48	69.76	47.96	69.76	52.32	41.42
75-79	78.48	67.58	47.96	69.76	52.32	41.42
70-74	78.48	63.22	43.60	69.76	50.14	37.06
65-69	76.30	54.50	37.06	67.58	47.96	30.52
DISABLED						
60-64	45.14	72.73	45.14	57.68	75.24	60.19
55-59	55.18	65.21	37.62	70.22	70.22	55.18
45-54	65.21	62.70	32.60	87.78	65.21	50.16
35-44	67.72	50.16	25.08	87.78	55.18	40.13
UNDER 35	67.72	45.14	17.56	87.78	45.14	32.60

Table 3 sets forth the actual per capita rates of payment by State for Medicare enrollees who have been medically determined to have ESRD. These rates are *not* multiplied by the demographic cost factors in Table 1.

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TABLE 1

Demographic Cost Factors For 1985

AGE GROUP	MALE			FEMALE		
	INSTITUTIONALIZED	NONINSTITUTIONALIZED		INSTITUTIONALIZED	NONINSTITUTIONALIZED	
		MEDICAID	NON-MEDICAID		MEDICAID	NON-MEDICAID
PART A - HOSPITAL INSURANCE						
AGED						
85 & OVER	2.25	2.30	1.20	2.00	1.85	1.10
80-84	2.25	2.25	1.15	2.00	1.70	1.05
75-79	2.25	2.00	1.05	2.00	1.45	.85
70-74	2.25	1.65	.85	1.90	1.15	.70
65-69	2.00	1.35	.70	1.70	.90	.60
DISABLED						
60-64	.55	1.70	.90	.65	1.50	1.25
55-59	.80	1.40	.75	1.00	1.45	1.00
45-54	1.10	1.30	.65	1.45	1.45	.95
35-44	1.20	1.05	.55	1.50	1.30	.65
UNDER 35	1.45	.90	.50	1.65	1.15	.50
PART B - SUPPLEMENTAL MEDICAL INSURANCE						
AGED						
85 & OVER	1.80	1.60	1.10	1.60	1.20	.95
80-84	1.80	1.60	1.10	1.60	1.20	.95
75-79	1.80	1.55	1.10	1.60	1.20	.95
70-74	1.80	1.45	1.00	1.60	1.15	.85
65-69	1.75	1.25	.85	1.55	1.10	.70
DISABLED						
60-64	.90	1.45	.90	1.15	1.50	1.20
55-59	1.10	1.30	.75	1.40	1.40	1.10
45-54	1.30	1.25	.65	1.75	1.30	1.00
35-44	1.35	1.00	.50	1.75	1.10	.80
UNDER 35	1.35	.90	.35	1.75	.90	.65

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ALABAMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
AUTAUGA	$111.81	$43.60	$125.12	$50.16
BARBOUR	$91.33	$36.30	$100.60	$43.61
BLOUNT	$120.47	$50.62	$135.80	$62.74
BUTLER	$90.89	$34.82	$101.94	$42.61
CHAMBERS	$88.39	$40.82	$110.94	$60.10
CHILTON	$98.09	$42.71	$120.31	$57.29
CLARKE	$95.20	$41.16	$98.11	$43.80
CLEBURNE	$104.27	$40.57	$141.42	$61.18
COLBERT	$117.00	$39.97	$145.94	$54.31
COOSA	$86.71	$42.51	$100.36	$53.40
CRENSHAW	$93.41	$37.65	$86.96	$36.15
DALE	$90.13	$39.89	$113.57	$50.37
DE KALB	$75.91	$33.46	$100.81	$43.90
ESCAMBIA	$110.51	$48.04	$132.54	$59.85
FAYETTE	$80.24	$35.87	$111.61	$54.96
GENEVA	$91.12	$40.95	$82.07	$39.83
HALE	$72.32	$31.56	$108.39	$44.42
HOUSTON	$103.63	$45.82	$127.47	$56.03
JEFFERSON	$140.73	$60.29	$173.24	$71.23
LAUDERDALE	$97.80	$38.17	$122.22	$54.39
LEE	$78.92	$38.38	$98.55	$46.46
LOWNDES	$80.01	$42.86	$64.57	$36.95
MADISON	$102.46	$48.56	$114.51	$56.69
MARION	$106.26	$41.96	$123.83	$52.08
MOBILE	$133.05	$51.79	$146.42	$57.97
MONTGOMERY	$118.55	$46.73	$112.95	$47.24
PERRY	$72.73	$32.35	$82.72	$38.55
PIKE	$84.17	$35.24	$105.14	$43.62
RUSSELL	$123.32	$42.63	$169.16	$57.97
SHELBY	$133.86	$62.40	$164.20	$77.67
TALLADEGA	$104.97	$52.39	$112.11	$61.16
TUSCALOOSA	$99.29	$42.10	$107.11	$46.62
WASHINGTON	$113.76	$47.68	$116.91	$47.41
WINSTON	$100.31	$38.76	$143.73	$56.65
STATE: ALASKA				
ALEUTIAN	$79.32	$31.36	$99.26	$36.86
ANGOON	$97.39	$19.49	$112.99	$58.10
BETHEL	$45.20	$14.77	$54.73	$6.20
BRISTOL BAY	$54.43	$24.42	$47.90	$19.00
FAIRBANKS	$198.42	$93.18	$181.88	$100.16
JUNEAU	$158.27	$57.42	$155.15	$72.86
KETCHIKAN	$116.50	$64.29	$116.11	$65.60
KODIAK	$146.53	$67.81	$151.98	$82.04
MATANUSKA	$155.83	$60.84	$83.72	$43.61
OUTER KETCHIKAN	$89.35	$26.42	$179.31	$90.68
SEWARD	$168.11	$68.43	$254.61	$70.34
SKAGWAY-YAKUTAT	$186.77	$51.74	$130.80	$64.16
UPPER YUKON	$131.49	$39.56	$164.10	$78.75

STATE: ALABAMA COUNTY NAME	****** AGED ****** PART A	 PAPT B	*** DISABLED *** PART A	 PART B
BALDWIN	$101.23	$45.98	$111.20	$57.21
BIBB	$90.21	$47.06	$113.00	$52.55
BULLOCK	$64.76	$26.69	$84.59	$30.74
CALHOUN	$105.54	$46.53	$116.78	$54.80
CHEROKEE	$93.16	$42.11	$139.94	$66.25
CHOCTAW	$93.10	$45.01	$120.72	$56.22
CLAY	$66.55	$30.95	$83.78	$39.75
COFFEE	$94.58	$40.02	$117.33	$48.61
CONECUH	$99.64	$43.94	$120.17	$54.94
COVINGTON	$113.55	$46.05	$147.19	$61.65
CULLMAN	$112.85	$43.47	$141.50	$57.89
DALLAS	$89.01	$39.92	$104.34	$46.42
ELMORE	$115.59	$42.94	$137.55	$53.33
ETOWAH	$108.39	$40.31	$127.90	$49.57
FRANKLIN	$104.70	$39.69	$142.02	$56.27
GREENE	$61.11	$27.08	$57.64	$25.92
HENRY	$93.29	$38.98	$117.67	$48.57
JACKSON	$76.28	$36.02	$88.15	$44.80
LAMAR	$87.28	$30.64	$115.01	$44.69
LAWRENCE	$104.35	$45.30	$141.51	$61.41
LIMESTONE	$79.17	$34.24	$90.07	$40.71
MACON	$68.78	$31.53	$58.01	$29.96
MARENGO	$99.15	$37.19	$112.87	$41.45
MARSHALL	$74.89	$34.85	$102.67	$49.21
MONROE	$100.81	$37.78	$99.84	$47.91
MORGAN	$118.96	$43.39	$133.22	$53.58
PICKENS	$85.44	$36.98	$104.92	$41.03
RANDOLPH	$96.26	$35.73	$109.62	$46.59
ST CLAIR	$117.88	$48.49	$137.87	$62.40
SUMTER	$94.36	$44.00	$130.56	$50.92
TALLAPOOSA	$86.92	$38.18	$114.91	$54.99
WALKER	$143.19	$58.15	$155.20	$65.35
WILCOX	$64.12	$29.33	$70.92	$28.93
STATE: ALASKA				
ANCHORAGE	$186.66	$90.20	$160.65	$79.88
BARROW-NORTH SLOPE	$70.41	$31.39	$178.12	$47.48
BRISTOL BAY BOROUGH	$154.95	$78.89	$239.61	$109.12
CORDOVA-MC CARTHY	$152.09	$61.34	$216.44	$101.47
HAINES	$100.15	$33.58	$173.05	$82.70
KENAI-COOK INLET	$127.55	$55.76	$131.81	$52.92
KOBUK	$44.83	$20.20	$136.75	$70.48
KUSKOKWIN	$60.38	$30.79	$174.91	$76.30
NOME	$93.25	$27.78	$65.61	$21.44
PRINCE OF WALES	$95.11	$28.34	$188.94	$92.80
SITKA	$141.88	$56.36	$200.33	$88.85
SOUTHEAST FAIRBANKS	$112.31	$54.06	$156.63	$64.21
VALDZ-CHITNA-WHITIER	$95.52	$40.30	$234.29	$81.49

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ALASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WADE HAMPTON	$30.46	$7.78	$100.72	$17.10
YUKON-KOYUKUK	$143.51	$47.84	$324.56	$111.37
STATE: ARIZONA				
APACHE	$55.11	$19.58	$43.61	$18.40
COCONINO	$83.46	$44.75	$102.30	$54.45
GRAHAM	$109.29	$58.71	$104.29	$55.80
MARICOPA	$131.30	$76.91	$164.09	$101.16
NAVAJO	$81.85	$37.75	$79.17	$43.41
PINAL	$110.58	$58.86	$118.20	$73.45
YAVAPAI	$91.03	$53.53	$93.52	$62.29
STATE: ARKANSAS				
ARKANSAS	$107.47	$58.25	$89.10	$52.83
BAXTER	$90.68	$43.99	$110.18	$55.97
BOONE	$73.52	$39.05	$63.43	$43.68
CALHOUN	$84.12	$47.43	$118.68	$69.98
CHICOT	$95.66	$42.71	$78.68	$44.20
CLAY	$99.92	$44.81	$86.38	$46.73
CLEVELAND	$74.72	$46.10	$54.14	$35.64
CONWAY	$97.03	$55.41	$88.04	$58.77
CRAWFORD	$101.43	$50.26	$93.41	$56.97
CROSS	$92.04	$39.55	$97.31	$47.30
DESHA	$83.39	$42.71	$86.53	$49.66
FAULKNER	$91.76	$49.84	$81.91	$52.16
FULTON	$81.00	$39.05	$68.85	$46.02
GRANT	$78.16	$48.71	$60.88	$42.04
HEMPSTEAD	$84.07	$40.84	$83.83	$49.04
HOWARD	$84.14	$44.17	$71.57	$40.45
IZARD	$70.08	$38.04	$73.65	$43.55
JEFFERSON	$59.51	$42.13	$64.83	$48.23
LAFAYETTE	$68.83	$33.94	$74.93	$52.46
LEE	$79.97	$37.24	$93.99	$55.07
LITTLE RIVER	$85.27	$42.89	$91.62	$54.66
LONOKE	$97.26	$56.98	$86.37	$56.48
MARION	$97.69	$44.25	$100.29	$56.41
MISSISSIPPI	$115.53	$51.16	$107.69	$51.12
MONTGOMERY	$73.44	$49.28	$61.37	$49.59
NEWTON	$52.60	$31.55	$60.46	$37.05
PERRY	$102.65	$57.13	$63.00	$53.88
PIKE	$78.35	$43.89	$71.03	$49.78
POLK	$76.34	$40.85	$65.00	$46.23
PRAIRIE	$113.44	$62.45	$98.25	$65.46
RANDOLPH	$89.46	$43.80	$70.90	$41.96
SALINE	$107.79	$60.04	$96.97	$63.56
SEARCY	$55.92	$34.86	$56.91	$37.58
SEVIER	$86.66	$41.24	$99.44	$58.15
STONE	$105.15	$44.39	$76.45	$45.43
VAN BUREN	$73.78	$44.78	$62.09	$43.88

STATE: ALASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WRANGELL-PETERSBURG	$126.25	$64.73	$69.38	$39.86
STATEWIDE	$148.31	$69.38	$150.70	$72.42
STATE: ARIZONA				
COCHISE	$111.55	$56.28	$105.83	$66.34
GILA	$122.38	$61.56	$123.24	$69.56
GREENLEE	$98.36	$48.37	$112.50	$56.22
MOHAVE	$124.32	$61.87	$132.33	$83.54
PIMA	$132.76	$70.02	$141.67	$87.16
SANTA CRUZ	$99.69	$46.59	$102.58	$49.75
YUMA	$108.10	$59.81	$119.58	$74.51
STATE: ARKANSAS				
ASHLEY	$85.15	$39.10	$102.99	$47.71
BENTON	$100.77	$46.91	$107.36	$54.85
BRADLEY	$75.02	$35.33	$57.35	$37.93
CARROLL	$77.50	$36.42	$78.19	$48.76
CLARK	$91.67	$48.84	$72.23	$50.19
CLEBURNE	$71.87	$42.88	$80.24	$56.38
COLUMBIA	$79.41	$32.93	$79.51	$36.12
CRAIGHEAD	$87.96	$53.56	$99.30	$63.39
CRITTENDEN	$95.36	$44.51	$112.04	$53.77
DALLAS	$82.09	$47.02	$73.62	$47.23
DREW	$75.29	$38.83	$86.44	$45.71
FRANKLIN	$81.26	$40.19	$66.83	$50.90
GARLAND	$101.97	$60.96	$99.14	$67.55
GREENE	$79.65	$42.08	$82.60	$64.02
HOT SPRING	$100.50	$54.49	$79.42	$57.15
INDEPENDENCE	$93.91	$43.78	$77.01	$51.41
JACKSON	$143.19	$78.75	$134.89	$81.15
JOHNSON	$102.96	$55.37	$70.55	$51.26
LAWRENCE	$84.04	$48.40	$85.22	$50.83
LINCOLN	$60.66	$44.49	$66.21	$47.11
LOGAN	$83.76	$46.51	$82.57	$49.39
MADISON	$82.55	$34.12	$77.59	$49.08
MILLER	$89.48	$47.60	$107.78	$63.72
MONROE	$83.28	$45.77	$79.82	$44.40
NEVADA	$78.14	$44.52	$73.47	$42.96
OUACHITA	$78.16	$48.52	$75.38	$50.81
PHILLIPS	$88.93	$40.67	$104.81	$51.60
POINSETT	$94.14	$50.23	$113.64	$71.12
POPE	$99.51	$47.91	$89.25	$54.44
PULASKI	$116.01	$65.76	$107.50	$68.87
ST FRANCIS	$85.47	$39.72	$104.25	$47.99
SCOTT	$84.30	$47.01	$79.38	$60.64
SEBASTIAN	$110.19	$57.52	$115.41	$68.00
SHARP	$73.99	$42.08	$58.92	$40.62
UNION	$98.98	$44.81	$96.16	$49.29
WASHINGTON	$105.59	$45.28	$84.23	$50.01

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ARKANSAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WHITE	$90.85	$54.03	$90.15	$60.35
YELL	$86.06	$47.14	$79.02	$52.42
STATE: CALIFORNIA				
ALAMEDA	$154.50	$84.90	$156.79	$106.59
AMADOR	$113.01	$70.33	$97.71	$87.48
CALAVERAS	$111.37	$68.71	$112.69	$94.08
CONTRA COSTA	$144.68	$95.84	$147.73	$107.40
ELDORADO	$95.78	$69.76	$108.44	$78.88
GLENN	$111.10	$66.67	$93.50	$75.94
IMPERIAL	$121.69	$88.00	$108.39	$86.65
KERN	$130.02	$80.33	$122.16	$95.19
LAKE	$135.96	$81.90	$121.05	$94.26
LOS ANGELES	$192.42	$108.99	$195.70	$126.25
MARIN	$134.86	$87.10	$178.63	$113.38
MENDOCINO	$117.05	$65.66	$115.02	$82.17
MODOC	$130.11	$66.66	$129.35	$74.75
MONTEREY	$94.73	$67.46	$113.52	$84.88
NEVADA	$100.17	$62.03	$101.77	$75.10
PLACER	$111.69	$72.48	$98.18	$80.04
RIVERSIDE	$139.36	$85.29	$141.49	$99.05
SAN BENITO	$98.05	$63.48	$103.90	$78.99
SAN DIEGO	$127.04	$91.28	$156.91	$120.62
SAN JOAQUIN	$104.09	$73.69	$103.61	$91.97
SAN MATEO	$157.51	$84.78	$179.43	$107.18
SANTA CLARA	$122.15	$79.00	$143.55	$94.91
SHASTA	$114.47	$74.65	$97.45	$83.41
SISKIYOU	$109.60	$63.40	$99.49	$72.97
SONOMA	$118.72	$74.62	$113.44	$86.57
SUTTER	$107.66	$76.27	$116.86	$97.30
TRINITY	$107.92	$65.26	$108.26	$85.30
TUOLUMNE	$126.25	$70.01	$119.50	$84.48
YOLO	$101.41	$73.37	$115.91	$94.54
STATE: COLORADO				
ADAMS	$141.56	$66.17	$158.40	$84.56
ARAPAHOE	$137.37	$66.38	$171.04	$90.90
BACA	$123.10	$44.55	$135.85	$43.98
BOULDER	$102.62	$50.67	$124.29	$70.44
CHEYENNE	$144.52	$45.55	$209.24	$87.22
CONEJOS	$105.00	$47.10	$78.23	$44.99
CROWLEY	$76.45	$40.32	$75.67	$43.87
DELTA	$72.64	$41.18	$75.07	$48.64
DOLORES	$122.18	$50.88	$119.27	$67.81
EAGLE	$127.72	$51.34	$173.79	$86.58
EL PASO	$127.01	$59.62	$130.27	$75.18
GARFIELD	$117.75	$56.47	$177.27	$75.74
GRAND	$148.79	$62.70	$120.25	$65.34
HINSDALE	$123.99	$58.93	$142.51	$75.12

STATE: ARKANSAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WOODRUFF	$103.36	$57.83	$84.69	$55.16
STATE: CALIFORNIA				
ALPINE	$128.48	$66.69	$100.78	$68.46
BUTTE	$111.53	$70.99	$103.39	$86.31
COLUSA	$153.58	$78.59	$137.07	$95.51
DEL NORTE	$128.87	$62.10	$115.22	$67.61
FRESNO	$81.06	$63.17	$79.40	$67.56
HUMBOLDT	$113.05	$73.61	$110.94	$88.23
INYO	$158.59	$72.68	$170.20	$94.11
KINGS	$81.50	$60.16	$80.82	$77.00
LASSEN	$120.37	$67.81	$128.37	$85.54
MADERA	$87.90	$65.46	$74.15	$67.82
MARIPOSA	$96.65	$65.36	$103.72	$87.41
MERCED	$108.95	$77.75	$100.80	$84.43
MONO	$142.87	$65.35	$96.65	$81.23
NAPA	$135.50	$84.01	$147.90	$112.93
ORANGE	$181.38	$107.58	$206.71	$136.45
PLUMAS	$126.30	$71.67	$136.41	$91.46
SACRAMENTO	$116.37	$79.14	$121.48	$91.84
SAN BERNARDINO	$139.83	$80.28	$141.98	$95.95
SAN FRANCISCO	$181.55	$89.32	$177.45	$99.84
SAN LUIS OBISPO	$119.97	$81.10	$131.34	$105.42
SANTA BARBARA	$129.09	$82.61	$119.39	$94.08
SANTA CRUZ	$94.59	$67.32	$114.47	$93.23
SIERRA	$122.03	$75.03	$71.03	$66.77
SOLANO	$122.04	$86.26	$121.77	$94.80
STANISLAUS	$110.24	$73.73	$109.42	$90.04
TEHAMA	$101.52	$64.38	$89.97	$73.56
TULARE	$85.37	$63.09	$79.44	$70.58
VENTURA	$134.87	$88.74	$144.45	$116.42
YUBA	$112.90	$79.39	$101.46	$87.53
STATE: COLORADO				
ALAMOSA	$92.28	$43.64	$70.10	$48.85
ARCHULETA	$94.05	$43.04	$170.80	$59.12
BENT	$80.32	$43.30	$44.75	$29.00
CHAFFEE	$108.53	$43.85	$122.99	$52.38
CLEAR CREEK	$149.33	$65.63	$102.54	$69.18
COSTILLA	$77.14	$39.46	$85.84	$35.77
CUSTER	$83.61	$54.88	$185.64	$104.47
DENVER	$156.15	$67.15	$167.94	$83.97
DOUGLAS	$116.70	$58.63	$161.65	$86.10
ELBERT	$109.00	$47.43	$133.09	$56.76
FREMONT	$84.65	$50.79	$108.21	$68.41
GILPIN	$160.15	$66.99	$178.59	$96.97
GUNNISON	$85.54	$46.18	$84.28	$47.91
HUERFANO	$100.05	$54.12	$88.95	$43.60

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: COLORADO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
JACKSON	$89.98	$43.40	$111.99	$29.84
KIOWA	$141.37	$49.09	$90.28	$26.02
LAKE	$195.57	$58.75	$217.06	$69.34
LARIMER	$84.09	$50.53	$105.48	$68.15
LINCOLN	$111.65	$45.04	$99.40	$52.39
MESA	$93.53	$49.83	$98.10	$65.97
MOFFAT	$98.79	$46.84	$140.27	$74.88
MONTROSE	$85.89	$44.57	$97.96	$58.74
OTERO	$87.48	$42.57	$78.04	$45.51
PARK	$91.59	$44.85	$125.52	$76.49
PITKIN	$169.62	$65.31	$210.16	$79.67
PUEBLO	$108.92	$55.63	$133.67	$75.97
RIO GRANDE	$99.29	$42.38	$111.63	$57.12
SAGUACHE	$100.74	$45.71	$42.20	$31.63
SAN MIGUEL	$88.23	$45.73	$124.39	$61.91
SUMMIT	$106.91	$53.41	$167.77	$115.47
WASHINGTON	$111.33	$44.20	$190.76	$86.35
YUMA	$97.13	$34.04	$112.78	$45.00
STATE: CONNECTICUT				
FAIRFIELD	$147.75	$67.83	$182.97	$92.34
LITCHFIELD	$125.05	$53.80	$168.15	$92.61
NEW HAVEN	$135.17	$61.49	$154.08	$86.05
TOLLAND	$135.64	$56.32	$182.34	$96.13
STATE: DELAWARE				
KENT	$107.11	$53.05	$120.26	$70.96
SUSSEX	$124.78	$52.38	$133.41	$66.59
STATE: DIST. OF COL.				
DISTRICT OF COLUMBIA	$192.25	$86.58	$208.81	$85.66
STATE: FLORIDA				
ALACHUA	$121.18	$61.08	$105.82	$58.99
BAY	$117.71	$66.49	$122.87	$78.80
BREVARD	$113.70	$70.46	$129.45	$90.50
CALHOUN	$84.75	$45.93	$98.10	$46.04
CITRUS	$103.10	$53.14	$98.91	$62.16
COLLIER	$92.37	$66.75	$125.37	$85.95
DADE	$203.32	$125.79	$227.63	$145.01
DIXIE	$122.63	$59.09	$58.24	$43.90
ESCAMBIA	$145.83	$69.41	$157.41	$83.16
FRANKLIN	$109.33	$53.16	$112.37	$55.13
GILCHRIST	$124.49	$63.07	$99.48	$66.43
GULF	$107.95	$64.75	$108.30	$62.91
HARDEE	$123.36	$61.54	$87.65	$46.33
HERNANDO	$95.28	$55.11	$97.02	$71.18
HILLSBOROUGH	$118.79	$69.04	$127.22	$82.33
INDIAN RIVER	$118.44	$72.43	$145.92	$94.28

STATE: COLORADO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
JEFFERSON	$129.51	$64.06	$156.05	$83.61
KIT CARSON	$135.15	$46.63	$147.51	$53.80
LA PLATA	$125.24	$47.97	$157.06	$72.53
LAS ANIMAS	$108.29	$53.45	$99.64	$51.70
LOGAN	$105.29	$47.59	$133.78	$56.34
MINERAL	$123.99	$56.93	$180.01	$88.04
MONTEZUMA	$114.73	$48.80	$123.61	$61.40
MORGAN	$88.28	$40.80	$117.50	$50.11
OURAY	$110.75	$46.55	$67.48	$73.41
PHILLIPS	$107.23	$49.21	$104.78	$64.06
PROWERS	$112.36	$43.29	$100.79	$39.77
RIO BLANCO	$111.93	$47.59	$116.76	$59.85
ROUTT	$104.87	$52.00	$162.30	$59.05
SAN JUAN	$147.27	$46.90	$149.43	$77.90
SEDGWICK	$100.67	$45.01	$125.00	$74.15
TELLER	$121.93	$61.84	$181.16	$85.00
WELD	$105.22	$53.70	$125.40	$70.37
STATE: CONNECTICUT				
HARTFORD	$134.82	$62.05	$158.60	$93.72
MIDDLESEX	$119.21	$58.47	$139.56	$87.00
NEW LONDON	$116.47	$50.71	$146.41	$83.90
WINDHAM	$130.91	$54.10	$156.53	$75.58
STATE: DELAWARE				
NEW CASTLE	$142.13	$61.40	$151.83	$77.94
STATE: DIST. OF COL.				
STATE: FLORIDA				
BAKER	$124.45	$65.23	$160.31	$77.64
BRADFORD	$132.84	$57.15	$154.58	$67.01
BROWARD	$160.98	$103.18	$202.80	$135.00
CHARLOTTE	$156.57	$79.45	$167.05	$100.63
CLAY	$128.89	$77.83	$134.44	$88.98
COLUMBIA	$141.74	$63.29	$135.81	$73.56
DE SOTO	$115.02	$60.54	$124.27	$65.89
DUVAL	$147.96	$77.74	$173.56	$99.24
FLAGLER	$167.84	$66.73	$159.10	$72.62
GADSDEN	$74.71	$41.64	$92.40	$52.64
GLADES	$149.20	$67.95	$174.57	$81.02
HAMILTON	$126.51	$52.16	$118.41	$56.45
HENDRY	$127.95	$59.22	$136.84	$75.12
HIGHLANDS	$101.87	$53.99	$115.70	$63.55
HOLMES	$114.25	$49.46	$123.93	$65.02
JACKSON	$91.07	$42.54	$98.04	$51.56

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: FLORIDA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
JEFFERSON	$61.11	$31.70	$78.84	$39.93
LAKE	$98.05	$60.25	$108.75	$69.56
LEON	$95.06	$54.57	$124.47	$70.15
LIBERTY	$100.33	$53.28	$79.78	$48.54
MANATEE	$115.70	$59.08	$130.37	$74.82
MARTIN	$99.97	$61.55	$106.53	$75.95
NASSAU	$154.71	$68.31	$162.50	$81.19
OKEECHOBEE	$165.73	$70.17	$147.85	$81.73
OSCEOLA	$150.90	$69.88	$164.97	$83.19
PASCO	$104.35	$60.82	$103.89	$71.30
POLK	$92.07	$52.76	$108.82	$63.98
ST JOHNS	$141.57	$72.65	$167.66	$85.30
SANTA ROSA	$170.99	$81.10	$181.01	$97.96
SEMINOLE	$119.15	$62.54	$135.93	$78.78
SUWANNEE	$111.47	$56.47	$96.22	$52.63
UNION	$182.54	$73.69	$160.58	$65.77
WAKULLA	$85.24	$51.27	$107.44	$60.65
WASHINGTON	$118.34	$54.99	$117.30	$67.65
STATE: GEORGIA				
APPLING	$93.49	$53.72	$107.97	$63.17
BACON	$83.46	$47.44	$101.52	$55.02
BALDWIN	$85.79	$38.90	$91.89	$40.44
BARROW	$93.87	$43.57	$117.93	$58.81
BEN HILL	$79.80	$40.17	$96.41	$46.87
BIBB	$82.42	$46.50	$93.36	$59.22
BRANTLEY	$98.16	$54.42	$94.31	$56.47
BRYAN	$112.88	$55.70	$91.85	$57.27
BURKE	$93.04	$42.61	$88.99	$45.09
CALHOUN	$65.98	$33.33	$81.67	$34.84
CANDLER	$82.08	$46.07	$84.23	$49.75
CATOOSA	$128.41	$47.22	$127.81	$59.21
CHATHAM	$110.39	$58.72	$150.48	$82.30
CHATTOOGA	$69.79	$35.36	$105.06	$54.27
CLARKE	$87.86	$41.94	$102.65	$54.34
CLAYTON	$133.18	$71.04	$176.40	$105.14
COBB	$126.45	$63.69	$163.27	$90.95
COLQUITT	$86.99	$43.75	$92.79	$52.03
COOK	$71.03	$42.74	$62.71	$51.65
CRAWFORD	$70.77	$36.85	$72.31	$54.87
DADE	$103.41	$40.89	$124.18	$50.78
DECATUR	$70.21	$37.03	$86.85	$51.17
DODGE	$100.87	$48.93	$101.38	$54.35
DOUGHERTY	$74.92	$37.42	$93.75	$52.34
EARLY	$83.28	$45.77	$99.41	$57.64
EFFINGHAM	$98.52	$51.07	$138.40	$76.08
EMANUEL	$83.28	$43.37	$91.27	$55.42
FANNIN	$99.46	$39.10	$128.14	$55.76
FLOYD	$78.58	$40.66	$95.90	$54.36

STATE: FLORIDA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LAFAYETTE	$106.14	$54.81	$90.38	$66.38
LEE	$119.87	$66.82	$125.00	$76.80
LEVY	$110.44	$55.96	$87.86	$58.01
MADISON	$82.54	$40.91	$90.31	$48.64
MARION	$95.01	$51.53	$95.87	$59.82
MONROE	$159.23	$74.99	$162.76	$87.38
OKALOOSA	$150.84	$69.11	$153.82	$79.84
ORANGE	$134.25	$68.47	$148.99	$86.82
PALM BEACH	$114.84	$80.99	$136.99	$99.01
PINELLAS	$129.83	$64.82	$152.03	$83.17
PUTNAM	$112.37	$56.68	$113.99	$69.36
ST LUCIE	$109.02	$64.76	$120.99	$76.05
SARASOTA	$109.88	$68.10	$135.63	$84.56
SUMTER	$109.63	$57.20	$94.50	$62.53
TAYLOR	$108.03	$60.14	$103.42	$70.40
VOLUSIA	$120.31	$59.46	$142.60	$77.79
WALTON	$139.43	$59.21	$134.82	$64.81
STATE: GEORGIA				
ATKINSON	$110.18	$52.64	$96.15	$45.93
BAKER	$95.69	$46.34	$104.25	$56.35
BANKS	$95.00	$41.53	$147.31	$62.04
BARTOW	$82.02	$36.80	$104.04	$54.54
BERRIEN	$121.55	$56.25	$136.50	$64.94
BLECKLEY	$102.30	$38.74	$97.82	$42.93
BROOKS	$73.45	$39.42	$76.95	$47.19
BULLOCH	$83.93	$50.90	$90.96	$61.40
BUTTS	$99.09	$42.80	$135.18	$65.46
CAMDEN	$126.18	$62.75	$137.16	$86.39
CARROLL	$122.54	$47.82	$147.89	$66.04
CHARLTON	$108.21	$52.04	$95.95	$55.83
CHATTAHOOCHEE	$113.70	$51.46	$62.25	$47.84
CHEROKEE	$122.36	$51.88	$119.79	$64.64
CLAY	$68.07	$32.96	$79.23	$57.47
CLINCH	$111.59	$54.26	$111.90	$59.39
COFFEE	$95.83	$45.74	$96.35	$47.35
COLUMBIA	$123.22	$59.63	$103.39	$69.50
COWETA	$110.56	$47.91	$146.86	$72.67
CRISP	$79.56	$38.57	$95.07	$48.81
DAWSON	$104.47	$46.81	$103.18	$55.97
DE KALB	$111.28	$57.85	$133.61	$72.76
DOOLY	$90.25	$43.44	$118.95	$60.76
DOUGLAS	$153.11	$71.96	$214.48	$107.48
ECHOLS	$140.21	$63.24	$68.01	$39.31
ELBERT	$82.80	$33.24	$99.69	$41.16
EVANS	$110.96	$47.65	$135.13	$67.34
FAYETTE	$99.85	$53.12	$159.27	$87.41
FORSYTH	$97.14	$48.57	$135.53	$66.21

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
FRANKLIN	$81.15	$39.67	$97.37	$49.54
GILMER	$112.40	$43.66	$126.84	$50.01
GLYNN	$103.83	$55.78	$124.69	$76.61
GRADY	$83.35	$39.18	$93.13	$46.85
GWINNETT	$128.93	$53.11	$165.79	$81.87
HALL	$92.23	$42.55	$128.99	$62.23
HARALSON	$124.30	$49.14	$131.57	$61.40
HART	$73.93	$36.40	$90.99	$47.21
HENRY	$116.49	$56.87	$131.36	$73.32
IRWIN	$60.08	$39.31	$65.95	$43.45
JASPER	$87.97	$42.82	$102.43	$48.19
JEFFERSON	$83.17	$39.08	$83.49	$44.94
JOHNSON	$71.62	$36.14	$68.73	$42.68
LAMAR	$76.43	$33.39	$76.16	$38.59
LAURENS	$67.04	$37.69	$72.87	$44.62
LIBERTY	$88.69	$48.29	$89.42	$55.47
LONG	$107.70	$52.98	$82.37	$47.66
LUMPKIN	$87.40	$39.61	$113.89	$59.59
MC INTOSH	$101.07	$59.63	$98.76	$66.71
MADISON	$81.81	$38.80	$95.85	$54.01
MERIWETHER	$71.40	$39.14	$83.74	$60.43
MITCHELL	$70.05	$38.20	$65.25	$42.76
MONTGOMERY	$109.19	$53.92	$122.49	$69.55
MURRAY	$98.40	$41.25	$132.30	$61.99
NEWTON	$104.09	$44.11	$99.01	$52.01
OGLETHORPE	$81.22	$38.83	$76.08	$43.11
PEACH	$91.95	$41.09	$99.02	$45.88
PIERCE	$87.73	$48.33	$84.37	$52.45
POLK	$91.41	$42.41	$103.59	$56.26
PUTNAM	$120.92	$44.21	$125.80	$67.31
RABUN	$112.42	$48.42	$129.52	$61.42
RICHMOND	$112.09	$58.78	$93.28	$60.28
SCHLEY	$87.46	$36.06	$107.83	$46.24
SEMINOLE	$84.44	$41.95	$123.31	$59.99
STEPHENS	$77.95	$36.87	$86.55	$44.83
SUMTER	$72.41	$30.53	$89.70	$43.91
TALIAFERRO	$73.97	$37.35	$112.09	$52.36
TAYLOR	$70.71	$35.83	$85.53	$43.67
TERRELL	$70.71	$31.98	$84.33	$39.36
TIFT	$62.38	$42.71	$78.65	$55.59
TOWNS	$75.61	$29.78	$65.92	$35.81
TROUP	$97.99	$46.43	$106.00	$56.85
TWIGGS	$76.75	$37.04	$54.47	$28.14
UPSON	$69.48	$31.83	$81.67	$42.23
WALTON	$114.01	$43.80	$119.27	$55.54
WARREN	$73.28	$40.88	$90.76	$52.50
WAYNE	$112.56	$53.21	$114.93	$61.72
WHEELER	$92.27	$47.35	$119.14	$57.80
WHITFIELD	$97.28	$42.58	$120.03	$60.90

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
FULTON	$115.69	$58.82	$130.66	$71.41
GLASCOCK	$77.57	$42.02	$77.75	$46.43
GORDON	$91.67	$40.85	$100.30	$56.29
GREENE	$67.29	$32.76	$68.13	$34.07
HABERSHAM	$79.30	$41.46	$102.46	$53.76
HANCOCK	$73.78	$34.51	$83.51	$36.72
HARRIS	$78.49	$37.45	$100.27	$49.39
HEARD	$109.99	$45.17	$116.46	$51.53
HOUSTON	$99.39	$48.27	$100.79	$53.62
JACKSON	$101.23	$43.85	$127.56	$57.48
JEFF DAVIS	$107.74	$50.49	$116.19	$54.34
JENKINS	$87.25	$38.51	$88.56	$45.29
JONES	$63.09	$35.14	$93.00	$54.38
LANIER	$111.51	$52.29	$125.17	$80.14
LEE	$70.60	$36.85	$102.47	$47.24
LINCOLN	$86.06	$41.38	$89.66	$58.63
LOWNDES	$86.44	$50.32	$86.62	$51.21
MC DUFFIE	$99.00	$46.61	$104.30	$59.53
MACON	$83.78	$36.72	$96.30	$46.66
MARION	$85.66	$42.36	$99.64	$53.32
MILLER	$64.17	$35.30	$60.53	$34.83
MONROE	$74.04	$34.78	$86.45	$51.75
MORGAN	$80.31	$37.07	$88.33	$42.87
MUSCOGEE	$100.69	$52.15	$107.86	$65.90
OCONEE	$79.76	$42.17	$80.00	$48.20
PAULDING	$134.22	$61.69	$173.97	$86.40
PICKENS	$108.86	$47.21	$100.78	$49.82
PIKE	$74.40	$34.15	$94.79	$47.57
PULASKI	$83.91	$36.83	$97.27	$47.95
QUITMAN	$83.91	$35.80	$132.50	$54.26
RANDOLPH	$58.28	$29.82	$65.21	$32.36
ROCKDALE	$112.37	$52.47	$141.57	$71.55
SCREVEN	$87.92	$44.65	$101.80	$49.08
SPALDING	$79.40	$39.05	$94.69	$51.91
STEWART	$87.48	$37.24	$113.00	$51.46
TALBOT	$69.74	$31.24	$53.41	$41.78
TATTNALL	$102.88	$49.73	$111.20	$60.29
TELFAIR	$84.50	$40.29	$81.15	$43.26
THOMAS	$72.49	$40.38	$72.86	$48.10
TOOMBS	$96.98	$50.07	$106.80	$62.65
TREUTLEN	$75.49	$42.76	$89.75	$51.40
TURNER	$69.58	$39.07	$80.07	$41.81
UNION	$86.27	$40.60	$99.32	$58.49
WALKER	$111.90	$42.74	$131.19	$57.70
WARE	$77.59	$48.88	$95.16	$60.98
WASHINGTON	$73.06	$32.83	$78.77	$35.65
WEBSTER	$97.17	$37.17	$95.58	$42.42
WHITE	$74.23	$36.98	$120.48	$58.21
WILCOX	$76.64	$35.57	$90.41	$41.95

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WILKES	$71.47	$35.64	$82.35	$42.77
WORTH	$72.85	$37.91	$66.07	$38.19
STATE: HAWAII				
HAWAII	$77.58	$52.33	$86.30	$67.71
KALAWAO	$80.39	$65.70	$84.68	$72.30
MAUI	$90.41	$76.60	$93.29	$68.57
STATE: IDAHO				
ADA	$100.57	$47.83	$114.30	$64.02
BANNOCK	$114.80	$49.46	$133.30	$69.25
BENEWAH	$94.95	$40.35	$104.11	$46.63
BLAINE	$127.71	$49.54	$192.67	$72.68
BONNER	$108.43	$45.91	$106.48	$56.01
BOUNDARY	$109.69	$41.73	$140.54	$61.37
CAMAS	$98.60	$39.87	$103.79	$61.17
CARIBOU	$96.07	$44.95	$78.11	$44.97
CLARK	$108.63	$43.89	$119.15	$63.72
CUSTER	$112.57	$41.81	$86.45	$34.84
FRANKLIN	$77.42	$42.43	$112.64	$64.13
GEM	$85.20	$36.54	$89.74	$52.30
IDAHO	$87.55	$40.69	$70.14	$33.87
JEROME	$97.70	$44.43	$94.63	$59.83
LATAH	$74.84	$39.47	$81.28	$55.78
LEWIS	$94.10	$45.26	$52.33	$45.26
MADISON	$100.66	$42.26	$100.32	$48.33
NEZ PERCE	$108.11	$53.08	$126.75	$67.03
OWYHEE	$115.76	$46.70	$137.06	$48.33
POWER	$114.80	$45.33	$65.67	$45.60
TETON	$96.99	$41.85	$170.27	$56.55
VALLEY	$113.16	$45.33	$123.63	$57.29
STATE: ILLINOIS				
ADAMS	$126.25	$42.26	$134.56	$51.99
BOND	$113.62	$33.85	$162.40	$53.78
BROWN	$108.62	$30.81	$156.80	$53.12
CALHOUN	$159.01	$42.00	$149.57	$43.06
CASS	$139.01	$43.28	$186.76	$61.75
CHRISTIAN	$167.61	$57.12	$209.03	$78.93
CLAY	$89.22	$30.26	$77.77	$33.76
COLES	$93.84	$38.60	$112.04	$49.18
CRAWFORD	$110.78	$38.55	$139.98	$59.71
DE KALB	$121.72	$42.85	$150.63	$59.06
DOUGLAS	$124.61	$43.21	$126.65	$46.21
EDGAR	$83.58	$33.44	$96.81	$53.35
EFFINGHAM	$103.17	$34.72	$114.16	$42.79
FORD	$121.23	$44.18	$144.65	$61.95
FULTON	$151.65	$48.16	$191.37	$74.94
GREENE	$114.89	$36.38	$115.29	$41.97

STATE: GEORGIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WILKINSON	$86.28	$39.94	$105.02	$54.31
STATE: HAWAII				
HONOLULU	$123.89	$75.89	$132.06	$87.83
KAUAI	$111.10	$48.82	$135.40	$67.78
STATE: IDAHO				
ADAMS	$107.27	$39.44	$116.48	$57.48
BEAR LAKE	$94.54	$40.75	$200.26	$103.93
BINGHAM	$97.12	$38.70	$116.79	$55.41
BOISE	$92.50	$37.64	$51.77	$48.82
BONNEVILLE	$103.59	$46.57	$93.07	$54.08
BUTTE	$89.87	$34.60	$76.78	$42.96
CANYON	$115.93	$45.40	$112.53	$55.36
CASSIA	$91.47	$39.21	$115.05	$55.18
CLEARWATER	$98.60	$45.68	$101.42	$48.48
ELMORE	$114.77	$53.03	$71.21	$45.38
FREMONT	$101.27	$42.74	$156.11	$72.08
GOODING	$94.80	$43.97	$71.38	$40.47
JEFFERSON	$109.65	$44.00	$123.42	$54.05
KOOTENAI	$90.77	$49.87	$97.81	$61.13
LEMHI	$101.48	$40.22	$105.51	$57.98
LINCOLN	$112.55	$44.83	$106.38	$59.55
MINIDOKA	$103.71	$44.40	$115.04	$62.23
ONEIDA	$112.75	$41.93	$103.76	$60.74
PAYETTE	$85.52	$37.57	$88.53	$47.50
SHOSHONE	$109.27	$42.85	$140.84	$61.51
TWIN FALLS	$101.82	$46.49	$99.84	$53.74
WASHINGTON	$83.99	$34.33	$77.59	$38.81
STATE: ILLINOIS				
ALEXANDER	$119.37	$40.89	$106.71	$44.35
BOONE	$106.81	$44.50	$161.05	$69.02
BUREAU	$129.92	$40.45	$143.74	$50.78
CARROLL	$96.31	$36.61	$118.22	$52.43
CHAMPAIGN	$142.15	$51.48	$159.20	$67.83
CLARK	$74.92	$35.25	$92.93	$51.42
CLINTON	$134.12	$43.59	$126.16	$49.82
COOK	$216.20	$67.27	$240.44	$81.20
CUMBERLAND	$91.66	$30.97	$105.81	$53.63
DE WITT	$136.05	$44.74	$166.40	$63.84
DU PAGE	$165.17	$61.52	$224.66	$89.75
EDWARDS	$94.68	$31.51	$115.70	$39.30
FAYETTE	$96.69	$35.55	$94.14	$42.27
FRANKLIN	$117.78	$44.41	$96.04	$45.07
GALLATIN	$136.64	$43.26	$118.41	$51.39
GRUNDY	$135.29	$52.23	$178.02	$70.51

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: ILLINOIS COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
HAMILTON	$135.99	$37.20	$121.29	$44.24
HARDIN	$145.93	$44.55	$130.59	$47.58
HENRY	$109.55	$37.73	$145.67	$54.09
JACKSON	$107.16	$39.50	$98.60	$49.00
JEFFERSON	$139.20	$43.64	$128.56	$53.54
JO DAVIESS	$126.20	$41.89	$102.89	$43.48
KANE	$144.55	$53.98	$202.86	$82.49
KENDALL	$125.46	$46.30	$166.30	$73.94
LAKE	$160.75	$56.15	$166.28	$72.19
LAWRENCE	$108.88	$32.53	$125.61	$47.64
LIVINGSTON	$133.88	$44.35	$163.01	$59.77
MC DONOUGH	$123.15	$37.15	$122.43	$48.67
MC LEAN	$124.55	$45.30	$150.75	$61.25
MACOUPIN	$147.58	$42.46	$175.73	$58.58
MARION	$129.28	$43.47	$136.51	$55.33
MASON	$160.26	$48.12	$161.22	$61.62
MENARD	$157.30	$47.17	$138.67	$51.70
MONROE	$112.42	$36.39	$131.24	$53.57
MORGAN	$121.62	$39.21	$109.72	$39.72
OGLE	$99.12	$38.24	$126.16	$59.66
PERRY	$126.42	$41.25	$134.50	$47.78
PIKE	$125.89	$41.64	$109.92	$50.26
PULASKI	$100.67	$36.54	$77.96	$34.39
RANDOLPH	$114.44	$36.49	$139.97	$54.49
ROCK ISLAND	$140.73	$44.29	$181.07	$70.62
SALINE	$119.02	$39.64	$107.56	$44.09
SCHUYLER	$127.43	$30.37	$123.43	$40.85
SHELBY	$117.86	$35.84	$90.43	$37.97
STEPHENSON	$103.60	$39.84	$135.47	$58.52
UNION	$99.40	$36.60	$76.28	$34.58
WABASH	$114.29	$32.75	$121.31	$36.19
WASHINGTON	$112.46	$38.83	$142.59	$62.88
WHITE	$100.02	$38.87	$122.94	$47.63
WILL	$148.91	$56.86	$188.54	$82.45
WINNEBAGO	$106.87	$46.87	$142.83	$67.81
STATE: INDIANA				
ADAMS	$110.40	$36.78	$142.08	$55.24
BARTHOLOMEW	$125.04	$42.10	$140.49	$58.91
BLACKFORD	$122.71	$36.38	$148.90	$47.49
BROWN	$107.32	$37.49	$163.83	$61.39
CASS	$117.43	$41.44	$137.03	$48.41
CLAY	$94.12	$36.29	$98.82	$47.46
CRAWFORD	$96.76	$27.54	$63.72	$25.25
DEARBORN	$141.65	$39.26	$126.58	$42.13
DE KALB	$99.50	$37.13	$125.10	$50.35
DUBOIS	$128.55	$37.94	$148.80	$53.11
FAYETTE	$129.45	$42.41	$151.86	$49.69
FOUNTAIN	$110.25	$35.82	$133.28	$51.04

STATE: ILLINOIS COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
HANCOCK	$125.71	$39.41	$142.46	$46.61
HENDERSON	$132.27	$40.59	$183.86	$61.32
IROQUOIS	$133.31	$50.05	$166.51	$70.03
JASPER	$107.25	$34.13	$118.99	$36.91
JERSEY	$142.48	$43.45	$190.25	$62.21
JOHNSON	$113.53	$36.95	$100.46	$45.22
KANKAKEE	$166.67	$55.93	$187.24	$73.34
KNOX	$144.39	$46.18	$151.26	$57.47
LA SALLE	$142.57	$44.45	$159.69	$63.44
LEE	$122.31	$40.15	$109.54	$40.61
LOGAN	$121.89	$41.91	$127.39	$43.36
MC HENRY	$142.17	$48.83	$196.10	$76.11
MACON	$118.21	$41.86	$140.58	$60.86
MADISON	$172.84	$50.63	$234.04	$76.08
MARSHALL	$140.34	$46.78	$144.01	$48.88
MASSAC	$120.36	$38.03	$116.24	$44.28
MERCER	$134.34	$42.90	$151.45	$48.85
MONTGOMERY	$127.55	$38.16	$148.95	$53.85
MOULTRIE	$96.79	$32.14	$93.04	$45.70
PEORIA	$144.65	$50.82	$180.38	$76.32
PIATT	$117.71	$41.01	$90.60	$36.88
POPE	$127.05	$37.81	$99.41	$35.17
PUTNAM	$159.50	$51.14	$141.47	$70.57
RICHLAND	$105.28	$33.62	$114.66	$43.13
ST CLAIR	$132.86	$45.62	$166.33	$62.94
SANGAMON	$174.79	$53.57	$208.16	$73.91
SCOTT	$113.22	$40.15	$173.98	$56.30
STARK	$105.75	$40.65	$117.40	$48.23
TAZEWELL	$131.07	$48.79	$169.89	$70.35
VERMILION	$120.36	$42.41	$121.27	$49.28
WARREN	$119.32	$40.04	$129.69	$52.89
WAYNE	$98.73	$34.51	$108.51	$43.70
WHITESIDE	$94.43	$34.77	$115.42	$53.90
WILLIAMSON	$125.39	$50.09	$117.10	$48.22
WOODFORD	$117.77	$43.09	$149.60	$57.83
STATE: INDIANA				
ALLEN	$112.84	$45.96	$132.63	$58.20
BENTON	$143.71	$43.85	$215.19	$68.02
BOONE	$134.21	$42.56	$185.44	$78.60
CARROLL	$125.46	$43.16	$121.24	$50.63
CLARK	$137.18	$47.92	$155.94	$60.55
CLINTON	$99.37	$33.85	$120.64	$47.71
DAVIESS	$118.60	$35.69	$114.13	$42.78
DECATUR	$149.27	$40.76	$172.12	$61.93
DELAWARE	$132.66	$44.56	$146.97	$55.19
ELKHART	$91.64	$38.98	$127.52	$58.03
FLOYD	$119.91	$38.13	$141.00	$54.78
FRANKLIN	$110.02	$34.69	$109.29	$41.83

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: INDIANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
FULTON	$111.38	$42.66	$114.76	$50.94
GRANT	$102.79	$42.80	$110.84	$57.75
HAMILTON	$153.42	$45.92	$174.43	$64.67
HARRISON	$104.22	$27.17	$120.61	$38.95
HENRY	$132.58	$45.80	$119.07	$49.02
HUNTINGTON	$103.27	$33.24	$114.51	$42.36
JASPER	$145.79	$44.76	$167.04	$62.75
JEFFERSON	$107.55	$37.17	$96.69	$48.23
JOHNSON	$132.39	$41.74	$178.18	$64.18
KOSCIUSKO	$101.85	$38.87	$145.34	$64.71
LAKE	$174.97	$51.71	$218.18	$72.10
LAWRENCE	$156.86	$44.53	$167.14	$60.60
MARION	$159.91	$52.50	$187.17	$71.36
MARTIN	$126.18	$36.94	$105.67	$40.56
MONROE	$108.95	$42.31	$137.63	$61.48
MORGAN	$141.18	$47.47	$154.44	$62.79
NOBLE	$105.06	$34.73	$116.10	$46.59
ORANGE	$124.04	$37.07	$116.89	$44.84
PARKE	$95.40	$38.57	$115.74	$53.12
PIKE	$141.26	$44.55	$139.07	$59.13
POSEY	$129.26	$41.74	$126.20	$47.27
PUTNAM	$128.00	$38.20	$115.19	$42.37
RIPLEY	$110.13	$33.72	$115.00	$44.35
ST JOSEPH	$105.75	$40.81	$142.69	$60.48
SHELBY	$134.98	$44.72	$161.06	$65.23
STARKE	$117.27	$42.00	$127.49	$47.21
SULLIVAN	$145.45	$40.27	$101.85	$42.45
TIPPECANOE	$129.26	$45.08	$150.25	$63.67
UNION	$101.04	$39.43	$110.91	$41.76
VERMILLION	$102.82	$42.23	$129.36	$66.94
WABASH	$92.42	$40.62	$121.01	$56.94
WARRICK	$134.37	$49.02	$167.99	$71.09
WAYNE	$94.74	$36.34	$104.35	$46.12
WHITE	$132.14	$42.60	$169.92	$66.30
STATE: IOWA				
ADAIR	$112.73	$35.60	$141.11	$54.28
ALLAMAKEE	$92.08	$38.15	$98.15	$47.46
AUDUBON	$92.74	$29.68	$123.20	$56.49
BLACK HAWK	$115.39	$43.12	$137.30	$60.90
BREMER	$92.32	$33.88	$115.17	$51.60
BUENA VISTA	$85.05	$35.48	$103.05	$41.69
CALHOUN	$103.68	$38.32	$106.38	$42.22
CASS	$124.19	$35.46	$154.31	$41.93
CERRO GORDO	$108.75	$40.02	$124.67	$59.49
CHICKASAW	$116.00	$48.16	$138.33	$75.53
CLAY	$85.46	$37.98	$115.93	$50.12
CLINTON	$135.56	$39.61	$172.56	$63.77
DALLAS	$137.37	$44.93	$138.22	$50.60

STATE: INDIANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
GIBSON	$129.84	$45.67	$157.42	$51.53
GREENE	$110.05	$38.43	$120.02	$46.66
HANCOCK	$117.44	$44.14	$137.79	$58.14
HENDRICKS	$137.83	$43.59	$173.91	$69.01
HOWARD	$142.92	$50.23	$163.97	$68.01
JACKSON	$120.43	$33.13	$124.60	$48.06
JAY	$127.50	$37.98	$128.20	$45.95
JENNINGS	$121.03	$36.83	$94.42	$26.50
KNOX	$133.90	$40.98	$151.59	$54.29
LAGRANGE	$112.66	$46.40	$103.86	$50.11
LA PORTE	$117.92	$47.85	$151.29	$67.38
MADISON	$151.92	$46.19	$170.75	$60.92
MARSHALL	$92.25	$39.88	$95.55	$47.80
MIAMI	$126.38	$52.10	$121.12	$60.65
MONTGOMERY	$98.03	$40.13	$125.00	$59.23
NEWTON	$138.77	$42.75	$157.29	$56.68
OHIO	$115.71	$35.38	$98.81	$41.30
OWEN	$98.49	$32.74	$124.94	$53.34
PERRY	$110.86	$31.30	$102.99	$38.95
PORTER	$146.91	$59.42	$204.33	$86.56
PULASKI	$115.27	$37.52	$126.54	$48.00
RANDOLPH	$121.32	$38.14	$138.21	$49.49
RUSH	$126.97	$35.25	$151.09	$52.47
SCOTT	$132.78	$40.87	$118.69	$50.06
SPENCER	$119.86	$38.75	$136.90	$52.68
STEUBEN	$94.97	$38.57	$124.33	$55.28
SWITZERLAND	$117.26	$35.97	$111.14	$42.55
TIPTON	$186.91	$40.74	$187.93	$56.01
VANDERBURGH	$133.23	$47.74	$166.03	$68.02
VIGO	$100.02	$45.41	$135.13	$68.69
WARREN	$129.26	$37.02	$128.38	$44.33
WASHINGTON	$114.39	$30.02	$132.56	$48.72
WELLS	$120.23	$38.93	$116.62	$47.44
WHITLEY	$105.26	$35.88	$178.89	$61.73
STATE: IOWA				
ADAMS	$109.01	$39.73	$84.29	$45.69
APPANOOSE	$128.22	$32.99	$159.63	$46.31
BENTON	$99.68	$36.46	$118.22	$39.33
BOONE	$126.32	$42.56	$133.88	$48.04
BUCHANAN	$105.96	$36.94	$127.56	$59.46
BUTLER	$101.48	$37.60	$141.56	$53.45
CARROLL	$112.35	$35.71	$113.61	$44.15
CEDAR	$96.67	$33.55	$140.10	$44.93
CHEROKEE	$108.58	$35.46	$114.90	$58.05
CLARKE	$134.13	$36.22	$86.87	$33.94
CLAYTON	$101.49	$34.13	$105.20	$49.74
CRAWFORD	$116.77	$36.07	$128.45	$51.43
DAVIS	$127.24	$35.11	$130.40	$43.58

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: IOWA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DECATUR	$109.72	$34.92	$94.37	$42.45
DES MOINES	$104.67	$35.07	$117.71	$43.28
DUBUQUE	$135.88	$43.09	$171.64	$64.31
FAYETTE	$110.57	$39.28	$125.81	$54.83
FRANKLIN	$103.63	$37.18	$118.16	$49.31
GREENE	$107.81	$35.65	$117.91	$52.20
GUTHRIE	$114.53	$35.91	$104.98	$41.88
HANCOCK	$89.93	$34.16	$106.86	$62.63
HARRISON	$143.45	$41.93	$154.41	$48.00
HOWARD	$87.21	$38.22	$86.34	$63.39
IDA	$102.20	$32.79	$124.96	$40.38
JACKSON	$142.41	$40.32	$156.77	$56.67
JEFFERSON	$99.12	$31.88	$92.82	$39.04
JONES	$105.97	$34.32	$132.47	$45.66
KOSSUTH	$99.48	$39.94	$94.77	$39.68
LINN	$116.66	$42.41	$173.46	$67.54
LUCAS	$160.42	$44.31	$184.01	$61.57
MADISON	$129.77	$40.65	$102.11	$40.45
MARION	$117.34	$38.09	$119.99	$44.20
MILLS	$140.87	$48.01	$90.58	$35.11
MONONA	$120.81	$37.97	$116.62	$53.33
MONTGOMERY	$131.11	$54.44	$155.71	$70.06
O BRIEN	$87.21	$32.82	$105.06	$41.31
PAGE	$106.82	$39.63	$153.40	$61.13
PLYMOUTH	$97.95	$34.26	$93.49	$43.35
POLK	$161.40	$54.72	$203.07	$75.87
POWESHIEK	$110.13	$39.12	$149.82	$55.64
SAC	$98.01	$35.90	$88.40	$36.71
SHELBY	$134.01	$37.97	$209.74	$71.56
STORY	$105.27	$41.93	$152.61	$64.85
TAYLOR	$106.69	$34.98	$117.59	$39.35
VAN BUREN	$108.55	$29.26	$91.05	$31.42
WARREN	$122.38	$42.60	$133.90	$55.22
WAYNE	$130.02	$34.21	$100.18	$36.55
WINNEBAGO	$90.38	$37.07	$106.70	$47.43
WOODBURY	$146.89	$42.18	$199.27	$57.23
WRIGHT	$91.29	$35.25	$134.87	$65.96
STATE: KANSAS				
ALLEN	$128.50	$43.96	$141.92	$57.89
ATCHISON	$123.58	$45.68	$125.54	$54.57
BARTON	$132.19	$51.74	$146.34	$62.17
BROWN	$139.31	$45.89	$157.70	$57.75
CHASE	$117.75	$38.73	$82.73	$48.51
CHEROKEE	$132.12	$43.77	$157.44	$63.50
CLARK	$137.83	$57.12	$178.28	$86.23
CLOUD	$106.09	$42.60	$142.04	$65.02
COMANCHE	$120.47	$42.88	$127.44	$38.85
CRAWFORD	$110.39	$46.01	$112.19	$56.28

STATE: IOWA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DELAWARE	$107.31	$35.69	$125.35	$43.31
DICKINSON	$95.80	$41.96	$94.85	$51.69
EMMET	$94.06	$43.40	$96.07	$49.79
FLOYD	$86.91	$39.45	$120.02	$56.60
FREMONT	$143.73	$39.78	$163.20	$47.85
GRUNDY	$103.56	$39.44	$94.14	$47.34
HAMILTON	$116.04	$44.08	$131.69	$51.63
HARDIN	$108.29	$35.66	$104.91	$44.46
HENRY	$87.67	$31.84	$96.31	$37.16
HUMBOLDT	$110.03	$36.65	$135.43	$55.33
IOWA	$94.36	$31.23	$123.07	$38.50
JASPER	$123.86	$40.43	$155.44	$54.32
JOHNSON	$92.42	$32.91	$177.90	$59.41
KEOKUK	$103.05	$34.93	$124.22	$46.78
LEE	$125.25	$36.62	$163.50	$53.13
LOUISA	$93.57	$33.14	$89.46	$35.81
LYON	$98.72	$32.95	$78.35	$39.73
MAHASKA	$95.84	$30.96	$66.20	$31.53
MARSHALL	$91.42	$40.57	$118.67	$54.21
MITCHELL	$73.46	$35.84	$109.93	$63.24
MONROE	$131.61	$38.91	$163.95	$55.52
MUSCATINE	$100.80	$33.56	$124.66	$52.54
OSCEOLA	$77.68	$28.61	$72.62	$25.45
PALO ALTO	$116.96	$41.50	$100.05	$44.81
POCAHONTAS	$94.75	$37.16	$123.68	$50.63
POTTAWATTAMIE	$168.13	$53.12	$190.55	$74.37
RINGGOLD	$116.40	$33.97	$83.35	$25.94
SCOTT	$128.79	$43.27	$155.70	$58.34
SIOUX	$95.18	$33.63	$96.49	$43.44
TAMA	$105.80	$40.93	$126.16	$58.39
UNION	$114.32	$38.25	$129.33	$56.45
WAPELLO	$125.20	$40.74	$129.66	$54.42
WASHINGTON	$87.50	$28.04	$104.62	$37.99
WEBSTER	$103.41	$38.66	$134.74	$51.95
WINNESHIEK	$100.26	$38.80	$122.41	$44.09
WORTH	$98.65	$37.51	$106.66	$46.62
STATE: KANSAS				
ANDERSON	$111.83	$41.75	$131.29	$53.04
BARBER	$173.22	$56.34	$198.63	$69.51
BOURBON	$110.77	$45.56	$144.81	$66.98
BUTLER	$159.16	$61.09	$226.89	$97.46
CHAUTAUQUA	$159.42	$50.10	$198.80	$64.17
CHEYENNE	$109.15	$39.37	$69.90	$31.67
CLAY	$98.38	$36.13	$124.29	$45.24
COFFEY	$142.46	$41.66	$122.76	$47.16
COWLEY	$118.93	$56.66	$107.67	$56.68
DECATUR	$113.42	$50.58	$140.00	$62.60

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: KANSAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DICKINSON	$118.40	$45.70	$102.68	$46.43
DOUGLAS	$110.59	$49.18	$165.26	$72.04
ELK	$112.88	$46.23	$222.02	$60.86
ELLSWORTH	$116.32	$41.21	$110.06	$46.35
FORD	$124.25	$52.30	$122.66	$55.52
GEARY	$123.58	$48.58	$92.54	$46.94
GRAHAM	$157.39	$62.65	$146.92	$61.52
GRAY	$113.99	$51.53	$188.08	$80.70
GREENWOOD	$151.05	$55.67	$178.58	$66.21
HARPER	$184.35	$69.11	$290.78	$126.01
HASKELL	$175.78	$65.63	$141.67	$70.59
JACKSON	$120.73	$46.09	$151.14	$67.32
JEWELL	$84.38	$33.76	$84.99	$55.00
KEARNY	$204.47	$62.40	$179.67	$98.89
KIOWA	$160.70	$50.64	$186.98	$65.15
LANE	$165.43	$56.63	$203.34	$51.70
LINCOLN	$94.53	$37.98	$129.68	$76.31
LOGAN	$148.37	$54.48	$257.15	$91.39
MC PHERSON	$105.59	$43.02	$128.22	$75.24
MARSHALL	$114.49	$40.67	$83.10	$40.70
MIAMI	$123.94	$51.81	$179.48	$87.25
MONTGOMERY	$117.93	$48.18	$142.96	$62.79
MORTON	$177.40	$55.93	$296.02	$79.40
NEOSHO	$125.55	$45.98	$161.16	$63.41
NORTON	$125.25	$46.68	$98.66	$41.68
OSBORNE	$121.60	$52.09	$131.31	$62.84
PAWNEE	$144.66	$50.56	$204.22	$66.13
POTTAWATOMIE	$126.97	$49.48	$131.50	$55.76
RAWLINS	$155.24	$53.29	$144.29	$67.29
REPUBLIC	$74.96	$32.29	$72.07	$40.60
RILEY	$127.34	$50.17	$168.30	$69.51
RUSH	$143.95	$60.27	$151.63	$72.76
SALINE	$94.18	$42.89	$128.84	$62.72
SEDGWICK	$164.10	$62.18	$201.86	$82.99
SHAWNEE	$143.40	$59.43	$130.92	$64.59
SHERMAN	$169.23	$56.44	$205.12	$74.75
STAFFORD	$166.58	$60.18	$273.67	$108.77
STEVENS	$111.09	$42.40	$157.83	$109.59
THOMAS	$163.66	$56.79	$175.69	$69.18
WABAUNSEE	$108.33	$43.02	$124.86	$51.82
WASHINGTON	$127.40	$42.05	$131.71	$49.61
WILSON	$134.64	$45.65	$128.41	$64.56
WYANDOTTE	$175.60	$60.57	$211.65	$84.64
STATE: KENTUCKY				
ADAIR	$101.85	$33.81	$104.75	$37.64
ANDERSON	$96.68	$29.42	$104.97	$44.79
BARREN	$80.49	$26.56	$96.18	$39.60
BELL	$106.38	$45.29	$83.72	$37.01

STATE: KANSAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DONIPHAN	$122.47	$39.11	$126.62	$56.13
EDWARDS	$163.96	$55.23	$124.54	$55.61
ELLIS	$139.87	$58.16	$147.14	$82.09
FINNEY	$154.07	$53.62	$210.31	$68.52
FRANKLIN	$113.22	$43.36	$124.61	$56.83
GOVE	$117.79	$54.86	$92.91	$60.83
GRANT	$194.91	$60.45	$279.86	$141.70
GREELEY	$161.92	$61.55	$190.09	$68.24
HAMILTON	$159.14	$54.23	$221.39	$65.77
HARVEY	$97.01	$49.53	$141.34	$79.35
HODGEMAN	$134.80	$45.78	$181.36	$81.02
JEFFERSON	$110.90	$48.35	$102.66	$56.28
JOHNSON	$166.33	$68.67	$213.46	$98.71
KINGMAN	$134.11	$50.15	$126.03	$48.71
LABETTE	$149.85	$51.43	$140.49	$62.11
LEAVENWORTH	$134.49	$54.15	$124.80	$63.63
LINN	$110.29	$46.78	$147.84	$61.16
LYON	$160.97	$45.95	$147.01	$55.11
MARION	$100.31	$44.31	$118.08	$55.28
MEADE	$133.80	$49.39	$123.67	$53.66
MITCHELL	$132.50	$52.37	$162.73	$60.89
MORRIS	$125.50	$46.22	$128.22	$70.43
NEMAHA	$114.70	$45.89	$98.44	$46.81
NESS	$155.41	$54.87	$143.75	$62.55
OSAGE	$102.56	$40.12	$72.70	$43.18
OTTAWA	$104.16	$40.34	$123.94	$59.57
PHILLIPS	$132.96	$56.75	$169.96	$79.96
PRATT	$180.19	$57.86	$165.35	$66.90
RENO	$109.85	$50.29	$121.87	$61.94
RICE	$105.36	$43.86	$107.31	$54.27
ROOKS	$114.62	$50.70	$175.29	$92.09
RUSSELL	$154.17	$59.44	$171.96	$70.93
SCOTT	$125.33	$47.00	$93.28	$38.26
SEWARD	$140.58	$52.58	$141.45	$62.29
SHERIDAN	$117.26	$76.69	$147.62	$143.14
SMITH	$88.59	$33.75	$110.58	$67.07
STANTON	$190.83	$66.70	$199.67	$133.34
SUMNER	$148.90	$50.28	$182.43	$69.68
TREGO	$125.62	$61.52	$149.39	$74.96
WALLACE	$145.84	$57.42	$163.60	$71.20
WICHITA	$174.59	$64.67	$213.82	$80.29
WOODSON	$111.69	$39.96	$133.98	$61.15
STATE: KENTUCKY				
ALLEN	$98.52	$27.95	$108.10	$37.34
BALLARD	$112.55	$37.16	$120.35	$48.47
BATH	$72.99	$27.54	$68.14	$36.02
BOONE	$140.50	$42.98	$133.70	$50.53

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: KENTUCKY COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
BOURBON	$102.48	$33.98	$121.34	$51.14
BOYLE	$87.74	$33.27	$97.46	$40.03
BREATHITT	$70.01	$31.68	$49.80	$22.94
BULLITT	$117.59	$38.18	$140.76	$60.74
CALDWELL	$106.07	$35.49	$79.77	$38.69
CAMPBELL	$108.26	$36.79	$127.44	$43.98
CARROLL	$114.18	$32.41	$89.83	$36.85
CASEY	$83.64	$30.05	$64.82	$32.32
CLARK	$85.66	$31.67	$93.45	$40.38
CLINTON	$100.88	$35.63	$108.58	$46.44
CUMBERLAND	$89.70	$36.06	$104.33	$45.27
EDMONSON	$98.32	$36.26	$95.71	$41.75
ESTILL	$68.61	$28.01	$45.16	$21.89
FLEMING	$104.75	$33.92	$107.37	$39.07
FRANKLIN	$101.67	$31.66	$77.11	$34.71
GALLATIN	$128.20	$34.46	$79.72	$30.82
GRANT	$120.97	$37.37	$114.88	$44.71
GRAYSON	$101.91	$29.97	$99.57	$37.57
GREENUP	$116.61	$35.24	$106.11	$48.48
HARDIN	$91.40	$35.50	$68.71	$38.19
HARRISON	$97.52	$26.92	$128.18	$38.91
HENDERSON	$109.01	$40.45	$108.98	$48.74
HICKMAN	$108.58	$31.39	$108.33	$33.62
JACKSON	$85.64	$36.10	$55.98	$26.86
JESSAMINE	$74.97	$36.15	$73.72	$39.83
KENTON	$132.06	$41.75	$161.59	$54.85
KNOX	$93.13	$34.13	$82.73	$32.89
LAUREL	$79.11	$30.66	$75.34	$32.33
LEE	$74.99	$31.78	$56.72	$30.06
LETCHER	$102.79	$33.18	$74.89	$44.41
LINCOLN	$92.16	$31.04	$64.64	$34.78
LOGAN	$105.85	$37.51	$94.01	$43.42
MC CRACKEN	$123.14	$40.33	$137.32	$54.46
MC LEAN	$98.36	$37.57	$92.28	$42.90
MAGOFFIN	$92.69	$35.74	$55.57	$29.34
MARSHALL	$90.93	$33.32	$118.91	$49.74
MASON	$115.23	$30.29	$124.17	$44.96
MENIFEE	$68.05	$30.19	$35.13	$17.92
METCALFE	$88.37	$34.00	$81.89	$34.11
MONTGOMERY	$94.39	$30.66	$83.70	$36.45
MUHLENBERG	$104.57	$32.56	$88.47	$39.54
NICHOLAS	$83.74	$29.69	$123.27	$47.35
OLDHAM	$88.66	$31.83	$96.12	$43.17
OWSLEY	$60.03	$24.67	$57.08	$25.30
PERRY	$117.90	$49.91	$76.02	$34.29
POWELL	$86.51	$33.45	$64.65	$30.91
ROBERTSON	$92.25	$27.26	$140.34	$26.47
ROWAN	$69.60	$33.10	$64.44	$41.60
SCOTT	$86.14	$29.66	$68.09	$30.50

STATE: KENTUCKY COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
BOYD	$98.13	$33.96	$94.26	$41.40
BRACKEN	$105.00	$28.94	$105.00	$38.48
BRECKINRIDGE	$87.26	$26.05	$102.17	$36.61
BUTLER	$101.58	$39.72	$98.31	$42.94
CALLOWAY	$115.04	$39.59	$133.34	$56.57
CARLISLE	$122.83	$41.42	$115.98	$47.16
CARTER	$72.39	$30.54	$55.00	$24.81
CHRISTIAN	$97.35	$36.84	$88.39	$61.32
CLAY	$95.68	$32.22	$50.96	$24.31
CRITTENDEN	$127.29	$31.55	$130.24	$33.77
DAVIESS	$114.07	$42.26	$126.43	$55.21
ELLIOTT	$71.20	$31.13	$58.10	$25.42
FAYETTE	$82.45	$39.52	$90.09	$48.61
FLOYD	$119.47	$52.07	$77.04	$50.44
FULTON	$87.57	$29.95	$100.55	$36.10
GARRARD	$93.93	$31.80	$56.08	$27.40
GRAVES	$113.62	$38.95	$113.99	$50.63
GREEN	$83.07	$25.44	$94.17	$41.19
HANCOCK	$106.93	$34.33	$92.67	$39.63
HARLAN	$92.12	$48.24	$77.34	$42.14
HART	$89.47	$28.48	$86.86	$33.66
HENRY	$91.98	$30.37	$117.89	$38.02
HOPKINS	$124.60	$51.49	$135.43	$62.89
JEFFERSON	$125.03	$45.51	$144.30	$61.74
JOHNSON	$92.10	$39.40	$61.64	$38.22
KNOTT	$80.36	$42.92	$60.49	$40.84
LARUE	$88.78	$32.71	$84.59	$43.99
LAWRENCE	$111.72	$36.07	$76.51	$34.42
LESLIE	$86.25	$36.19	$63.48	$28.28
LEWIS	$92.75	$30.31	$79.53	$34.05
LIVINGSTON	$109.48	$29.99	$132.04	$49.13
LYON	$108.92	$37.24	$95.84	$39.40
MC CREARY	$85.21	$40.74	$77.20	$39.41
MADISON	$92.21	$32.26	$66.80	$30.23
MARION	$89.82	$29.64	$96.40	$34.10
MARTIN	$101.19	$41.47	$57.26	$38.74
MEADE	$110.90	$37.22	$135.50	$46.11
MERCER	$100.19	$33.21	$93.00	$43.63
MONROE	$88.86	$28.54	$111.72	$39.62
MORGAN	$78.64	$26.89	$65.29	$31.68
NELSON	$84.35	$32.76	$81.87	$35.43
OHIO	$110.67	$34.02	$122.84	$46.87
OWEN	$101.86	$27.86	$111.85	$45.81
PENDLETON	$98.45	$28.49	$80.76	$33.30
PIKE	$98.88	$46.47	$66.04	$38.18
PULASKI	$78.22	$30.62	$70.66	$33.59
ROCKCASTLE	$106.75	$32.34	$61.29	$26.23
RUSSELL	$87.25	$29.68	$80.82	$35.47
SHELBY	$89.53	$30.57	$79.65	$38.11

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: KENTUCKY COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SIMPSON	$105.25	$35.99	$94.56	$37.35
TAYLOR	$95.70	$29.58	$103.63	$40.66
TRIGG	$96.74	$34.96	$107.94	$46.16
UNION	$113.90	$37.85	$139.00	$52.60
WASHINGTON	$85.68	$27.82	$84.13	$29.56
WEBSTER	$123.09	$44.57	$113.84	$62.85
WOLFE	$70.33	$26.69	$63.54	$22.95
STATE: LOUISIANA				
ACADIA	$87.74	$35.28	$64.92	$28.87
ASCENSION	$111.99	$45.75	$99.13	$46.33
AVOYELLES	$74.19	$31.50	$62.62	$28.48
BIENVILLE	$71.91	$29.31	$72.37	$33.82
CADDO	$90.11	$37.92	$86.69	$37.72
CALDWELL	$133.75	$38.54	$127.66	$43.02
CATAHOULA	$89.75	$30.98	$75.34	$29.31
CONCORDIA	$75.89	$28.01	$89.44	$35.80
EAST BATON ROUGE	$112.04	$48.85	$98.42	$44.78
EAST FELICIANA	$90.87	$31.72	$81.35	$29.15
FRANKLIN	$62.79	$28.74	$87.43	$35.64
IBERIA	$90.01	$34.70	$74.58	$32.30
JACKSON	$88.25	$34.12	$78.02	$39.30
JEFFERSON DAVIS	$84.98	$35.62	$70.26	$31.39
LAFOURCHE	$103.01	$37.69	$89.55	$36.13
LINCOLN	$78.14	$32.91	$83.70	$39.97
MADISON	$49.36	$26.78	$54.28	$27.96
NATCHITOCHES	$68.73	$31.78	$74.95	$38.48
OUACHITA	$85.50	$37.23	$87.16	$42.66
POINTE COUPEE	$86.42	$37.38	$72.37	$35.98
RED RIVER	$60.02	$33.56	$84.59	$41.37
SABINE	$88.85	$34.76	$74.16	$32.48
ST CHARLES	$131.91	$44.81	$127.14	$59.09
ST JAMES	$83.80	$31.45	$78.91	$30.77
ST LANDRY	$85.12	$35.05	$79.85	$33.46
ST MARY	$116.16	$38.19	$113.73	$46.02
TANGIPAHOA	$97.95	$39.56	$88.35	$38.12
TERREBONNE	$80.38	$35.36	$86.95	$43.65
VERMILION	$114.56	$38.90	$90.45	$38.42
WASHINGTON	$126.63	$41.86	$117.18	$43.92
WEST BATON ROUGE	$96.64	$41.58	$77.66	$32.56
WEST FELICIANA	$84.05	$33.02	$88.28	$35.03
STATE: MAINE				
ANDROSCOGGIN	$111.05	$48.97	$118.78	$68.51
CUMBERLAND	$134.74	$51.46	$137.38	$66.55
HANCOCK	$129.88	$44.93	$140.99	$61.19
KNOX	$103.08	$42.31	$93.26	$45.22
OXFORD	$122.22	$47.61	$120.14	$56.44
PISCATAQUIS	$117.25	$38.91	$104.88	$45.45

STATE: KENTUCKY COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SPENCER	$86.06	$38.80	$94.45	$39.95
TODD	$73.43	$30.66	$83.96	$38.34
TRIMBLE	$92.41	$28.90	$76.29	$30.99
WARREN	$115.95	$39.54	$121.47	$57.34
WAYNE	$82.26	$35.29	$77.51	$41.20
WHITLEY	$88.73	$35.25	$76.17	$34.95
WOODFORD	$105.20	$30.86	$104.82	$41.15
STATE: LOUISIANA				
ALLEN	$102.08	$37.57	$81.87	$36.22
ASSUMPTION	$84.24	$36.21	$69.74	$33.55
BEAUREGARD	$102.13	$38.66	$90.88	$41.06
BOSSIER	$93.75	$33.82	$110.33	$42.27
CALCASIEU	$110.45	$46.80	$105.37	$52.70
CAMERON	$133.06	$52.13	$122.86	$56.06
CLAIBORNE	$61.83	$24.41	$81.13	$31.07
DE SOTO	$69.94	$30.48	$65.38	$30.91
EAST CARROLL	$42.78	$21.70	$49.80	$23.72
EVANGELINE	$108.50	$34.04	$107.19	$37.17
GRANT	$84.63	$34.21	$62.49	$28.89
IBERVILLE	$103.60	$40.65	$73.19	$33.94
JEFFERSON	$153.90	$55.42	$143.31	$63.37
LAFAYETTE	$98.92	$36.89	$90.54	$39.96
LA SALLE	$130.23	$44.03	$142.10	$58.96
LIVINGSTON	$122.77	$49.34	$108.22	$51.47
MOREHOUSE	$63.44	$25.86	$71.45	$31.14
ORLEANS	$138.75	$45.67	$118.21	$43.49
PLAQUEMINES	$154.87	$53.96	$127.00	$50.20
RAPIDES	$91.21	$35.81	$72.98	$39.07
RICHLAND	$55.23	$23.52	$66.97	$28.74
ST BERNARD	$192.10	$56.78	$164.64	$68.00
ST HELENA	$88.60	$33.54	$76.66	$31.26
ST JOHN BAPTIST	$95.41	$34.09	$98.31	$40.43
ST MARTIN	$77.63	$31.25	$63.52	$29.03
ST TAMMANY	$145.99	$54.33	$130.56	$55.32
TENSAS	$54.07	$24.55	$73.84	$31.43
UNION	$78.19	$28.82	$48.20	$22.77
VERNON	$128.34	$38.23	$113.62	$36.03
WEBSTER	$94.03	$31.25	$92.46	$35.07
WEST CARROLL	$67.54	$26.19	$64.76	$35.69
WINN	$124.38	$37.94	$115.46	$42.11
STATE: MAINE				
AROOSTOOK	$128.10	$43.90	$120.35	$54.08
FRANKLIN	$106.02	$42.73	$110.91	$54.74
KENNEBEC	$117.99	$44.53	$114.63	$53.99
LINCOLN	$103.87	$39.56	$132.63	$59.07
PENOBSCOT	$125.40	$44.90	$130.13	$66.89
SAGADAHOC	$110.41	$46.27	$98.84	$53.49

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STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MAINE COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SOMERSET	$127.92	$43.97	$137.24	$56.18
WASHINGTON	$117.13	$37.48	$127.80	$55.65
STATE: MARYLAND				
ALLEGANY	$153.66	$49.84	$162.98	$58.86
BALTIMORE	$170.32	$63.37	$210.90	$89.39
CALVERT	$170.10	$70.94	$168.47	$92.62
CARROLL	$114.31	$49.57	$138.37	$68.82
CHARLES	$189.45	$81.40	$203.18	$108.87
FREDERICK	$97.31	$41.77	$138.10	$62.35
HARFORD	$189.06	$69.27	$180.36	$78.28
KENT	$138.76	$51.51	$170.44	$69.71
PRINCE GEORGES	$208.78	$99.20	$252.31	$130.53
ST MARYS	$138.56	$57.62	$141.36	$67.47
TALBOT	$111.58	$43.89	$124.51	$55.00
WICOMICO	$111.64	$48.35	$139.58	$68.54
STATE: MASSACHUSETTS				
BARNSTABLE	$123.46	$53.97	$148.52	$73.84
BRISTOL	$116.99	$51.78	$121.30	$64.63
ESSEX	$158.34	$66.95	$169.40	$84.34
HAMPDEN	$129.68	$58.72	$133.33	$73.24
MIDDLESEX	$179.95	$72.06	$176.46	$87.49
NORFOLK	$177.96	$73.21	$175.60	$84.76
SUFFOLK	$204.30	$81.46	$180.34	$93.43
STATE: MICHIGAN				
ALCONA	$116.82	$49.82	$151.23	$69.73
ALLEGAN	$120.29	$46.63	$137.94	$67.30
ANTRIM	$121.18	$50.87	$151.96	$72.12
BARAGA	$112.05	$38.66	$117.38	$52.76
BAY	$152.76	$59.36	$178.48	$86.24
BERRIEN	$110.62	$46.52	$127.43	$63.67
CALHOUN	$155.55	$57.46	$154.25	$75.14
CHARLEVOIX	$129.10	$52.05	$137.41	$69.63
CHIPPEWA	$126.41	$46.22	$102.32	$42.89
CLINTON	$138.25	$52.37	$156.39	$76.46
DELTA	$104.57	$44.03	$97.75	$48.87
EATON	$146.85	$52.93	$182.13	$87.17
GENESEE	$191.55	$86.24	$198.66	$105.24
GOGEBIC	$100.67	$34.12	$98.32	$43.99
GRATIOT	$108.39	$46.51	$118.38	$64.53
HOUGHTON	$107.78	$39.09	$90.22	$47.69
INGHAM	$144.23	$56.87	$163.42	$81.12
IOSCO	$135.64	$57.09	$137.38	$74.82
ISABELLA	$136.35	$58.00	$119.97	$64.75
KALAMAZOO	$142.54	$57.21	$173.23	$88.88
KENT	$108.12	$46.40	$128.58	$66.40
LAKE	$107.19	$49.41	$112.74	$63.51

STATE: MAINE COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WALDO	$122.24	$41.65	$128.23	$52.05
YORK	$119.89	$49.28	$130.08	$62.91
STATE: MARYLAND				
ANNE ARUNDEL	$157.21	$68.60	$194.19	$92.42
BALTIMORE CITY	$193.10	$66.12	$203.22	$80.95
CAROLINE	$104.36	$41.01	$118.65	$51.01
CECIL	$145.48	$51.96	$173.33	$69.63
DORCHESTER	$129.49	$53.75	$159.31	$67.83
GARRETT	$112.29	$36.45	$113.46	$41.99
HOWARD	$169.38	$67.09	$175.65	$80.45
MONTGOMERY	$135.99	$87.31	$171.94	$109.32
QUEEN ANNES	$121.80	$46.11	$132.80	$58.25
SOMERSET	$115.32	$42.84	$122.92	$51.05
WASHINGTON	$93.32	$39.52	$117.37	$56.17
WORCESTER	$107.90	$45.28	$128.72	$60.12
STATE: MASSACHUSETTS				
BERKSHIRE	$147.56	$54.80	$152.50	$68.91
DUKES	$212.12	$73.68	$275.58	$83.71
FRANKLIN	$125.76	$48.75	$134.94	$59.85
HAMPSHIRE	$123.28	$51.17	$121.98	$58.91
NANTUCKET	$163.35	$54.99	$101.53	$41.95
PLYMOUTH	$144.86	$60.65	$143.62	$71.96
WORCESTER	$166.48	$65.72	$168.50	$81.70
STATE: MICHIGAN				
ALGER	$112.66	$38.58	$94.93	$41.55
ALPENA	$128.06	$46.43	$157.00	$62.77
ARENAC	$153.82	$62.57	$146.09	$67.13
BARRY	$127.36	$51.75	$138.61	$68.59
BENZIE	$134.47	$50.11	$152.55	$71.55
BRANCH	$113.09	$42.64	$108.06	$55.31
CASS	$127.82	$49.20	$150.53	$65.41
CHEBOYGAN	$143.93	$56.02	$158.47	$75.15
CLARE	$137.35	$60.22	$130.95	$70.69
CRAWFORD	$147.54	$52.35	$147.02	$76.66
DICKINSON	$101.25	$38.27	$89.21	$41.27
EMMET	$132.98	$52.44	$153.42	$66.23
GLADWIN	$166.17	$74.73	$170.24	$96.68
GRAND TRAVERSE	$123.55	$51.85	$143.16	$85.62
HILLSDALE	$125.50	$46.84	$112.79	$50.87
HURON	$139.13	$52.01	$134.73	$66.42
IONIA	$141.83	$52.33	$154.49	$66.63
IRON	$121.25	$47.06	$113.06	$51.28
JACKSON	$126.72	$54.75	$158.30	$74.50
KALKASKA	$147.08	$52.11	$140.95	$73.35
KEWEENAW	$103.17	$40.56	$70.22	$46.72
LAPEER	$171.97	$68.15	$120.06	$74.71

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MICHIGAN COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LEELANAU	$127.49	$46.98	$181.26	$73.26
LIVINGSTON	$154.21	$68.76	$160.94	$77.42
MACKINAC	$123.78	$50.40	$99.66	$48.15
MANISTEE	$143.73	$45.09	$148.09	$64.30
MASON	$104.95	$43.98	$108.56	$59.05
MENOMINEE	$97.09	$31.06	$92.52	$39.50
MISSAUKEE	$139.13	$45.49	$148.10	$67.54
MONTCALM	$130.57	$51.29	$149.67	$70.27
MUSKEGON	$145.15	$62.47	$147.50	$78.97
OAKLAND	$186.41	$99.27	$206.66	$124.47
OGEMAW	$132.44	$58.63	$149.34	$85.58
OSCEOLA	$125.13	$44.22	$107.10	$52.94
OTSEGO	$119.09	$56.29	$103.84	$62.79
PRESQUE ISLE	$146.89	$49.61	$145.66	$59.96
SAGINAW	$151.13	$56.75	$176.82	$76.90
ST JOSEPH	$124.94	$44.69	$151.42	$71.87
SCHOOLCRAFT	$109.86	$48.18	$85.65	$50.94
TUSCOLA	$138.48	$52.30	$166.56	$74.73
WASHTENAW	$179.12	$68.80	$206.48	$106.72
WEXFORD	$137.68	$44.32	$153.61	$61.63
STATE: MINNESOTA				
AITKIN	$102.51	$36.54	$88.77	$39.28
BECKER	$105.44	$38.20	$134.29	$55.71
BENTON	$94.47	$35.31	$104.00	$50.86
BLUE EARTH	$78.50	$40.62	$79.27	$56.77
CARLTON	$104.70	$35.19	$108.39	$43.01
CASS	$95.30	$35.63	$110.47	$45.32
CHISAGO	$114.06	$37.47	$151.34	$65.18
CLEARWATER	$86.95	$31.24	$104.14	$42.12
COTTONWOOD	$106.72	$38.91	$136.67	$49.65
DAKOTA	$141.87	$52.41	$162.40	$67.33
DOUGLAS	$91.75	$34.86	$117.00	$44.71
FILLMORE	$74.45	$50.18	$111.59	$95.81
GOODHUE	$82.92	$51.26	$102.78	$69.10
HENNEPIN	$152.01	$59.21	$209.66	$84.84
HUBBARD	$111.03	$40.23	$101.67	$48.46
ITASCA	$103.70	$36.31	$132.90	$51.62
KANABEC	$119.48	$39.66	$121.74	$54.13
KITTSON	$116.75	$41.70	$116.77	$47.14
LAC QUI PARLE	$96.24	$33.97	$144.13	$55.33
LAKE OF WOODS	$91.25	$27.93	$184.72	$35.35
LINCOLN	$98.55	$33.91	$104.56	$37.44
MC LEOD	$110.92	$36.76	$96.94	$47.13
MARSHALL	$125.01	$44.08	$138.45	$51.15
MEEKER	$105.25	$34.36	$126.73	$40.19
MORRISON	$97.35	$35.98	$117.74	$48.77
MURRAY	$97.16	$32.37	$85.11	$42.44
NOBLES	$88.80	$36.55	$101.81	$54.27

STATE: MICHIGAN COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LENAWEE	$138.35	$48.07	$170.22	$68.16
LUCE	$115.12	$43.45	$119.15	$50.58
MACOMB	$189.30	$99.01	$200.47	$121.18
MARQUETTE	$136.57	$56.10	$129.57	$71.61
MECOSTA	$125.90	$55.35	$122.65	$70.71
MIDLAND	$132.20	$54.37	$180.88	$83.84
MONROE	$165.30	$68.62	$190.51	$90.13
MONTMORENCY	$128.04	$60.44	$143.77	$76.51
NEWAYGO	$118.61	$50.81	$131.64	$70.12
OCEANA	$125.47	$51.42	$116.12	$63.53
ONTONAGON	$149.10	$47.58	$161.42	$56.27
OSCODA	$122.09	$50.25	$137.82	$91.57
OTTAWA	$102.20	$45.16	$138.01	$71.68
ROSCOMMON	$141.38	$57.79	$146.18	$74.80
ST CLAIR	$133.54	$60.29	$159.50	$78.96
SANILAC	$159.14	$55.24	$158.38	$66.98
SHIAWASSEE	$140.15	$56.22	$162.41	$72.32
VAN BUREN	$133.96	$52.56	$152.08	$68.96
WAYNE	$203.74	$91.92	$227.69	$113.10
STATE: MINNESOTA				
ANOKA	$139.34	$62.15	$185.57	$78.36
BELTRAMI	$86.69	$33.39	$108.44	$47.41
BIG STONE	$115.30	$35.04	$126.04	$49.20
BROWN	$88.43	$32.44	$107.10	$57.78
CARVER	$120.54	$44.39	$143.11	$59.94
CHIPPEWA	$78.94	$30.28	$53.86	$24.85
CLAY	$121.62	$42.61	$180.89	$64.84
COOK	$143.61	$52.09	$104.19	$52.76
CROW WING	$114.68	$41.58	$94.31	$55.22
DODGE	$73.34	$69.09	$90.97	$69.25
FARIBAULT	$83.54	$44.33	$82.94	$43.04
FREEBORN	$71.53	$40.10	$94.67	$62.22
GRANT	$119.10	$40.98	$95.90	$47.70
HOUSTON	$77.80	$40.86	$108.91	$55.13
ISANTI	$124.80	$39.00	$119.36	$46.97
JACKSON	$117.33	$43.46	$88.19	$42.73
KANDIYOHI	$76.58	$33.85	$92.11	$43.37
KOOCHICHING	$136.23	$45.88	$146.64	$54.00
LAKE	$90.47	$44.64	$147.41	$70.26
LE SUEUR	$96.18	$41.57	$105.60	$54.27
LYON	$99.49	$36.16	$129.37	$47.46
MAHNOMEN	$97.83	$32.67	$110.75	$34.77
MARTIN	$83.12	$43.15	$86.57	$43.69
MILLE LACS	$125.94	$40.90	$168.43	$63.75
MOWER	$89.56	$53.69	$106.57	$78.45
NICOLLET	$84.48	$37.58	$107.48	$51.35
NORMAN	$89.74	$34.19	$87.57	$39.29

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MINNESOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
OLMSTED	$78.58	$91.43	$112.30	$124.76
PENNINGTON	$101.28	$48.82	$148.84	$48.65
PIPESTONE	$87.43	$34.03	$71.23	$36.55
POPE	$90.96	$34.14	$84.37	$39.98
RED LAKE	$141.16	$48.07	$140.45	$60.97
RENVILLE	$93.90	$31.45	$118.59	$41.82
ROCK	$87.77	$33.83	$65.82	$40.11
ST LOUIS	$117.59	$42.83	$135.65	$53.22
SHERBURNE	$106.62	$40.79	$138.18	$66.61
STEARNS	$111.95	$41.08	$103.80	$46.43
STEVENS	$116.09	$43.05	$112.65	$41.35
TODD	$103.14	$35.94	$99.42	$37.60
WABASHA	$89.07	$61.39	$95.07	$77.53
WASECA	$78.58	$43.95	$78.08	$58.44
WATONWAN	$84.96	$36.63	$110.31	$52.05
WINONA	$91.92	$52.34	$95.14	$61.02
YELLOW MEDICINE	$103.05	$32.15	$129.50	$46.71
STATE: MISSISSIPPI				
ADAMS	$96.45	$38.41	$90.57	$36.58
AMITE	$88.74	$33.08	$91.98	$38.45
BENTON	$85.46	$37.03	$84.46	$43.01
CALHOUN	$100.83	$38.24	$93.82	$37.56
CHICKASAW	$90.41	$37.11	$109.51	$45.93
CLAIBORNE	$75.53	$37.12	$49.94	$29.28
CLAY	$64.57	$26.62	$82.48	$32.75
COPIAH	$84.40	$35.94	$71.71	$37.10
DESOTO	$119.96	$45.11	$131.94	$59.43
FRANKLIN	$82.48	$35.19	$86.60	$42.95
GREENE	$120.25	$51.71	$105.43	$50.17
HANCOCK	$133.43	$51.10	$131.99	$57.78
HINDS	$93.59	$43.24	$93.89	$51.10
HUMPHREYS	$94.97	$41.07	$70.65	$34.14
ITAWAMBA	$81.04	$35.52	$89.89	$46.43
JASPER	$82.25	$44.12	$66.32	$38.87
JEFFERSON DAVIS	$95.80	$40.83	$78.33	$43.08
KEMPER	$80.01	$30.90	$65.36	$28.44
LAMAR	$115.19	$48.84	$104.38	$50.23
LAWRENCE	$138.72	$54.10	$115.77	$50.20
LEE	$94.41	$42.55	$92.85	$48.61
LINCOLN	$87.91	$39.10	$85.20	$41.66
MADISON	$75.23	$34.50	$74.06	$39.50
MARSHALL	$89.81	$37.19	$103.25	$44.80
MONTGOMERY	$90.88	$39.26	$80.24	$38.33
NEWTON	$96.75	$40.67	$107.37	$50.67
OKTIBBEHA	$64.39	$31.94	$60.59	$36.26
PEARL RIVER	$139.66	$51.15	$119.11	$50.55
PIKE	$86.97	$39.24	$87.86	$39.75
PRENTISS	$108.71	$36.55	$116.48	$39.58

STATE: MINNESOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
OTTER TAIL	$106.13	$39.50	$95.96	$43.43
PINE	$107.95	$34.20	$139.29	$51.67
POLK	$111.16	$41.57	$122.28	$49.93
RAMSEY	$157.42	$58.53	$218.06	$87.62
REDWOOD	$89.73	$32.35	$80.03	$37.96
RICE	$101.87	$44.83	$100.88	$54.67
ROSEAU	$110.40	$39.13	$113.50	$45.14
SCOTT	$114.89	$42.45	$125.30	$53.96
SIBLEY	$99.71	$33.54	$108.65	$43.29
STEELE	$78.97	$47.81	$103.56	$68.08
SWIFT	$92.95	$32.05	$94.12	$33.18
TRAVERSE	$110.49	$40.42	$93.17	$41.62
WADENA	$103.73	$33.91	$125.04	$55.62
WASHINGTON	$127.03	$46.06	$196.95	$78.03
WILKIN	$114.45	$35.99	$102.58	$38.93
WRIGHT	$112.35	$39.68	$128.26	$60.36
STATE: MISSISSIPPI				
ALCORN	$111.30	$41.76	$110.45	$49.36
ATTALA	$76.55	$29.08	$69.02	$32.80
BOLIVAR	$78.39	$33.65	$91.30	$39.02
CARROLL	$85.97	$39.27	$78.11	$38.45
CHOCTAW	$74.80	$34.69	$63.66	$35.72
CLARKE	$113.02	$43.66	$124.91	$56.17
COAHOMA	$84.77	$35.72	$81.27	$37.58
COVINGTON	$136.97	$45.85	$99.28	$41.57
FORREST	$118.55	$50.65	$114.13	$53.48
GEORGE	$145.24	$50.27	$124.61	$50.88
GRENADA	$112.05	$39.90	$135.25	$51.09
HARRISON	$139.36	$51.24	$130.46	$56.44
HOLMES	$81.67	$32.40	$69.03	$33.65
ISSAQUENA	$67.13	$33.08	$97.29	$42.03
JACKSON	$151.63	$52.99	$140.93	$58.92
JEFFERSON	$102.74	$42.30	$76.73	$37.60
JONES	$93.39	$41.51	$84.99	$43.97
LAFAYETTE	$83.22	$33.26	$89.73	$37.28
LAUDERDALE	$110.67	$45.17	$119.62	$57.01
LEAKE	$77.76	$32.66	$79.72	$41.54
LEFLORE	$87.71	$42.14	$90.97	$40.98
LOWNDES	$82.64	$33.30	$88.52	$37.29
MARION	$119.30	$44.83	$108.75	$47.09
MONROE	$74.87	$35.01	$70.20	$38.44
NESHOBA	$83.91	$41.22	$100.49	$52.51
NOXUBEE	$87.65	$34.25	$82.33	$33.38
PANOLA	$100.12	$36.98	$102.95	$39.89
PERRY	$128.99	$49.91	$81.55	$41.56
PONTOTOC	$92.77	$36.77	$83.37	$42.76
QUITMAN	$91.76	$33.96	$89.05	$35.61

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MISSISSIPPI COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
RANKIN	$73.08	$38.47	$83.85	$50.11
SHARKEY	$77.61	$38.41	$58.36	$28.19
SMITH	$93.22	$46.09	$90.35	$45.11
SUNFLOWER	$90.08	$39.20	$79.36	$37.43
TATE	$115.49	$41.59	$127.94	$54.25
TISHOMINGO	$100.38	$38.73	$112.40	$50.60
UNION	$79.23	$32.61	$81.82	$43.46
WARREN	$76.95	$39.52	$84.59	$44.45
WAYNE	$112.54	$43.82	$86.04	$44.24
WILKINSON	$76.21	$31.66	$63.38	$27.15
YALOBUSHA	$84.03	$33.40	$83.68	$39.58
STATE: MISSOURI				
ADAIR	$163.36	$48.40	$178.28	$57.18
ATCHISON	$133.06	$39.08	$118.31	$32.17
BARRY	$99.53	$35.34	$95.88	$46.73
BATES	$136.59	$50.33	$118.55	$51.69
BOLLINGER	$103.70	$35.27	$110.29	$43.55
BUCHANAN	$127.14	$44.05	$136.44	$58.65
CALDWELL	$102.08	$33.36	$138.38	$54.63
CAMDEN	$136.29	$43.93	$106.15	$52.96
CARROLL	$132.00	$43.66	$129.14	$54.40
CASS	$139.95	$51.89	$157.44	$70.19
CHARITON	$122.99	$40.00	$65.90	$32.07
CLARK	$153.06	$44.19	$99.64	$37.63
CLINTON	$129.60	$42.26	$146.17	$52.98
COOPER	$140.88	$42.58	$120.87	$50.60
DADE	$95.42	$34.46	$129.23	$50.70
DAVIESS	$102.41	$32.61	$100.55	$43.29
DENT	$125.73	$36.68	$107.18	$41.80
DUNKLIN	$108.72	$39.52	$106.50	$46.67
GASCONADE	$121.18	$34.01	$122.46	$40.85
GREENE	$105.62	$43.42	$128.42	$61.08
HARRISON	$126.97	$38.77	$102.92	$44.68
HICKORY	$112.26	$42.35	$88.56	$42.67
HOWARD	$126.88	$40.39	$134.30	$45.68
IRON	$123.00	$34.76	$110.35	$37.52
JASPER	$117.96	$40.35	$117.84	$54.33
JOHNSON	$129.56	$44.56	$134.64	$63.40
LACLEDE	$84.11	$31.88	$84.28	$40.26
LAWRENCE	$105.03	$35.69	$131.37	$58.80
LINCOLN	$139.84	$39.07	$186.35	$51.84
LIVINGSTON	$101.87	$30.94	$109.79	$41.80
MACON	$124.81	$40.12	$153.82	$63.02
MARIES	$136.17	$37.32	$138.37	$44.12
MERCER	$106.26	$31.63	$109.32	$43.45
MISSISSIPPI	$91.00	$36.25	$79.13	$36.12
MONROE	$111.21	$36.46	$153.28	$47.73
MORGAN	$91.04	$34.10	$110.58	$46.74

STATE: MISSISSIPPI COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SCOTT	$72.39	$34.44	$85.46	$46.11
SIMPSON	$111.46	$40.29	$95.55	$38.90
STONE	$128.93	$43.96	$75.25	$40.10
TALLAHATCHIE	$74.49	$36.76	$65.90	$38.83
TIPPAH	$104.25	$39.51	$94.48	$46.94
TUNICA	$75.71	$35.13	$78.88	$34.85
WALTHALL	$92.07	$39.00	$92.18	$38.69
WASHINGTON	$87.28	$34.85	$84.68	$39.77
WEBSTER	$88.77	$37.42	$105.41	$49.50
WINSTON	$59.47	$29.21	$62.55	$33.03
YAZOO	$81.01	$35.44	$84.28	$40.16
STATE: MISSOURI				
ANDREW	$114.30	$35.35	$123.84	$46.70
AUDRAIN	$132.48	$43.78	$185.98	$65.25
BARTON	$113.45	$34.30	$85.17	$30.85
BENTON	$107.77	$40.29	$114.61	$52.11
BOONE	$138.69	$50.35	$170.59	$69.40
BUTLER	$141.51	$50.62	$122.17	$53.98
CALLAWAY	$111.25	$37.86	$118.33	$51.45
CAPE GIRARDEAU	$117.67	$40.06	$112.91	$47.08
CARTER	$111.29	$44.22	$109.73	$58.03
CEDAR	$83.81	$32.80	$82.55	$40.67
CHRISTIAN	$98.10	$40.89	$117.41	$53.18
CLAY	$165.82	$64.08	$186.59	$82.97
COLE	$133.66	$43.84	$158.61	$56.58
CRAWFORD	$119.16	$37.37	$108.10	$42.62
DALLAS	$89.57	$38.60	$90.39	$41.81
DE KALB	$131.06	$39.50	$124.42	$49.23
DOUGLAS	$90.95	$36.11	$74.53	$32.89
FRANKLIN	$153.32	$43.99	$154.17	$55.32
GENTRY	$126.02	$37.91	$69.09	$32.73
GRUNDY	$123.64	$34.81	$108.02	$44.93
HENRY	$114.19	$39.31	$98.71	$50.58
HOLT	$127.13	$38.95	$147.89	$46.86
HOWELL	$86.85	$32.12	$72.23	$35.74
JACKSON	$179.15	$67.64	$196.39	$85.78
JEFFERSON	$173.61	$51.83	$204.78	$70.27
KNOX	$140.05	$39.83	$102.23	$33.53
LAFAYETTE	$117.72	$45.25	$141.66	$62.96
LEWIS	$125.52	$37.20	$199.51	$61.51
LINN	$123.20	$37.68	$117.53	$44.73
MC DONALD	$96.75	$33.59	$100.04	$37.17
MADISON	$153.06	$44.44	$136.36	$49.30
MARION	$129.97	$35.02	$108.86	$36.17
MILLER	$132.73	$37.22	$102.23	$37.50
MONITEAU	$122.44	$37.07	$116.10	$41.97
MONTGOMERY	$126.89	$38.16	$116.02	$51.04
NEW MADRID	$87.63	$36.65	$78.73	$31.97

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MISSOURI COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
NEWTON	$94.20	$34.73	$82.63	$40.61
OREGON	$76.62	$32.02	$69.06	$34.68
OZARK	$95.61	$37.65	$82.29	$38.86
PERRY	$127.49	$42.58	$122.33	$46.83
PHELPS	$109.82	$35.45	$104.72	$40.69
PLATTE	$155.15	$57.12	$171.06	$71.32
PULASKI	$114.88	$35.03	$106.84	$42.36
RALLS	$122.45	$38.63	$144.67	$53.19
RAY	$129.53	$46.73	$163.10	$76.67
RIPLEY	$101.78	$35.32	$102.69	$44.24
ST CLAIR	$125.06	$42.51	$123.26	$49.00
ST LOUIS	$164.31	$54.10	$210.83	$74.30
STE GENEVIEVE	$151.34	$40.85	$156.88	$52.92
SCHUYLER	$153.27	$42.88	$102.22	$44.48
SCOTT	$113.24	$40.52	$100.41	$43.53
SHELBY	$96.39	$32.08	$97.05	$34.82
STONE	$98.77	$41.34	$119.36	$61.21
TANEY	$113.33	$42.33	$101.11	$48.83
VERNON	$103.98	$39.76	$128.53	$48.59
WASHINGTON	$137.58	$39.68	$119.74	$42.39
WEBSTER	$88.72	$36.81	$94.29	$55.05
WRIGHT	$94.92	$36.04	$80.94	$40.39
STATE: MONTANA				
BEAVERHEAD	$109.39	$48.02	$94.83	$48.66
BLAINE	$127.57	$46.01	$114.30	$40.06
CARBON	$91.64	$46.38	$95.84	$48.64
CASCADE	$134.95	$54.97	$140.49	$69.35
CUSTER	$115.56	$41.48	$120.43	$52.93
DAWSON	$123.36	$46.60	$66.04	$48.92
FALLON	$107.24	$42.83	$194.02	$50.51
FLATHEAD	$89.25	$44.81	$103.52	$64.28
GARFIELD	$109.53	$38.65	$71.78	$39.01
GOLDEN VALLEY	$95.70	$49.87	$21.24	$13.17
HILL	$148.74	$50.59	$114.10	$54.44
JUDITH BASIN	$145.64	$55.43	$174.66	$74.24
LEWIS AND CLARK	$121.68	$63.34	$107.24	$65.82
LINCOLN	$88.98	$40.44	$92.52	$48.54
MADISON	$89.28	$42.10	$121.14	$49.83
MINERAL	$123.43	$58.98	$89.73	$63.19
MUSSELSHELL	$101.30	$53.20	$105.87	$60.46
PETROLEUM	$108.09	$42.90	$125.94	$68.62
PONDERA	$136.06	$43.37	$126.96	$55.63
POWELL	$135.82	$50.02	$92.90	$55.23
RAVALLI	$78.80	$41.50	$96.14	$60.62
ROOSEVELT	$125.56	$40.39	$170.91	$59.52
SANDERS	$118.48	$42.97	$109.64	$54.94
SILVER BOW	$152.83	$65.04	$160.73	$86.10
SWEET GRASS	$77.17	$34.58	$123.23	$37.88

STATE: MISSOURI COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
NODAWAY	$145.21	$37.80	$133.49	$42.34
OSAGE	$124.63	$37.95	$164.69	$46.31
PEMISCOT	$98.57	$36.78	$91.86	$41.18
PETTIS	$96.37	$35.46	$110.55	$47.19
PIKE	$145.27	$38.54	$115.42	$37.42
POLK	$92.29	$39.18	$88.64	$42.67
PUTNAM	$129.50	$34.78	$127.09	$37.55
RANDOLPH	$139.42	$44.09	$105.31	$43.02
REYNOLDS	$131.09	$36.53	$118.00	$43.10
ST CHARLES	$156.57	$49.40	$187.48	$64.51
ST FRANCOIS	$141.51	$37.20	$132.56	$46.45
ST LOUIS CITY	$164.73	$47.90	$178.77	$58.13
SALINE	$119.80	$37.51	$115.70	$37.90
SCOTLAND	$154.91	$38.65	$75.86	$29.19
SHANNON	$92.86	$32.60	$90.29	$53.38
STODDARD	$95.50	$37.01	$94.54	$44.09
SULLIVAN	$143.51	$40.35	$119.57	$41.89
TEXAS	$93.53	$30.55	$81.26	$41.23
WARREN	$134.29	$39.29	$177.63	$62.51
WAYNE	$112.06	$44.07	$103.24	$45.45
WORTH	$98.02	$25.73	$109.80	$47.34
STATE: MONTANA				
BIG HORN	$89.94	$39.98	$132.80	$48.13
BROADWATER	$122.80	$49.29	$88.82	$34.37
CARTER	$78.92	$36.07	$126.88	$53.85
CHOUTEAU	$140.69	$55.01	$145.92	$54.71
DANIELS	$79.49	$31.86	$106.24	$34.51
DEER LODGE	$126.73	$55.78	$108.80	$61.32
FERGUS	$93.81	$43.94	$85.63	$48.06
GALLATIN	$62.64	$53.20	$79.42	$73.76
GLACIER	$125.77	$47.95	$120.07	$47.81
GRANITE	$125.65	$57.69	$101.17	$53.57
JEFFERSON	$92.19	$50.81	$117.37	$70.75
LAKE	$104.98	$44.64	$90.57	$54.42
LIBERTY	$93.49	$37.64	$52.35	$34.44
MC CONE	$132.82	$42.57	$106.60	$41.67
MEAGHER	$123.99	$56.00	$33.00	$41.26
MISSOULA	$98.00	$51.67	$112.52	$68.40
PARK	$89.19	$43.12	$100.88	$54.36
PHILLIPS	$111.79	$39.07	$148.03	$38.80
POWDER RIVER	$79.36	$37.45	$111.39	$64.13
PRAIRIE	$114.87	$36.06	$92.79	$26.97
RICHLAND	$150.88	$51.37	$151.83	$58.18
ROSEBUD	$101.31	$34.23	$75.52	$35.38
SHERIDAN	$83.20	$30.33	$102.65	$34.62
STILLWATER	$91.87	$39.13	$100.25	$48.76
TETON	$112.19	$46.71	$141.19	$59.08

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: MONTANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
TOOLE	$130.82	$41.18	$138.71	$45.08
VALLEY	$149.02	$46.15	$183.22	$55.82
WIBAUX	$130.97	$50.56	$134.13	$77.47
STATE: NEBRASKA				
ADAMS	$90.20	$35.07	$116.24	$56.21
ARTHUR	$133.27	$32.00	$205.61	$90.75
BLAINE	$130.30	$37.08	$178.19	$78.65
BOX BUTTE	$97.77	$34.22	$172.51	$65.65
BROWN	$92.60	$33.84	$109.89	$43.63
BURT	$106.58	$34.31	$169.24	$59.98
CASS	$140.45	$41.34	$168.79	$60.24
CHASE	$107.34	$36.89	$66.28	$32.55
CHEYENNE	$110.01	$41.79	$99.44	$47.67
COLFAX	$105.33	$31.98	$140.68	$56.17
CUSTER	$94.37	$32.51	$89.91	$35.18
DAWES	$115.19	$40.53	$122.63	$54.06
DEUEL	$109.90	$41.52	$57.43	$26.32
DODGE	$110.90	$42.98	$151.28	$73.35
DUNDY	$114.66	$38.53	$104.02	$39.23
FRANKLIN	$77.59	$32.82	$64.48	$29.84
FURNAS	$90.71	$35.20	$74.52	$38.11
GARDEN	$71.26	$28.61	$83.77	$45.35
GOSPER	$81.86	$38.79	$72.88	$30.10
GREELEY	$87.77	$36.04	$133.67	$62.77
HAMILTON	$87.23	$38.99	$93.13	$53.74
HAYES	$138.35	$49.16	$149.53	$73.16
HOLT	$113.51	$34.85	$112.36	$43.27
HOWARD	$83.00	$36.62	$73.31	$44.67
JOHNSON	$78.87	$31.51	$71.08	$25.39
KEITH	$113.87	$36.29	$121.81	$52.69
KIMBALL	$113.21	$41.01	$113.77	$69.26
LANCASTER	$107.65	$45.00	$120.72	$57.39
LOGAN	$86.72	$29.58	$175.27	$71.50
MC PHERSON	$82.90	$36.03	$145.27	$70.43
MERRICK	$95.58	$36.18	$134.66	$57.12
NANCE	$113.48	$38.94	$111.42	$64.96
NUCKOLLS	$81.79	$29.45	$68.19	$28.48
PAWNEE	$101.23	$35.29	$89.96	$48.80
PHELPS	$96.98	$45.71	$103.71	$47.89
PLATTE	$103.58	$33.22	$93.53	$62.09
REDWILLOW	$104.30	$38.72	$99.13	$43.66
ROCK	$107.71	$35.65	$129.06	$49.00
SARPY	$189.75	$58.71	$220.79	$89.60
SCOTTS BLUFF	$96.76	$36.66	$115.69	$52.16
SHERIDAN	$80.99	$29.68	$93.15	$38.82
SIOUX	$125.30	$41.03	$153.62	$69.39
THAYER	$71.37	$30.11	$87.93	$54.87
THURSTON	$115.49	$33.81	$146.02	$52.88

STATE: MONTANA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
TREASURE	$116.39	$56.72	$127.08	$73.31
WHEATLAND	$103.24	$50.19	$142.30	$81.18
YELLOWSTONE	$98.07	$49.32	$109.42	$65.22
STATE: NEBRASKA				
ANTELOPE	$119.29	$41.74	$143.33	$57.21
BANNER	$93.12	$33.12	$133.65	$62.09
BOONE	$99.23	$33.69	$109.58	$54.00
BOYD	$112.43	$32.27	$79.11	$34.07
BUFFALO	$97.40	$36.71	$107.59	$53.05
BUTLER	$97.63	$30.15	$92.32	$44.82
CEDAR	$89.91	$32.46	$129.70	$51.30
CHERRY	$91.48	$32.88	$105.29	$38.55
CLAY	$92.42	$33.30	$105.31	$52.65
CUMING	$86.36	$31.42	$105.07	$48.73
DAKOTA	$147.98	$38.60	$167.73	$57.36
DAWSON	$86.68	$34.89	$82.11	$40.19
DIXON	$92.53	$28.83	$170.31	$66.32
DOUGLAS	$177.51	$55.77	$218.01	$89.40
FILLMORE	$75.23	$35.26	$69.13	$34.67
FRONTIER	$89.77	$38.82	$159.32	$78.72
GAGE	$89.53	$32.18	$67.04	$33.18
GARFIELD	$83.72	$32.10	$92.09	$33.47
GRANT	$112.11	$36.32	$152.74	$62.09
HALL	$98.11	$39.17	$78.75	$43.64
HARLAN	$87.53	$38.46	$50.92	$30.32
HITCHCOCK	$103.22	$36.05	$92.86	$54.45
HOOKER	$82.42	$35.99	$158.93	$69.77
JEFFERSON	$90.25	$36.43	$89.07	$50.30
KEARNEY	$73.58	$32.99	$49.93	$35.70
KEYA PAHA	$106.39	$34.59	$157.23	$71.93
KNOX	$101.31	$36.12	$106.75	$44.62
LINCOLN	$95.45	$34.82	$86.22	$45.90
LOUP	$150.54	$43.34	$141.92	$68.06
MADISON	$85.80	$33.05	$142.49	$48.66
MORRILL	$94.67	$33.30	$105.57	$55.06
NEMAHA	$124.07	$41.78	$116.68	$51.70
OTOE	$103.46	$32.77	$126.53	$44.14
PERKINS	$87.38	$35.74	$155.48	$68.77
PIERCE	$84.79	$33.15	$114.88	$46.09
POLK	$124.59	$40.64	$147.86	$60.61
RICHARDSON	$98.48	$36.05	$107.70	$50.26
SALINE	$85.23	$35.00	$115.97	$51.66
SAUNDERS	$104.16	$37.90	$125.49	$52.69
SEWARD	$84.85	$32.35	$128.59	$52.51
SHERMAN	$108.45	$37.89	$68.66	$47.46
STANTON	$82.44	$29.66	$180.64	$44.41
THOMAS	$98.35	$43.00	$207.61	$93.44
VALLEY	$68.86	$28.20	$51.06	$29.53

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: NEBRASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WASHINGTON	$105.36	$32.25	$137.83	$60.15
WEBSTER	$69.82	$28.39	$78.45	$29.52
YORK	$84.87	$33.89	$150.93	$63.84
STATE: NEVADA				
CHURCHILL	$151.89	$71.87	$149.87	$84.91
DOUGLAS	$114.18	$64.06	$133.79	$94.22
ESMERALDA	$187.51	$74.01	$240.05	$138.80
HUMBOLDT	$149.46	$60.73	$104.75	$46.94
LINCOLN	$166.13	$67.41	$184.82	$82.54
MINERAL	$158.20	$70.14	$106.30	$66.64
CARSON CITY	$131.30	$70.58	$134.39	$89.97
STOREY	$151.33	$77.64	$209.79	$129.54
WHITE PINE	$119.81	$46.56	$123.21	$55.47
STATE: NEW HAMPSHIRE				
BELKNAP	$96.11	$42.41	$77.71	$41.41
CHESHIRE	$133.64	$50.64	$156.75	$65.78
GRAFTON	$128.26	$47.62	$124.76	$58.31
MERRIMACK	$107.87	$45.98	$125.47	$61.11
STRAFFORD	$98.84	$48.84	$101.15	$61.02
STATE: NEW JERSEY				
ATLANTIC	$119.53	$67.53	$135.46	$80.45
BURLINGTON	$129.48	$65.61	$144.80	$83.69
CAPE MAY	$116.92	$54.78	$114.11	$62.45
ESSEX	$162.68	$75.93	$180.11	$93.85
HUDSON	$156.05	$69.98	$159.67	$84.78
MERCER	$153.82	$67.70	$152.68	$82.33
MONMOUTH	$124.91	$60.78	$155.57	$89.98
OCEAN	$102.34	$56.57	$121.87	$72.98
SALEM	$118.67	$57.42	$126.54	$76.27
SUSSEX	$121.59	$65.05	$165.45	$112.88
WARREN	$122.76	$62.81	$136.98	$85.90
STATE: NEW MEXICO				
BERNALILLO	$122.80	$70.11	$119.15	$87.14
CHAVES	$86.55	$50.71	$81.26	$55.91
CURRY	$101.17	$45.19	$86.79	$45.63
DONA ANA	$120.56	$67.58	$114.97	$72.44
GRANT	$93.26	$40.42	$88.54	$45.50
HARDING	$104.68	$49.05	$123.36	$79.94
LEA	$112.77	$55.83	$118.64	$66.36
LOS ALAMOS	$141.03	$79.48	$218.78	$90.32
MC KINLEY	$77.92	$30.80	$61.68	$30.76
OTERO	$118.66	$58.62	$89.94	$52.67
RIO ARRIBA	$119.79	$60.09	$88.86	$62.97
SANDOVAL	$95.76	$56.79	$129.06	$69.82
SAN MIGUEL	$93.35	$46.85	$64.40	$41.30

STATE: NEBRASKA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
WAYNE	$93.16	$29.92	$92.59	$38.06
WHEELER	$86.59	$31.31	$188.68	$87.85
STATE: NEVADA				
CLARK	$187.46	$92.33	$221.27	$123.90
ELKO	$101.48	$46.20	$157.95	$63.91
EUREKA	$107.66	$48.88	$198.14	$120.93
LANDER	$121.56	$52.74	$99.02	$52.54
LYON	$133.60	$63.36	$131.76	$87.59
NYE	$164.55	$71.63	$177.48	$104.24
PERSHING	$125.59	$66.78	$132.09	$70.90
WASHOE	$165.52	$79.68	$191.43	$105.09
STATE: NEW HAMPSHIRE				
CARROLL	$110.96	$43.75	$132.00	$65.58
COOS	$133.37	$43.25	$136.59	$54.12
HILLSBORO	$127.88	$47.28	$152.05	$74.96
ROCKINGHAM	$116.30	$50.73	$145.44	$71.57
SULLIVAN	$127.84	$50.47	$112.49	$59.20
STATE: NEW JERSEY				
BERGEN	$123.36	$69.88	$166.98	$99.25
CAMDEN	$154.09	$71.92	$172.44	$90.50
CUMBERLAND	$125.64	$62.81	$127.48	$69.93
GLOUCESTER	$135.87	$65.69	$150.79	$83.83
HUNTERDON	$130.00	$56.42	$120.20	$77.15
MIDDLESEX	$152.88	$64.95	$167.20	$97.95
MORRIS	$134.02	$70.30	$177.15	$108.76
PASSAIC	$128.35	$67.52	$157.91	$104.67
SOMERSET	$126.31	$58.40	$133.74	$76.96
UNION	$148.43	$68.67	$158.53	$85.75
STATE: NEW MEXICO				
CATRON	$92.59	$38.59	$42.72	$23.65
COLFAX	$112.29	$49.85	$79.62	$49.97
DE BACA	$71.14	$34.32	$82.94	$46.97
EDDY	$118.40	$54.24	$129.55	$65.64
GUADALUPE	$103.43	$42.36	$71.66	$34.28
HIDALGO	$116.73	$55.79	$74.07	$44.44
LINCOLN	$112.40	$50.92	$71.94	$43.30
LUNA	$87.25	$41.74	$98.26	$52.31
MORA	$70.40	$38.60	$118.01	$59.80
QUAY	$101.50	$45.90	$90.79	$48.02
ROOSEVELT	$91.66	$45.34	$103.52	$50.67
SAN JUAN	$86.24	$43.26	$79.95	$46.15
SANTA FE	$120.00	$62.25	$116.13	$63.24

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: NEW MEXICO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SIERRA	$91.31	$47.31	$82.65	$45.79
TAOS	$114.61	$48.51	$81.13	$43.10
UNION	$91.52	$41.11	$48.25	$29.95
STATE: NEW YORK				
ALBANY	$133.38	$62.15	$126.13	$71.44
BRONX	$183.57	$91.08	$184.86	$90.30
CATTARAUGUS	$96.79	$45.14	$81.13	$48.47
CHAUTAUQUA	$96.11	$45.80	$165.05	$57.94
CHENANGO	$95.19	$37.42	$96.13	$53.27
COLUMBIA	$95.32	$44.38	$95.86	$50.66
DELAWARE	$123.89	$42.88	$103.35	$48.22
ERIE	$103.92	$46.99	$109.74	$54.08
FRANKLIN	$93.20	$48.11	$79.60	$55.76
GENESEE	$102.66	$42.42	$81.77	$44.39
HAMILTON	$114.79	$51.61	$109.52	$48.60
JEFFERSON	$116.04	$45.53	$125.19	$64.06
LEWIS	$125.85	$45.06	$120.35	$54.50
MADISON	$88.24	$40.42	$84.45	$48.90
MONTGOMERY	$108.87	$40.92	$107.78	$56.98
NEW YORK	$179.55	$100.94	$193.74	$98.28
ONEIDA	$105.88	$45.91	$100.96	$55.54
ONTARIO	$107.36	$45.38	$94.58	$54.71
ORLEANS	$99.68	$46.37	$110.10	$53.11
OTSEGO	$133.38	$34.44	$151.35	$50.45
QUEENS	$148.88	$77.72	$157.51	$90.17
RICHMOND	$171.98	$79.10	$166.52	$88.63
ST LAWRENCE	$95.49	$49.45	$94.76	$57.65
SCHENECTADY	$148.16	$58.01	$142.96	$81.15
SCHUYLER	$127.32	$54.13	$111.57	$65.14
STEUBEN	$118.12	$50.56	$93.02	$58.70
SULLIVAN	$186.49	$65.22	$165.57	$68.73
TOMPKINS	$97.19	$46.77	$131.85	$57.51
WARREN	$119.37	$59.76	$131.99	$74.96
WAYNE	$112.12	$44.66	$85.10	$47.74
WYOMING	$91.11	$41.86	$80.19	$44.22
STATE: N. CAROLINA				
ALAMANCE	$101.51	$40.77	$137.78	$58.50
ALLEGHANY	$90.02	$32.47	$68.29	$34.21
ASHE	$102.21	$33.81	$101.93	$44.36
BEAUFORT	$107.66	$35.54	$119.78	$44.04
BLADEN	$109.90	$39.69	$102.20	$46.76
BUNCOMBE	$83.54	$43.48	$93.90	$56.19
CABARRUS	$109.65	$43.15	$124.98	$56.37
CAMDEN	$100.78	$45.61	$94.19	$42.06
CASWELL	$85.18	$35.80	$115.50	$52.23
CHATHAM	$126.16	$44.07	$145.39	$55.61
CHOWAN	$94.55	$43.25	$95.61	$45.79

STATE: NEW MEXICO COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
SOCORRO	$107.51	$54.08	$99.69	$47.69
TORRANCE	$99.94	$49.04	$77.43	$50.31
VALENCIA	$110.98	$58.15	$96.56	$67.75
STATE: NEW YORK				
ALLEGANY	$113.21	$49.53	$119.05	$64.02
BROOME	$126.46	$57.16	$129.43	$72.82
CAYUGA	$95.09	$45.66	$96.77	$58.51
CHEMUNG	$132.83	$64.72	$129.75	$84.48
CLINTON	$109.47	$63.65	$117.21	$76.34
CORTLAND	$105.99	$42.48	$102.84	$53.23
DUTCHESS	$104.72	$55.38	$86.21	$58.26
ESSEX	$117.69	$59.11	$106.40	$61.83
FULTON	$106.15	$50.92	$99.55	$57.78
GREENE	$106.14	$43.67	$116.24	$51.93
HERKIMER	$103.41	$36.94	$89.90	$39.51
KINGS	$163.20	$82.60	$160.04	$84.70
LIVINGSTON	$110.65	$42.67	$78.34	$41.50
MONROE	$129.47	$51.03	$134.88	$68.43
NASSAU	$149.82	$81.82	$166.61	$97.11
NIAGARA	$111.45	$50.75	$122.58	$66.76
ONONDAGA	$107.91	$52.12	$111.45	$71.19
ORANGE	$129.05	$58.77	$125.22	$73.65
OSWEGO	$92.86	$40.41	$97.77	$52.26
PUTNAM	$144.37	$69.20	$160.71	$87.32
RENSSELAER	$143.34	$62.29	$140.89	$77.25
ROCKLAND	$138.38	$83.66	$119.24	$94.60
SARATOGA	$122.80	$56.16	$121.33	$78.25
SCHOHARIE	$96.86	$36.46	$97.15	$47.22
SENECA	$100.96	$44.42	$98.85	$51.88
SUFFOLK	$118.17	$64.74	$114.29	$76.32
TIOGA	$117.28	$50.26	$136.68	$67.47
ULSTER	$108.45	$51.08	$112.01	$64.08
WASHINGTON	$134.20	$53.37	$127.34	$69.70
WESTCHESTER	$153.46	$80.57	$186.02	$96.87
YATES	$105.08	$42.13	$77.06	$47.92
STATE: N. CAROLINA				
ALEXANDER	$129.18	$42.08	$142.45	$54.79
ANSON	$97.33	$42.03	$117.05	$58.09
AVERY	$143.35	$43.90	$138.78	$53.15
BERTIE	$131.72	$40.96	$133.71	$52.26
BRUNSWICK	$132.20	$41.15	$148.35	$51.43
BURKE	$100.09	$38.40	$110.98	$41.45
CALDWELL	$128.26	$47.94	$135.38	$58.74
CARTERET	$114.10	$42.39	$123.44	$54.21
CATAWBA	$108.97	$39.63	$140.26	$57.71
CHEROKEE	$110.37	$39.66	$140.25	$57.94
CLAY	$91.36	$38.40	$88.13	$47.88

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: N. CAROLINA COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
CLEVELAND	$92.44	$33.56	$113.08	$46.90
CRAVEN	$120.27	$54.93	$129.03	$64.12
CURRITUCK	$116.41	$49.22	$107.72	$52.44
DAVIDSON	$93.43	$38.92	$124.28	$58.76
DUPLIN	$109.52	$40.59	$100.91	$42.66
EDGECOMBE	$106.20	$39.96	$120.94	$50.96
FRANKLIN	$117.09	$38.43	$124.76	$49.25
GATES	$115.60	$46.53	$111.97	$51.79
GRANVILLE	$120.34	$38.58	$94.93	$35.76
GUILFORD	$105.92	$48.21	$139.70	$65.79
HARNETT	$120.84	$42.69	$132.19	$53.69
HENDERSON	$89.78	$40.36	$110.69	$60.08
HOKE	$83.11	$38.53	$104.69	$47.14
IREDELL	$107.62	$39.74	$135.19	$56.25
JOHNSTON	$111.76	$44.93	$134.59	$60.88
LEE	$104.52	$42.48	$162.45	$62.82
LINCOLN	$121.60	$39.21	$139.77	$57.61
MACON	$106.07	$35.35	$118.26	$48.29
MARTIN	$128.64	$41.30	$117.12	$41.94
MITCHELL	$124.20	$41.49	$124.98	$51.56
MOORE	$89.61	$42.03	$131.32	$51.72
NEW HANOVER	$98.91	$38.89	$129.47	$53.08
ONSLOW	$123.03	$53.99	$139.34	$62.28
PAMLICO	$98.90	$44.11	$107.70	$51.77
PENDER	$94.90	$31.81	$102.67	$40.64
PERSON	$97.28	$36.91	$101.63	$48.75
POLK	$89.86	$38.22	$118.01	$53.95
RICHMOND	$116.30	$40.02	$118.47	$48.71
ROCKINGHAM	$106.67	$42.59	$146.31	$59.78
RUTHERFORD	$92.84	$35.27	$102.97	$47.73
SCOTLAND	$89.75	$39.00	$103.72	$46.13
STOKES	$127.84	$45.49	$151.39	$65.20
SWAIN	$100.89	$38.68	$110.55	$45.38
TYRRELL	$111.89	$45.90	$91.72	$45.22
VANCE	$78.22	$34.26	$99.46	$50.02
WARREN	$96.06	$38.46	$96.01	$38.93
WATAUGA	$118.00	$39.97	$116.99	$48.03
WILKES	$82.51	$34.98	$98.57	$44.94
YADKIN	$100.60	$38.50	$115.40	$52.25
STATE: N. DAKOTA				
ADAMS	$113.55	$46.67	$123.16	$49.06
BENSON	$144.92	$46.63	$114.31	$45.00
BOTTINEAU	$146.81	$48.50	$181.59	$55.48
BURKE	$132.43	$50.43	$141.13	$53.42
CASS	$132.73	$47.25	$163.83	$65.62
DICKEY	$121.30	$43.16	$186.10	$62.36
DUNN	$129.76	$46.59	$118.68	$44.35
EMMONS	$132.49	$51.38	$159.28	$79.31

STATE: N. CAROLINA COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
COLUMBUS	$130.98	$45.21	$143.64	$54.35
CUMBERLAND	$88.81	$42.47	$94.42	$51.00
DARE	$95.54	$44.51	$115.88	$55.86
DAVIE	$113.47	$42.26	$113.82	$54.68
DURHAM	$131.53	$48.99	$153.16	$66.21
FORSYTH	$93.01	$44.17	$121.45	$65.10
GASTON	$92.90	$37.13	$113.15	$51.93
GRAHAM	$91.83	$33.97	$88.07	$32.59
GREENE	$103.57	$46.38	$136.85	$65.49
HALIFAX	$96.58	$36.20	$120.79	$46.34
HAYWOOD	$96.42	$39.00	$96.52	$49.54
HERTFORD	$122.06	$43.75	$142.95	$54.47
HYDE	$88.06	$30.49	$69.69	$28.54
JACKSON	$91.19	$36.76	$105.17	$46.13
JONES	$124.85	$58.15	$133.49	$66.86
LENOIR	$112.34	$40.78	$113.61	$42.22
MC DOWELL	$77.26	$36.35	$90.83	$48.64
MADISON	$72.08	$36.36	$95.25	$54.55
MECKLENBURG	$109.20	$47.56	$138.34	$62.59
MONTGOMERY	$98.55	$36.90	$103.68	$43.13
NASH	$120.26	$45.50	$136.48	$57.95
NORTHAMPTON	$96.33	$35.81	$105.82	$44.70
ORANGE	$134.45	$51.45	$159.35	$65.01
PASQUOTANK	$90.00	$41.15	$101.69	$46.05
PERQUIMANS	$90.80	$39.88	$90.63	$48.66
PITT	$96.82	$42.23	$112.41	$54.38
RANDOLPH	$83.25	$38.34	$117.18	$57.80
ROBESON	$78.82	$37.94	$89.68	$44.76
ROWAN	$84.52	$37.28	$103.81	$53.08
SAMPSON	$114.93	$47.96	$127.99	$55.58
STANLY	$92.41	$38.20	$102.60	$49.49
SURRY	$94.73	$41.48	$102.90	$53.62
TRANSYLVANIA	$82.36	$40.18	$71.67	$42.54
UNION	$98.00	$37.98	$111.00	$51.76
WAKE	$131.91	$50.69	$162.23	$71.07
WASHINGTON	$120.99	$40.08	$98.60	$37.54
WAYNE	$92.03	$34.89	$103.38	$37.18
WILSON	$100.58	$52.41	$135.56	$67.94
YANCEY	$95.76	$36.83	$83.62	$45.49
STATE: N. DAKOTA				
BARNES	$123.92	$38.16	$138.84	$47.37
BILLINGS	$109.26	$38.38	$122.20	$51.81
BOWMAN	$121.25	$40.85	$123.21	$51.69
BURLEIGH	$126.16	$57.48	$156.64	$74.65
CAVALIER	$126.24	$43.23	$156.34	$63.07
DIVIDE	$141.91	$50.95	$147.77	$59.66
EDDY	$123.40	$43.67	$126.53	$63.72
FOSTER	$104.61	$44.29	$170.35	$68.00

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: N. DAKOTA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
GOLDEN VALLEY.....	$171.62	$59.70	$144.17	$41.84
GRANT.....	$155.86	$77.48	$90.04	$56.18
HETTINGER.....	$125.79	$54.85	$149.73	$73.33
LA MOURE.....	$117.31	$41.15	$159.49	$69.37
MC HENRY.....	$155.46	$53.06	$131.25	$48.07
MC KENZIE.....	$127.86	$53.84	$131.04	$62.91
MERCER.....	$151.20	$54.09	$208.52	$85.68
MOUNTRAIL.....	$125.33	$42.08	$222.86	$79.98
OLIVER.....	$131.44	$47.66	$166.98	$71.24
PIERCE.....	$141.06	$47.76	$106.27	$50.13
RANSOM.....	$106.41	$36.00	$108.53	$58.67
RICHLAND.....	$119.40	$36.47	$147.11	$47.20
SARGENT.....	$126.34	$43.45	$168.97	$63.27
SIOUX.....	$139.89	$58.50	$312.23	$89.49
STARK.....	$122.06	$47.51	$157.69	$63.49
STUTSMAN.....	$101.66	$43.77	$116.59	$47.89
TRAILL.....	$119.86	$37.62	$165.64	$48.48
WARD.....	$150.81	$55.30	$162.55	$71.51
WILLIAMS.....	$145.36	$52.73	$164.70	$71.31
STATE: OHIO				
ADAMS.....	$108.70	$36.18	$97.10	$41.46
ASHLAND.....	$102.33	$39.91	$130.86	$58.64
ATHENS.....	$114.82	$43.87	$102.58	$58.88
BELMONT.....	$152.85	$48.43	$150.30	$58.08
BUTLER.....	$129.36	$45.56	$159.54	$66.06
CHAMPAIGN.....	$112.47	$44.51	$122.54	$61.48
CLERMONT.....	$143.12	$48.79	$143.33	$61.11
COLUMBIANA.....	$127.83	$45.59	$146.80	$63.71
CRAWFORD.....	$123.04	$40.23	$156.99	$53.59
DARKE.....	$87.97	$34.26	$102.66	$49.93
DELAWARE.....	$111.12	$42.57	$133.31	$59.45
FAIRFIELD.....	$103.16	$39.56	$98.88	$50.70
FRANKLIN.....	$126.22	$54.14	$143.98	$71.40
GALLIA.....	$120.81	$45.16	$76.07	$45.41
GREENE.....	$109.39	$47.61	$149.70	$67.95
HAMILTON.....	$148.86	$52.35	$174.35	$70.20
HARDIN.....	$111.39	$36.89	$114.35	$48.66
HENRY.....	$117.58	$39.28	$158.52	$69.33
HOCKING.....	$101.89	$42.97	$111.59	$56.44
HURON.....	$134.26	$44.80	$160.72	$61.82
JEFFERSON.....	$187.68	$50.32	$218.71	$67.69
LAKE.....	$137.86	$58.73	$177.10	$78.71
LICKING.....	$90.14	$40.63	$114.25	$58.71
LORAIN.....	$152.01	$57.11	$181.36	$77.27
MADISON.....	$135.80	$53.57	$155.84	$72.76
MARION.....	$127.18	$50.60	$151.94	$70.55
MEIGS.....	$119.30	$40.42	$109.16	$47.80
MIAMI.....	$109.96	$41.88	$138.28	$61.00

STATE: N. DAKOTA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
GRAND FORKS.....	$117.73	$46.26	$143.28	$59.99
GRIGGS.....	$106.96	$37.72	$142.96	$35.52
KIDDER.....	$110.82	$46.75	$237.78	$132.34
LOGAN.....	$143.97	$49.67	$108.54	$55.08
MC INTOSH.....	$115.20	$43.28	$168.57	$72.96
MC LEAN.....	$143.00	$55.25	$138.32	$90.23
MORTON.....	$143.26	$58.05	$166.06	$76.89
NELSON.....	$129.07	$40.33	$175.37	$48.56
PEMBINA.....	$127.37	$47.59	$151.32	$64.61
RAMSEY.....	$126.83	$48.15	$163.28	$57.34
RENVILLE.....	$136.09	$49.40	$177.93	$73.41
ROLETTE.....	$175.27	$52.36	$124.27	$43.27
SHERIDAN.....	$127.08	$44.71	$194.83	$92.68
SLOPE.....	$112.33	$38.21	$166.53	$72.75
STEELE.....	$124.55	$44.12	$196.39	$87.68
TOWNER.....	$135.80	$49.05	$211.00	$81.62
WALSH.....	$123.97	$45.85	$88.57	$35.99
WELLS.....	$133.32	$49.31	$125.57	$67.41
STATE: OHIO				
ALLEN.....	$112.99	$35.57	$142.33	$52.21
ASHTABULA.....	$120.54	$48.58	$132.74	$63.75
AUGLAIZE.....	$123.42	$36.94	$157.26	$61.45
BROWN.....	$101.55	$33.21	$124.64	$47.69
CARROLL.....	$106.49	$44.91	$127.05	$64.46
CLARK.....	$124.41	$45.73	$148.64	$65.65
CLINTON.....	$112.16	$38.72	$125.85	$56.92
COSHOCTON.....	$103.09	$33.47	$114.37	$49.61
CUYAHOGA.....	$177.67	$63.93	$197.05	$78.77
DEFIANCE.....	$116.68	$45.11	$169.22	$62.22
ERIE.....	$167.08	$56.76	$220.53	$83.38
FAYETTE.....	$78.83	$32.54	$92.52	$40.27
FULTON.....	$141.85	$42.01	$169.25	$55.84
GEAUGA.....	$149.57	$56.90	$186.97	$83.03
GUERNSEY.....	$125.73	$41.58	$107.63	$60.43
HANCOCK.....	$100.81	$33.81	$126.00	$48.62
HARRISON.....	$127.36	$44.21	$110.99	$50.93
HIGHLAND.....	$111.12	$37.99	$100.75	$44.01
HOLMES.....	$58.16	$25.04	$70.57	$35.97
JACKSON.....	$97.46	$34.73	$82.67	$38.39
KNOX.....	$100.04	$36.36	$81.96	$46.96
LAWRENCE.....	$101.88	$37.68	$94.58	$46.79
LOGAN.....	$125.71	$46.35	$122.13	$59.39
LUCAS.....	$201.28	$64.61	$239.90	$91.97
MAHONING.....	$163.64	$61.25	$180.76	$82.01
MEDINA.....	$121.48	$48.91	$150.79	$67.30
MERCER.....	$129.71	$37.98	$147.93	$55.82
MONROE.....	$108.78	$36.07	$128.62	$43.23

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: OHIO COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
MONTGOMERY	$150.27	$54.30	$167.65	$74.18
MORROW	$112.83	$35.69	$116.18	$54.47
NOBLE	$108.26	$33.78	$108.38	$40.00
PAULDING	$140.58	$41.54	$136.22	$53.61
PICKAWAY	$95.80	$42.69	$64.46	$45.94
PORTAGE	$145.39	$47.67	$184.68	$66.24
PUTNAM	$119.29	$43.27	$132.38	$64.09
ROSS	$100.19	$36.00	$84.51	$38.21
SCIOTO	$120.44	$43.34	$130.66	$59.11
SHELBY	$101.08	$37.67	$137.27	$59.62
SUMMIT	$149.13	$57.35	$172.86	$79.08
TUSCARAWAS	$90.25	$35.66	$104.18	$51.86
VAN WERT	$118.04	$40.34	$124.64	$60.30
WARREN	$118.71	$46.47	$146.08	$66.01
WAYNE	$91.59	$36.27	$91.47	$49.88
WOOD	$146.49	$50.41	$196.37	$67.20
STATE: OKLAHOMA				
ADAIR	$97.40	$39.65	$93.10	$45.08
ATOKA	$93.61	$38.94	$104.20	$47.40
BECKHAM	$98.04	$35.45	$93.15	$40.64
BRYAN	$95.65	$43.28	$109.72	$56.60
CANADIAN	$120.24	$45.98	$150.86	$68.90
CHEROKEE	$107.38	$47.23	$110.17	$55.32
CIMARRON	$101.70	$38.78	$124.41	$51.83
COAL	$97.63	$36.30	$83.15	$35.02
COTTON	$85.20	$33.48	$94.03	$42.89
CREEK	$131.36	$48.28	$162.75	$59.83
DELAWARE	$100.19	$38.55	$98.41	$42.30
ELLIS	$128.49	$43.15	$160.97	$46.38
GARVIN	$95.69	$36.06	$107.96	$44.47
GRANT	$127.88	$42.39	$149.00	$58.07
HARMON	$99.85	$38.23	$71.05	$37.21
HASKELL	$88.25	$44.42	$93.83	$51.04
JACKSON	$115.69	$40.83	$111.74	$42.88
JOHNSTON	$87.31	$37.98	$94.96	$49.91
KINGFISHER	$131.75	$42.42	$138.15	$48.80
LATIMER	$91.66	$39.20	$65.10	$35.42
LINCOLN	$99.33	$37.91	$118.03	$48.34
LOVE	$120.29	$49.56	$117.41	$46.76
MC CURTAIN	$90.94	$41.90	$85.11	$42.24
MAJOR	$92.48	$31.46	$98.52	$38.27
MAYES	$124.37	$43.11	$112.39	$47.46
MUSKOGEE	$107.40	$40.57	$101.95	$44.12
NOWATA	$96.90	$37.62	$88.70	$38.38
OKLAHOMA	$132.17	$56.18	$146.70	$67.73
OSAGE	$130.44	$41.08	$130.88	$48.58
PAWNEE	$151.43	$51.48	$150.11	$62.30
PITTSBURG	$98.04	$42.78	$110.50	$50.61

STATE: OHIO COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
MORGAN	$95.54	$36.09	$106.60	$42.11
MUSKINGUM	$106.55	$34.66	$121.58	$52.44
OTTAWA	$159.94	$52.56	$157.87	$66.80
PERRY	$104.35	$36.15	$102.40	$45.11
PIKE	$85.85	$38.54	$79.92	$41.58
PREBLE	$106.94	$39.19	$139.09	$55.40
RICHLAND	$104.59	$40.44	$124.21	$54.69
SANDUSKY	$156.41	$48.81	$170.10	$70.23
SENECA	$126.69	$44.68	$122.25	$57.31
STARK	$120.88	$50.30	$135.49	$68.89
TRUMBULL	$155.38	$58.72	$177.40	$77.69
UNION	$125.22	$44.73	$170.61	$70.71
VINTON	$97.49	$33.99	$79.40	$37.89
WASHINGTON	$128.03	$40.24	$139.01	$56.31
WILLIAMS	$115.90	$41.56	$139.77	$54.72
WYANDOT	$107.08	$41.67	$136.59	$62.98
STATE: OKLAHOMA				
ALFALFA	$133.24	$38.06	$156.50	$48.44
BEAVER	$95.36	$42.68	$100.47	$45.99
BLAINE	$110.76	$37.35	$133.57	$46.03
CADDO	$108.24	$42.65	$99.81	$40.15
CARTER	$92.31	$41.75	$88.22	$41.04
CHOCTAW	$95.75	$48.75	$106.69	$45.78
CLEVELAND	$116.54	$49.32	$132.11	$59.77
COMANCHE	$114.20	$42.27	$107.98	$47.91
CRAIG	$99.13	$35.54	$109.39	$43.13
CUSTER	$123.18	$45.72	$142.99	$60.64
DEWEY	$123.80	$37.79	$123.16	$36.82
GARFIELD	$124.65	$38.68	$134.65	$45.75
GRADY	$102.30	$44.91	$108.96	$52.83
GREER	$125.00	$44.71	$104.07	$46.75
HARPER	$96.27	$35.60	$74.79	$32.08
HUGHES	$120.33	$41.60	$117.69	$45.91
JEFFERSON	$93.79	$40.54	$76.45	$39.46
KAY	$104.76	$40.56	$103.10	$43.30
KIOWA	$101.96	$39.39	$122.63	$53.08
LE FLORE	$85.91	$44.51	$79.27	$48.41
LOGAN	$122.52	$44.32	$121.03	$51.15
MC CLAIN	$100.25	$40.89	$115.85	$53.49
MC INTOSH	$100.00	$45.38	$96.56	$50.63
MARSHALL	$103.93	$46.14	$90.74	$41.88
MURRAY	$96.70	$38.67	$100.42	$41.85
NOBLE	$95.39	$31.83	$102.45	$36.06
OKFUSKEE	$109.22	$40.42	$123.36	$52.36
OKMULGEE	$119.81	$49.67	$110.29	$52.31
OTTAWA	$131.11	$47.57	$126.97	$48.86
PAYNE	$106.10	$37.54	$111.62	$40.48
PONTOTOC	$96.17	$42.09	$94.01	$45.30

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: OKLAHOMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
POTTAWATOMIE	$78.09	$37.11	$84.56	$44.71
ROGER MILLS	$107.93	$39.66	$128.78	$46.86
SEMINOLE	$98.39	$39.29	$89.61	$40.44
STEPHENS	$114.78	$42.18	$121.52	$45.89
TILLMAN	$116.72	$40.90	$117.23	$45.34
WAGONER	$131.58	$43.77	$138.38	$61.38
WASHITA	$113.53	$40.12	$136.53	$52.35
WOODWARD	$116.89	$39.57	$129.14	$48.46
STATE: OREGON				
BAKER	$128.70	$47.35	$129.60	$56.65
CLACKAMAS	$116.28	$57.62	$160.43	$88.93
COLUMBIA	$139.46	$52.35	$133.41	$70.24
CROOK	$109.86	$44.12	$110.25	$50.26
DESCHUTES	$110.46	$52.64	$118.40	$67.40
GILLIAM	$117.36	$45.94	$36.46	$25.49
HARNEY	$152.25	$47.81	$153.29	$51.15
JACKSON	$111.52	$51.17	$114.20	$63.41
JOSEPHINE	$92.13	$42.01	$93.94	$54.39
LAKE	$131.02	$49.58	$119.42	$49.57
LINCOLN	$136.68	$49.06	$130.45	$61.99
MALHEUR	$98.27	$39.55	$77.68	$46.24
MORROW	$141.39	$48.86	$138.44	$55.58
POLK	$108.12	$51.77	$103.09	$63.08
TILLAMOOK	$160.72	$54.49	$172.03	$72.76
UNION	$120.24	$47.04	$132.52	$69.15
WASCO	$136.72	$47.78	$141.19	$66.95
WHEELER	$135.01	$45.89	$218.85	$46.25
STATE: PENNSYLVANIA				
ADAMS	$81.00	$39.43	$98.99	$52.89
ARMSTRONG	$110.04	$46.05	$116.43	$52.18
BEDFORD	$98.13	$37.58	$98.36	$46.48
BLAIR	$120.09	$42.62	$122.40	$54.81
BUCKS	$145.73	$73.76	$206.98	$107.62
CAMBRIA	$167.37	$57.99	$158.40	$63.37
CARBON	$124.22	$56.19	$130.22	$80.45
CHESTER	$141.16	$61.09	$155.06	$73.35
CLEARFIELD	$122.91	$47.54	$117.53	$54.65
COLUMBIA	$110.90	$46.29	$116.90	$62.54
CUMBERLAND	$95.30	$50.21	$117.13	$71.89
DELAWARE	$159.89	$72.91	$201.57	$94.48
ERIE	$134.58	$49.32	$143.85	$65.17
FOREST	$154.23	$51.60	$130.35	$55.15
FULTON	$103.76	$41.49	$68.48	$37.35
HUNTINGDON	$108.34	$45.88	$113.07	$54.90
JEFFERSON	$100.84	$42.93	$114.08	$58.33
LACKAWANNA	$145.41	$59.85	$136.70	$74.99
LAWRENCE	$122.60	$47.67	$115.58	$58.21

STATE: OKLAHOMA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
PUSHMATAHA	$81.22	$37.04	$77.52	$45.40
ROGERS	$116.80	$47.67	$112.95	$55.03
SEQUOYAH	$92.87	$42.95	$85.40	$48.86
TEXAS	$114.90	$47.02	$115.29	$49.10
TULSA	$146.76	$59.71	$176.06	$75.63
WASHINGTON	$95.08	$38.74	$133.38	$54.11
WOODS	$121.90	$37.20	$141.29	$49.50
STATE: OREGON				
BENTON	$102.90	$51.17	$121.44	$78.89
CLATSOP	$161.37	$51.62	$157.11	$62.68
COOS	$116.11	$61.83	$114.13	$73.01
CURRY	$123.59	$56.03	$120.79	$59.31
DOUGLAS	$129.87	$52.39	$120.28	$64.64
GRANT	$109.34	$41.62	$137.58	$64.38
HOOD RIVER	$120.24	$42.32	$97.52	$53.49
JEFFERSON	$109.62	$48.26	$118.41	$55.67
KLAMATH	$96.12	$50.82	$113.89	$71.18
LANE	$91.63	$55.75	$108.95	$75.75
LINN	$103.05	$50.45	$101.35	$59.92
MARION	$93.67	$49.35	$88.55	$56.18
MULTNOMAH	$167.60	$64.97	$200.50	$88.41
SHERMAN	$144.35	$46.18	$109.08	$45.05
UMATILLA	$123.51	$47.83	$137.30	$77.64
WALLOWA	$158.55	$53.13	$159.31	$66.87
WASHINGTON	$143.24	$61.84	$190.09	$91.50
YAMHILL	$111.07	$50.49	$106.48	$57.97
STATE: PENNSYLVANIA				
ALLEGHENY	$179.21	$60.48	$190.32	$74.71
BEAVER	$139.24	$50.89	$146.69	$67.29
BERKS	$109.13	$50.30	$121.27	$66.08
BRADFORD	$131.03	$47.29	$125.74	$63.43
BUTLER	$129.16	$51.01	$136.72	$57.51
CAMERON	$119.81	$46.83	$131.10	$56.89
CENTRE	$117.00	$43.50	$113.31	$56.58
CLARION	$126.43	$47.23	$123.61	$57.73
CLINTON	$132.20	$54.32	$156.44	$73.98
CRAWFORD	$121.95	$46.17	$141.58	$63.41
DAUPHIN	$118.39	$56.36	$130.54	$80.29
ELK	$130.03	$52.15	$132.30	$75.77
FAYETTE	$121.61	$50.88	$117.98	$52.27
FRANKLIN	$81.64	$37.79	$86.35	$47.52
GREENE	$132.59	$52.32	$105.78	$47.91
INDIANA	$127.34	$51.31	$111.47	$47.97
JUNIATA	$93.10	$45.10	$111.44	$60.46
LANCASTER	$90.34	$39.43	$131.09	$60.90
LEBANON	$96.38	$41.41	$103.61	$52.78

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: PENNSYLVANIA COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
LEHIGH	$121.70	$63.61	$154.81	$90.18
LYCOMING	$131.74	$56.01	$142.30	$69.61
MERCER	$123.46	$54.52	$134.82	$62.46
MONROE	$105.65	$56.80	$116.04	$67.16
MONTOUR	$90.22	$62.26	$90.86	$103.68
NORTHUMBERLAND	$97.85	$45.33	$94.36	$57.32
PHILADELPHIA	$196.96	$90.25	$205.16	$97.00
POTTER	$116.51	$48.69	$118.99	$51.16
SNYDER	$86.48	$41.78	$71.06	$43.06
SULLIVAN	$122.87	$47.77	$112.69	$55.62
TIOGA	$118.82	$48.20	$115.17	$56.39
VENANGO	$147.17	$50.64	$134.11	$47.27
WASHINGTON	$155.24	$52.27	$148.26	$56.60
WESTMORELAND	$143.80	$55.37	$152.42	$69.76
YORK	$94.57	$44.31	$105.70	$58.42
STATE: PUERTO RICO				
ADJUNTAS	$29.21	$26.69	$13.81	$19.47
AGUADILLA	$18.21	$17.13	$12.85	$16.95
AIBONITO	$22.07	$27.33	$11.57	$17.93
ARECIBO	$13.75	$21.75	$13.23	$19.64
BARCELONETA	$14.50	$19.25	$12.44	$17.64
BAYAMON	$34.16	$34.37	$20.24	$28.41
CAGUAS	$23.31	$30.15	$15.83	$26.47
CANOVANAS	$27.92	$31.28	$12.49	$18.11
CATANO	$31.38	$30.08	$17.04	$25.45
CEIBA	$21.83	$20.28	$19.71	$20.52
CIDRA	$17.17	$23.85	$10.23	$15.78
COMERIO	$19.52	$27.98	$13.00	$23.44
CULEBRA	$24.99	$29.56	$40.94	$9.05
FAJARDO	$26.31	$26.36	$18.07	$22.34
GUANICA	$32.07	$28.15	$20.59	$21.21
GUAYANILLA	$29.60	$27.06	$14.69	$14.36
GURABO	$25.42	$31.37	$18.84	$28.31
HORMIGUEROS	$25.75	$22.91	$17.43	$46.85
ISABELA	$14.68	$19.45	$11.31	$13.02
JUANA DIAZ	$25.95	$22.75	$15.62	$17.96
LAJAS	$28.52	$20.71	$19.90	$34.62
LAS MARIAS	$18.93	$14.57	$9.51	$10.74
LOIZA	$18.54	$21.83	$16.27	$18.55
MANATI	$19.10	$27.00	$14.10	$20.89
MAUNABO	$21.35	$23.15	$8.88	$12.41
MOCA	$15.38	$20.52	$8.64	$15.05
NAGUABO	$23.51	$24.81	$17.85	$20.39
OROCOVIS	$21.78	$35.70	$10.14	$20.92
PENUELAS	$32.29	$28.82	$14.23	$20.16
QUEBRADILLAS	$17.25	$21.17	$11.59	$17.40
RIO GRANDE	$26.59	$28.19	$24.07	$25.63
SALINAS	$35.53	$25.95	$21.40	$22.16

STATE: PENNSYLVANIA COUNTY NAME	****** AGED PART A	****** PART B	*** DISABLED *** PART A	PART B
LUZERNE	$130.46	$62.14	$111.97	$67.13
MC KEAN	$113.75	$43.12	$115.28	$55.34
MIFFLIN	$106.46	$49.57	$103.68	$53.23
MONTGOMERY	$140.56	$70.17	$187.51	$94.15
NORTHAMPTON	$126.20	$59.72	$149.16	$78.47
PERRY	$113.24	$51.32	$108.92	$66.65
PIKE	$114.44	$49.77	$107.81	$54.18
SCHUYLKILL	$124.71	$50.98	$114.56	$63.07
SOMERSET	$114.01	$47.48	$126.82	$56.84
SUSQUEHANNA	$106.12	$47.65	$108.23	$58.54
UNION	$78.22	$38.53	$81.15	$45.64
WARREN	$108.36	$47.99	$133.02	$82.31
WAYNE	$118.18	$53.43	$112.32	$59.60
WYOMING	$140.64	$52.58	$152.87	$78.13
STATE: PUERTO RICO				
AGUADA	$14.74	$19.84	$14.22	$14.32
AGUAS BUENAS	$17.05	$25.58	$8.29	$25.17
ANASCO	$22.01	$23.04	$18.08	$29.51
ARROYO	$30.33	$26.80	$21.85	$24.45
BARRANQUITAS	$21.18	$29.20	$9.21	$24.12
CABO ROJO	$21.31	$20.36	$13.59	$20.53
CAMUY	$15.40	$19.40	$10.57	$14.98
CAROLINA	$35.53	$31.52	$23.80	$26.88
CAYEY	$25.34	$27.71	$10.61	$17.21
CIALES	$22.71	$32.80	$10.83	$17.39
COAMO	$23.42	$29.58	$19.68	$25.76
COROZAL	$25.10	$37.13	$13.27	$21.93
DORADO	$26.85	$26.10	$13.81	$24.61
FLORIDA	$17.80	$23.66	$5.92	$6.97
GUAYAMA	$35.78	$28.14	$25.34	$40.99
GUAYNABO	$31.56	$35.94	$21.43	$32.57
HATILLO	$13.62	$20.50	$12.22	$13.04
HUMACAO	$35.51	$31.43	$25.32	$23.64
JAYUYA	$20.46	$19.18	$9.23	$15.59
JUNCOS	$22.88	$29.07	$13.97	$22.45
LARES	$18.43	$20.40	$13.41	$12.93
LAS PIEDRAS	$29.83	$28.58	$20.48	$26.04
LUQUILLO	$24.86	$25.48	$19.88	$25.31
MARICAO	$20.84	$19.06	$6.88	$14.59
MAYAGUEZ	$24.22	$23.81	$16.88	$24.97
MOROVIS	$18.25	$31.41	$8.71	$15.86
NARANJITO	$18.06	$33.81	$6.41	$13.78
PATILLAS	$28.99	$24.74	$19.25	$17.44
PONCE	$32.88	$25.84	$24.34	$28.67
RINCON	$20.28	$18.55	$17.20	$36.89
SABANA GRANDE	$28.97	$22.79	$21.60	$20.71
SAN GERMAN	$31.41	$23.81	$19.82	$21.57

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: PUERTO RICO COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SAN JUAN	$37.13	$38.12	$27.12	$30.36
SAN SEBASTIAN	$18.56	$19.89	$12.74	$12.41
TOA ALTA	$25.75	$31.03	$14.44	$21.20
TRUJILLO ALTO	$32.22	$32.59	$20.16	$26.09
VEGA ALTA	$27.02	$30.63	$14.98	$21.45
VIEQUES	$25.54	$24.54	$19.64	$19.42
YABUCOA	$23.61	$24.23	$19.84	$19.84
STATE: RHODE ISLAND				
BRISTOL	$125.18	$53.12	$123.99	$61.42
NEWPORT	$145.60	$65.66	$118.77	$60.69
WASHINGTON	$123.40	$61.32	$124.47	$69.06
STATE: S. CAROLINA				
ABBEVILLE	$72.09	$26.52	$87.03	$40.08
ALLENDALE	$84.52	$33.15	$90.41	$32.15
BAMBERG	$93.57	$43.53	$90.01	$44.60
BEAUFORT	$123.57	$46.81	$125.99	$57.93
CALHOUN	$61.26	$35.39	$72.09	$34.73
CHEROKEE	$77.09	$33.63	$88.73	$40.57
CHESTERFIELD	$95.83	$36.05	$90.38	$39.60
COLLETON	$130.11	$45.53	$131.31	$50.55
DILLON	$122.12	$44.08	$124.98	$46.96
EDGEFIELD	$85.51	$35.38	$93.97	$42.85
FLORENCE	$93.19	$38.99	$106.98	$47.54
GREENVILLE	$92.33	$36.65	$100.59	$49.79
HAMPTON	$102.08	$37.79	$107.71	$44.65
JASPER	$133.77	$47.91	$142.29	$57.31
LANCASTER	$81.75	$34.25	$89.03	$42.91
LEE	$88.42	$30.24	$73.04	$30.73
MC CORMICK	$70.36	$30.04	$68.94	$35.31
MARLBORO	$93.47	$34.22	$106.80	$38.23
OCONEE	$86.53	$35.72	$93.40	$44.26
PICKENS	$91.27	$34.61	$105.35	$44.92
SALUDA	$70.61	$29.92	$83.49	$36.87
SUMTER	$78.92	$32.38	$82.60	$36.94
WILLIAMSBURG	$91.38	$34.40	$100.60	$37.67
STATE: S. DAKOTA				
AURORA	$135.74	$32.62	$91.58	$23.56
BENNETT	$113.13	$41.03	$158.91	$67.42
BROOKINGS	$87.68	$33.01	$79.29	$38.06
BRULE	$142.31	$39.47	$141.84	$40.30
BUTTE	$86.95	$33.16	$64.92	$31.07
CHARLES MIX	$92.84	$29.29	$73.75	$23.32
CLAY	$121.29	$42.40	$84.43	$38.47
CORSON	$111.55	$38.50	$135.25	$47.46
DAVISON	$145.80	$33.78	$127.03	$38.29
DEUEL	$110.71	$30.72	$93.19	$36.14

STATE: PUERTO RICO COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SAN LORENZO	$18.96	$25.20	$17.08	$24.87
SANTA ISABEL	$30.03	$25.91	$15.63	$17.87
TOA BAJA	$26.60	$27.26	$16.14	$24.68
UTUADO	$20.34	$19.64	$15.23	$16.78
VEGA BAJA	$23.13	$29.68	$15.26	$25.16
VILLALBA	$20.75	$23.63	$14.94	$20.20
YAUCO	$27.24	$30.74	$19.99	$20.88
STATE: RHODE ISLAND				
KENT	$125.05	$67.90	$131.66	$74.83
PROVIDENCE	$134.50	$66.36	$134.32	$73.40
STATE: S. CAROLINA				
AIKEN	$110.12	$49.81	$104.42	$61.24
ANDERSON	$74.77	$39.88	$89.72	$50.31
BARNWELL	$89.72	$41.50	$88.68	$50.87
BERKELEY	$105.65	$41.97	$101.32	$46.87
CHARLESTON	$114.16	$47.63	$104.55	$47.22
CHESTER	$97.75	$33.69	$104.83	$40.28
CLARENDON	$85.87	$31.41	$90.96	$38.18
DARLINGTON	$97.83	$37.72	$114.51	$47.06
DORCHESTER	$98.14	$39.67	$90.79	$48.42
FAIRFIELD	$93.79	$36.46	$87.50	$36.15
GEORGETOWN	$100.55	$34.97	$110.81	$40.58
GREENWOOD	$85.49	$32.10	$104.39	$46.14
HORRY	$106.56	$40.27	$106.37	$43.72
KERSHAW	$96.34	$41.05	$96.65	$46.27
LAURENS	$79.30	$28.47	$81.94	$27.74
LEXINGTON	$120.93	$47.68	$125.96	$58.33
MARION	$114.72	$42.38	$121.01	$45.65
NEWBERRY	$91.99	$31.03	$86.48	$36.55
ORANGEBURG	$67.62	$37.16	$70.75	$40.68
RICHLAND	$101.34	$44.70	$101.89	$53.41
SPARTANBURG	$95.49	$40.67	$102.55	$53.20
UNION	$92.08	$31.37	$101.47	$44.56
YORK	$80.07	$33.11	$94.61	$45.74
STATE: S. DAKOTA				
BEADLE	$109.93	$39.78	$104.26	$45.22
BON HOMME	$104.48	$33.24	$87.80	$42.94
BROWN	$137.75	$42.27	$144.20	$55.90
BUFFALO	$199.16	$51.64	$196.91	$64.43
CAMPBELL	$105.99	$39.19	$135.65	$47.82
CLARK	$100.13	$37.14	$70.40	$37.34
CODINGTON	$99.12	$33.88	$91.12	$38.64
CUSTER	$94.27	$36.44	$79.23	$36.67
DAY	$137.76	$43.76	$142.01	$54.52
DEWEY	$112.49	$37.43	$104.57	$48.47

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: S. DAKOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
DOUGLAS	$89.95	$28.22	$147.09	$59.04
FALL RIVER	$78.92	$28.13	$51.86	$24.96
GRANT	$103.51	$34.10	$165.35	$85.07
HAAKON	$102.37	$42.33	$113.28	$41.81
HAND	$113.25	$35.31	$88.32	$50.01
HARDING	$106.79	$36.23	$104.38	$44.85
HUTCHINSON	$77.59	$26.65	$104.09	$49.50
JACKSON	$77.99	$34.92	$140.32	$51.98
JONES	$113.60	$35.75	$110.48	$47.20
LAKE	$104.69	$34.17	$104.17	$47.69
LINCOLN	$99.90	$31.55	$129.20	$53.48
MC COOK	$97.31	$30.02	$91.89	$38.87
MARSHALL	$144.60	$39.00	$122.43	$45.90
MELLETTE	$83.76	$37.80	$113.60	$49.13
MINNEHAHA	$107.92	$36.77	$118.94	$49.31
PENNINGTON	$93.91	$44.43	$78.17	$46.20
POTTER	$170.72	$51.90	$226.30	$69.65
SANBORN	$128.16	$35.22	$106.38	$50.29
SPINK	$139.51	$42.76	$105.36	$35.60
SULLY	$126.19	$38.73	$121.21	$44.45
TRIPP	$135.93	$38.83	$106.81	$44.47
UNION	$111.45	$35.51	$131.29	$48.17
WASHABAUGH	$84.71	$33.87	$123.71	$54.19
ZIEBACH	$97.22	$30.07	$104.23	$44.48
STATE: TENNESSEE				
ANDERSON	$95.98	$38.01	$96.48	$50.62
BENTON	$110.42	$36.52	$110.24	$49.07
BLOUNT	$96.33	$38.53	$108.10	$50.99
CAMPBELL	$104.85	$46.82	$85.65	$45.52
CARROLL	$103.03	$33.83	$114.41	$46.97
CHEATHAM	$114.25	$44.98	$113.62	$49.58
CLAIBORNE	$75.83	$33.17	$77.12	$41.60
COCKE	$79.89	$29.46	$83.36	$40.03
CROCKETT	$75.73	$36.19	$77.67	$40.40
DAVIDSON	$135.14	$50.48	$145.92	$61.72
DE KALB	$119.30	$38.01	$131.46	$49.87
DYER	$89.31	$42.56	$97.92	$49.21
FENTRESS	$111.47	$43.48	$109.93	$48.87
GIBSON	$111.63	$36.62	$124.07	$50.00
GRAINGER	$82.72	$34.43	$72.05	$36.87
GRUNDY	$98.11	$42.06	$92.42	$41.89
HAMILTON	$122.39	$47.47	$132.63	$61.51
HARDEMAN	$87.28	$30.88	$122.38	$44.73
HAWKINS	$103.93	$35.85	$107.60	$44.94
HENDERSON	$65.62	$27.50	$77.43	$40.04
HICKMAN	$123.88	$46.34	$101.38	$49.19
HUMPHREYS	$136.82	$45.90	$125.20	$51.96
JEFFERSON	$87.38	$33.15	$103.80	$47.01

STATE: S. DAKOTA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
EDMUNDS	$138.79	$42.76	$133.38	$57.94
FAULK	$160.34	$44.53	$134.86	$66.20
GREGORY	$110.23	$28.93	$93.85	$27.96
HAMLIN	$90.97	$31.93	$156.65	$50.64
HANSON	$111.87	$28.23	$168.50	$52.23
HUGHES	$118.32	$39.74	$138.26	$46.70
HYDE	$101.48	$33.77	$143.13	$71.51
JERAULD	$115.33	$34.95	$171.09	$50.93
KINGSBURY	$96.62	$34.07	$78.27	$37.41
LAWRENCE	$92.41	$37.85	$90.08	$31.49
LYMAN	$140.22	$38.32	$149.74	$48.68
MC PHERSON	$120.70	$40.33	$142.61	$58.33
MEADE	$82.82	$39.05	$75.48	$40.55
MINER	$112.61	$33.99	$121.68	$50.41
MOODY	$88.77	$31.63	$91.73	$40.73
PERKINS	$105.20	$42.84	$135.32	$51.19
ROBERTS	$112.94	$35.20	$103.17	$44.43
SHANNON	$87.56	$25.34	$42.13	$18.06
STANLEY	$155.26	$50.07	$92.97	$41.94
TODD	$80.52	$30.57	$84.43	$15.92
TURNER	$73.74	$25.79	$88.95	$42.17
WALWORTH	$98.84	$33.44	$133.04	$41.56
YANKTON	$92.41	$34.04	$117.46	$46.17
STATE: TENNESSEE				
BEDFORD	$83.18	$31.68	$79.85	$38.81
BLEDSOE	$99.20	$39.33	$93.14	$48.11
BRADLEY	$101.35	$38.35	$107.29	$46.70
CANNON	$139.11	$42.18	$159.55	$55.30
CARTER	$82.14	$30.96	$73.23	$39.05
CHESTER	$63.26	$27.02	$70.09	$35.81
CLAY	$111.88	$40.13	$106.29	$45.16
COFFEE	$110.30	$43.01	$112.44	$52.28
CUMBERLAND	$99.33	$41.93	$106.55	$49.00
DECATUR	$95.55	$33.91	$87.42	$37.70
DICKSON	$112.77	$45.31	$101.76	$50.22
FAYETTE	$89.72	$34.34	$89.43	$43.73
FRANKLIN	$96.71	$40.64	$96.22	$47.69
GILES	$121.14	$46.72	$145.96	$66.38
GREENE	$84.00	$30.54	$100.41	$44.56
HAMBLEN	$114.38	$41.66	$121.15	$53.79
HANCOCK	$92.96	$31.67	$114.55	$44.50
HARDIN	$88.79	$35.87	$81.82	$42.11
HAYWOOD	$82.68	$32.48	$96.31	$46.46
HENRY	$89.19	$37.94	$92.93	$45.60
HOUSTON	$93.40	$32.56	$82.58	$37.86
JACKSON	$100.51	$37.47	$97.57	$45.26
JOHNSON	$106.42	$37.04	$91.02	$40.87

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TENNESSEE COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
KNOX	$103.36	$43.72	$118.20	$58.40
LAUDERDALE	$96.34	$37.40	$102.19	$45.94
LEWIS	$146.74	$39.46	$143.61	$44.87
LOUDON	$95.18	$35.81	$118.75	$54.90
MC NAIRY	$83.49	$31.22	$92.75	$36.86
MADISON	$87.97	$36.21	$96.76	$49.92
MARSHALL	$129.88	$45.51	$139.96	$69.20
MEIGS	$106.61	$36.35	$102.71	$46.29
MONTGOMERY	$79.21	$36.69	$83.91	$47.49
MORGAN	$92.57	$42.80	$64.28	$40.90
OVERTON	$105.36	$39.67	$117.37	$48.16
PICKETT	$136.47	$41.21	$118.74	$47.25
PUTNAM	$94.82	$40.01	$99.47	$50.28
ROANE	$108.77	$41.45	$109.81	$54.08
RUTHERFORD	$91.48	$37.07	$105.58	$57.61
SEQUATCHIE	$106.92	$40.48	$108.04	$57.44
SHELBY	$134.20	$50.39	$135.58	$56.81
STEWART	$75.58	$33.27	$76.81	$36.23
SUMNER	$118.01	$42.74	$144.27	$64.39
TROUSDALE	$109.86	$36.25	$159.74	$44.13
UNION	$90.07	$37.37	$91.43	$46.67
WARREN	$128.87	$44.02	$124.82	$55.21
WAYNE	$106.31	$37.20	$138.33	$55.26
WHITE	$91.92	$37.90	$91.06	$43.72
WILSON	$154.15	$46.84	$180.13	$67.99
STATE: TEXAS				
ANDERSON	$87.66	$39.80	$93.24	$43.57
ANGELINA	$96.19	$46.56	$88.85	$44.29
ARCHER	$95.98	$50.98	$81.31	$60.50
ATASCOSA	$111.90	$64.14	$111.16	$74.05
BAILEY	$125.94	$49.38	$167.09	$72.50
BASTROP	$92.53	$45.39	$87.46	$48.13
BEE	$100.20	$50.54	$91.23	$58.76
BEXAR	$121.47	$73.00	$126.36	$88.92
BORDEN	$117.58	$56.49	$138.40	$79.74
BOWIE	$100.44	$50.61	$127.79	$69.21
BRAZOS	$97.22	$42.52	$99.55	$48.20
BRISCOE	$108.31	$48.45	$100.40	$43.88
BROWN	$103.14	$43.01	$99.41	$54.51
BURNET	$88.68	$47.43	$89.94	$49.61
CALHOUN	$118.25	$50.26	$152.79	$68.29
CAMERON	$83.98	$50.44	$76.25	$52.47
CARSON	$111.24	$45.23	$116.65	$56.20
CASTRO	$116.91	$51.26	$162.41	$80.17
CHEROKEE	$120.79	$58.95	$120.77	$67.91
CLAY	$103.58	$39.01	$107.89	$42.31
COKE	$97.58	$50.37	$84.39	$40.23
COLLIN	$119.67	$51.21	$158.56	$72.60

STATE: TENNESSEE COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LAKE	$83.19	$38.77	$67.64	$36.27
LAWRENCE	$114.43	$36.82	$119.65	$48.49
LINCOLN	$100.90	$40.98	$91.28	$47.24
MC MINN	$92.69	$32.77	$99.00	$46.30
MACON	$109.52	$34.68	$125.81	$53.71
MARION	$122.12	$45.31	$126.04	$49.64
MAURY	$103.92	$39.42	$102.81	$48.44
MONROE	$79.31	$28.43	$80.74	$41.81
MOORE	$99.47	$32.86	$81.36	$43.12
OBION	$86.52	$33.53	$77.87	$35.49
PERRY	$133.90	$35.69	$157.40	$49.15
POLK	$97.17	$37.06	$104.62	$46.54
RHEA	$102.40	$37.86	$95.69	$48.84
ROBERTSON	$112.30	$42.66	$110.92	$52.39
SCOTT	$99.36	$40.81	$70.03	$44.73
SEVIER	$99.53	$38.65	$98.27	$47.41
SMITH	$121.43	$36.06	$105.93	$39.36
SULLIVAN	$110.34	$41.24	$103.56	$51.95
TIPTON	$102.09	$38.07	$106.92	$49.57
UNICOI	$95.60	$31.21	$79.24	$39.10
VAN BUREN	$128.70	$47.16	$69.80	$34.24
WASHINGTON	$98.56	$35.20	$91.68	$43.59
WEAKLEY	$85.01	$29.45	$76.66	$34.22
WILLIAMSON	$117.42	$53.04	$119.27	$62.32
STATE: TEXAS				
ANDREWS	$126.10	$48.45	$213.48	$94.54
ARANSAS	$121.37	$59.64	$119.60	$62.36
ARMSTRONG	$68.32	$37.91	$60.02	$30.25
AUSTIN	$87.91	$39.53	$132.90	$57.55
BANDERA	$76.86	$44.78	$65.80	$47.49
BAYLOR	$139.66	$46.22	$131.56	$53.72
BELL	$80.79	$47.68	$66.39	$60.20
BLANCO	$95.89	$51.40	$108.96	$65.91
BOSQUE	$83.66	$34.44	$107.54	$51.91
BRAZORIA	$141.79	$62.26	$170.27	$78.47
BREWSTER	$86.19	$40.47	$85.81	$42.66
BROOKS	$78.71	$45.56	$86.99	$45.70
BURLESON	$97.57	$42.65	$83.00	$43.64
CALDWELL	$84.89	$46.26	$89.20	$49.15
CALLAHAN	$108.30	$44.96	$141.40	$57.72
CAMP	$102.30	$44.75	$97.18	$52.98
CASS	$88.58	$46.48	$96.39	$52.52
CHAMBERS	$193.90	$75.41	$186.07	$79.75
CHILDRESS	$121.40	$43.21	$153.55	$54.42
COCHRAN	$131.39	$60.16	$222.47	$129.93
COLEMAN	$102.87	$44.69	$125.67	$58.19
COLLINGSWORTH	$98.72	$42.35	$103.90	$43.10

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
COLORADO	$109.83	$42.25	$112.35	$51.34
COMANCHE	$107.68	$46.08	$113.63	$58.91
COOKE	$116.36	$46.27	$130.53	$61.99
COTTLE	$127.98	$48.99	$165.31	$50.50
CROCKETT	$134.06	$51.56	$127.42	$77.17
CULBERSON	$143.13	$59.09	$114.61	$61.18
DALLAS	$144.05	$70.71	$158.90	$86.72
DEAF SMITH	$90.15	$42.90	$96.47	$41.73
DENTON	$128.56	$56.02	$127.84	$66.99
DICKENS	$159.90	$59.10	$92.19	$66.71
DONLEY	$77.03	$42.47	$46.42	$33.06
EASTLAND	$103.39	$41.90	$87.72	$49.82
EDWARDS	$112.11	$53.19	$63.11	$38.94
EL PASO	$135.88	$62.91	$129.47	$70.90
FALLS	$108.48	$41.35	$112.65	$46.10
FAYETTE	$90.19	$39.72	$76.03	$37.80
FLOYD	$121.41	$47.17	$143.24	$80.37
FORT BEND	$127.65	$59.54	$107.66	$55.05
FREESTONE	$113.68	$42.88	$106.30	$46.43
GAINES	$126.22	$53.22	$211.43	$89.37
GARZA	$129.97	$57.13	$135.52	$65.39
GLASSCOCK	$111.76	$52.43	$100.83	$56.62
GONZALES	$86.62	$42.73	$111.36	$58.32
GRAYSON	$116.44	$53.14	$132.97	$71.30
GRIMES	$121.11	$54.81	$135.51	$63.04
HALE	$115.95	$50.12	$106.76	$55.33
HAMILTON	$81.56	$36.35	$79.61	$42.93
HARDEMAN	$134.43	$53.30	$96.98	$41.92
HARRIS	$169.39	$73.40	$210.61	$94.39
HARTLEY	$66.86	$40.58	$131.46	$66.45
HAYS	$93.75	$56.11	$83.42	$62.88
HENDERSON	$87.67	$42.83	$100.88	$55.64
HILL	$103.61	$43.36	$101.22	$51.01
HOOD	$113.21	$50.20	$148.50	$89.19
HOUSTON	$145.71	$42.98	$117.88	$53.99
HUDSPETH	$135.15	$55.85	$131.56	$43.43
HUTCHINSON	$103.56	$43.50	$109.13	$55.03
JACK	$96.56	$41.98	$138.04	$65.71
JASPER	$140.33	$56.02	$147.26	$70.14
JEFFERSON	$154.76	$60.95	$182.34	$76.1.
JIM WELLS	$131.74	$70.37	$133.60	$73.59
JONES	$103.32	$43.57	$98.92	$46.00
KAUFMAN	$126.03	$51.47	$142.63	$71.54
KENEDY	$105.38	$53.60	$111.14	$65.12
KERR	$76.00	$42.46	$82.78	$47.38
KING	$117.58	$56.49	$244.51	$100.19
KLEBERG	$123.24	$61.35	$138.56	$67.61
LAMAR	$102.99	$48.85	$104.69	$52.26
LAMPASAS	$71.33	$37.62	$68.15	$55.10

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
COMAL	$78.43	$53.66	$86.20	$65.84
CONCHO	$120.94	$66.60	$128.35	$63.73
CORYELL	$97.87	$39.59	$67.05	$42.54
CRANE	$76.30	$43.98	$82.64	$58.07
CROSBY	$149.16	$58.01	$154.98	$67.49
DALLAM	$89.15	$43.22	$86.86	$63.29
DAWSON	$108.72	$46.46	$111.99	$49.96
DELTA	$102.39	$51.16	$84.29	$51.64
DE WITT	$102.40	$43.01	$110.60	$57.96
DIMMIT	$86.47	$52.41	$117.99	$73.75
DUVAL	$109.01	$66.86	$93.27	$58.72
ECTOR	$110.49	$59.82	$122.61	$59.42
ELLIS	$94.89	$46.67	$113.82	$57.65
ERATH	$93.70	$41.79	$106.35	$57.87
FANNIN	$105.86	$42.50	$114.91	$52.03
FISHER	$90.19	$39.36	$129.46	$65.06
FOARD	$87.83	$37.59	$97.68	$60.24
FRANKLIN	$112.38	$41.88	$167.94	$65.71
FRIO	$124.79	$67.08	$135.19	$69.60
GALVESTON	$160.63	$79.03	$194.13	$104.38
GILLESPIE	$80.96	$39.91	$83.94	$51.19
GOLIAD	$96.70	$47.63	$160.94	$64.75
GRAY	$110.33	$40.33	$137.33	$55.39
GREGG	$92.65	$46.64	$101.40	$56.29
GUADALOUPE	$73.86	$47.29	$72.90	$57.97
HALL	$76.79	$38.03	$114.53	$52.48
HANSFORD	$124.87	$48.20	$228.96	$83.67
HARDIN	$154.12	$59.16	$158.67	$69.75
HARRISON	$83.26	$39.53	$95.89	$48.41
HASKELL	$77.01	$38.49	$98.30	$51.29
HEMPHILL	$112.05	$35.80	$166.61	$58.37
HIDALGO	$62.64	$44.64	$58.07	$43.44
HOCKLEY	$152.24	$56.58	$151.98	$64.72
HOPKINS	$100.46	$42.48	$109.61	$55.82
HOWARD	$120.10	$45.51	$120.03	$52.85
HUNT	$89.72	$42.06	$113.24	$54.30
IRION	$101.38	$50.13	$151.47	$63.14
JACKSON	$110.56	$49.13	$118.11	$55.72
JEFF DAVIS	$89.79	$36.92	$104.49	$67.22
JIM HOGG	$82.52	$55.49	$90.75	$66.81
JOHNSON	$103.15	$52.14	$129.14	$65.93
KARNES	$104.70	$50.98	$95.48	$46.82
KENDALL	$92.32	$54.37	$116.76	$81.94
KENT	$97.68	$43.76	$95.18	$20.34
KIMBLE	$99.50	$48.21	$51.14	$33.12
KINNEY	$84.99	$49.77	$108.49	$60.21
KNOX	$110.63	$42.43	$109.74	$46.59
LAMB	$127.18	$51.35	$151.10	$61.24
LA SALLE	$105.29	$56.02	$110.36	$50.99

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LAVACA	$82.49	$38.85	$105.58	$47.20
LEON	$119.99	$43.33	$116.94	$49.97
LIMESTONE	$103.12	$40.14	$47.34	$22.47
LIVE OAK	$101.49	$58.37	$85.25	$62.19
LOVING	$117.58	$56.49	$222.28	$130.25
LYNN	$138.20	$54.95	$150.06	$64.57
MC LENNAN	$72.49	$39.28	$69.66	$46.98
MADISON	$127.45	$45.30	$95.18	$50.16
MARTIN	$100.42	$45.34	$108.86	$59.38
MATAGORDA	$128.11	$48.21	$168.48	$69.92
MEDINA	$107.71	$60.50	$112.51	$69.77
MIDLAND	$101.57	$53.88	$115.30	$70.54
MILLS	$97.65	$40.54	$42.93	$26.64
MONTAGUE	$81.09	$38.47	$78.32	$43.08
MOORE	$90.69	$46.70	$119.75	$75.75
MOTLEY	$117.48	$48.44	$175.72	$81.02
NAVARRO	$78.31	$47.27	$76.09	$50.23
NOLAN	$114.04	$46.38	$130.54	$52.45
OCHILTREE	$115.93	$49.19	$178.23	$75.01
ORANGE	$162.03	$63.70	$192.69	$91.22
PANOLA	$102.57	$43.14	$111.57	$54.27
PARMER	$78.89	$34.12	$82.48	$39.66
POLK	$109.08	$48.48	$134.57	$65.15
PRESIDIO	$86.10	$43.96	$71.72	$29.28
RANDALL	$89.85	$48.70	$129.24	$72.76
REAL	$88.36	$47.92	$57.50	$49.61
REEVES	$107.51	$45.76	$106.86	$52.69
ROBERTS	$106.18	$37.78	$152.82	$88.30
ROCKWALL	$130.99	$64.52	$163.96	$93.46
RUSK	$93.34	$42.02	$86.67	$50.05
SAN AUGUSTINE	$98.80	$40.87	$89.11	$41.74
SAN PATRICIO	$106.95	$59.27	$110.70	$64.38
SCHLEICHER	$107.07	$56.81	$79.84	$48.62
SHACKELFORD	$101.20	$45.89	$76.83	$43.22
SHERMAN	$86.09	$47.40	$125.68	$67.90
SOMERVELL	$115.80	$38.40	$95.38	$35.18
STEPHENS	$98.72	$43.47	$123.69	$58.28
STONEWALL	$117.97	$50.39	$83.18	$56.91
SWISHER	$96.39	$48.27	$145.80	$65.92
TAYLOR	$97.83	$46.08	$82.18	$43.07
TERRY	$136.27	$57.80	$169.60	$68.11
TITUS	$119.62	$48.47	$150.38	$56.17
TRAVIS	$103.28	$59.90	$90.03	$56.53
TYLER	$119.47	$48.80	$118.38	$55.63
UPTON	$90.26	$43.93	$114.29	$66.75
VAL VERDE	$93.42	$46.87	$83.20	$49.92
VICTORIA	$112.34	$58.83	$161.04	$81.96
WALLER	$139.83	$55.75	$149.04	$60.60
WASHINGTON	$93.03	$44.15	$71.48	$35.05

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
LEE	$94.42	$41.04	$103.93	$53.80
LIBERTY	$153.39	$62.78	$171.16	$78.34
LIPSCOMB	$114.42	$47.53	$107.66	$35.64
LLANO	$88.23	$45.97	$78.23	$52.67
LUBBOCK	$133.31	$58.28	$138.65	$64.55
MC CULLOCH	$87.03	$41.62	$86.34	$39.72
MC MULLEN	$120.48	$71.32	$94.04	$54.27
MARION	$92.67	$41.83	$83.84	$41.85
MASON	$84.78	$45.07	$52.44	$40.89
MAVERICK	$95.23	$50.00	$76.00	$46.95
MENARD	$100.60	$46.79	$174.31	$90.65
MILAM	$92.73	$41.85	$74.79	$39.62
MITCHELL	$99.39	$40.49	$109.35	$48.49
MONTGOMERY	$150.37	$67.74	$169.10	$84.37
MORRIS	$113.17	$49.00	$135.46	$54.12
NACOGDOCHES	$130.92	$53.49	$135.77	$62.55
NEWTON	$128.29	$50.87	$122.57	$55.78
NUECES	$134.74	$70.49	$148.26	$84.50
OLDHAM	$107.54	$48.40	$109.81	$43.28
PALO PINTO	$107.17	$41.54	$118.31	$55.80
PARKER	$96.28	$43.97	$111.53	$63.26
PECOS	$104.67	$38.16	$142.90	$74.32
POTTER	$100.61	$51.20	$108.57	$67.27
RAINS	$117.38	$49.74	$123.10	$58.11
REAGAN	$126.02	$62.66	$151.03	$83.66
RED RIVER	$108.68	$38.74	$127.54	$48.74
REFUGIO	$105.27	$50.22	$112.10	$49.47
ROBERTSON	$88.47	$42.76	$89.48	$44.84
RUNNELS	$87.86	$48.80	$102.58	$50.56
SABINE	$113.02	$43.73	$112.26	$52.15
SAN JACINTO	$151.81	$67.00	$168.06	$80.11
SAN SABA	$95.58	$44.87	$98.39	$56.17
SCURRY	$149.99	$49.58	$163.70	$65.13
SHELBY	$118.47	$46.84	$109.56	$49.86
SMITH	$87.88	$48.49	$112.79	$59.26
STARR	$55.91	$37.25	$58.55	$31.78
STERLING	$76.41	$40.71	$124.75	$65.78
SUTTON	$120.50	$62.41	$171.10	$98.94
TARRANT	$111.39	$55.24	$137.41	$76.49
TERRELL	$104.09	$45.41	$134.87	$46.66
THROCKMORTON	$184.22	$66.83	$295.72	$126.25
TOM GREEN	$95.49	$53.24	$88.70	$53.10
TRINITY	$98.36	$47.32	$139.68	$69.43
UPSHUR	$89.61	$42.26	$111.36	$55.99
UVALDE	$98.00	$51.38	$128.00	$74.00
VAN ZANDT	$100.98	$48.27	$115.83	$58.90
WALKER	$148.09	$67.39	$158.56	$74.39
WARD	$134.45	$55.15	$130.97	$52.30
WEBB	$86.89	$53.11	$72.45	$51.86

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WHARTON	$103.94	$43.01	$117.62	$56.53
WICHITA	$91.06	$52.02	$106.05	$64.25
WILLACY	$80.50	$47.47	$69.97	$46.11
WILSON	$97.77	$54.45	$108.89	$69.87
WISE	$99.87	$35.22	$101.16	$46.28
YOAKUM	$136.30	$55.63	$105.78	$60.23
ZAPATA	$85.11	$48.92	$57.27	$41.84
STATE: UTAH				
BEAVER	$122.92	$55.53	$110.36	$47.97
CACHE	$65.50	$38.30	$83.95	$50.16
DAGGETT	$102.55	$47.02	$139.33	$79.58
DUCHESNE	$92.59	$40.07	$111.80	$60.11
GARFIELD	$113.78	$48.58	$73.96	$50.19
IRON	$103.46	$49.26	$104.89	$55.63
KANE	$94.86	$41.58	$153.15	$81.79
MORGAN	$90.59	$43.96	$133.53	$77.40
RICH	$76.93	$44.22	$217.16	$150.20
SAN JUAN	$80.58	$34.59	$55.39	$29.76
SEVIER	$84.84	$38.84	$95.21	$51.03
TOOELE	$101.62	$44.71	$104.22	$52.93
UTAH	$106.79	$49.47	$111.32	$64.43
WASHINGTON	$89.93	$46.29	$96.10	$54.15
WEBER	$97.32	$50.54	$119.77	$68.35
STATE: VERMONT				
ADDISON	$105.33	$42.98	$93.79	$42.82
CALEDONIA	$113.13	$45.12	$91.84	$51.38
ESSEX	$126.87	$39.99	$112.72	$46.10
GRAND ISLE	$130.02	$46.61	$126.49	$62.72
ORANGE	$117.27	$46.33	$116.31	$52.43
RUTLAND	$113.53	$44.07	$106.28	$52.01
WINDHAM	$118.51	$48.33	$164.67	$71.96
STATE: VIRGIN ISLANDS				
ST CROIX	$54.72	$23.11	$69.93	$23.56
STATE: VIRGINIA				
ACCOMACK	$85.22	$34.92	$106.90	$48.25
ALEXANDRIA CITY	$177.24	$85.88	$225.57	$117.14
AMELIA	$108.09	$34.95	$120.09	$46.43
APPOMATTOX	$74.82	$29.98	$79.47	$42.41
AUGUSTA	$85.38	$32.86	$129.80	$52.68
BEDFORD CITY	$71.32	$28.48	$79.70	$44.17
BLAND	$129.29	$43.04	$117.33	$51.84
BRISTOL CITY	$84.31	$36.14	$65.40	$40.02
BUCHANAN	$140.69	$60.91	$93.55	$56.40
BUENA VISTA CITY	$83.70	$36.00	$87.23	$53.11
CAROLINE	$123.26	$44.96	$108.59	$48.65

STATE: TEXAS COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
WHEELER	$120.89	$47.29	$156.28	$58.22
WILBARGER	$109.76	$46.73	$136.72	$57.55
WILLIAMSON	$76.26	$41.29	$87.09	$53.11
WINKLER	$128.78	$46.36	$143.01	$64.36
WOOD	$103.65	$45.96	$104.14	$54.52
YOUNG	$107.24	$45.19	$131.80	$60.35
ZAVALA	$100.98	$65.70	$97.28	$60.75
STATE: UTAH				
BOX ELDER	$87.58	$44.13	$92.55	$50.86
CARBON	$125.82	$67.59	$120.28	$62.26
DAVIS	$112.93	$55.92	$140.26	$77.29
EMERY	$106.21	$55.60	$110.26	$52.82
GRAND	$107.34	$39.18	$134.98	$57.35
JUAB	$125.98	$46.66	$81.85	$42.54
MILLARD	$89.31	$38.70	$63.49	$42.82
PIUTE	$102.33	$42.08	$132.09	$50.23
SALT LAKE	$103.09	$53.56	$127.56	$70.95
SANPETE	$99.05	$44.38	$126.04	$59.64
SUMMIT	$113.29	$45.36	$180.15	$73.88
UINTAH	$101.27	$51.49	$130.07	$49.34
WASATCH	$103.98	$46.33	$119.69	$80.02
WAYNE	$94.89	$46.26	$221.01	$63.96
STATE: VERMONT				
BENNINGTON	$123.41	$52.63	$121.24	$63.25
CHITTENDEN	$124.63	$47.46	$136.58	$68.83
FRANKLIN	$120.84	$42.91	$133.26	$59.86
LAMOILLE	$123.42	$53.14	$106.24	$51.56
ORLEANS	$117.21	$36.07	$107.61	$45.29
WASHINGTON	$94.34	$39.49	$97.64	$57.76
WINDSOR	$119.76	$50.23	$109.96	$57.63
STATE: VIRGIN ISLANDS				
ST THOMAS-JOHN	$51.33	$19.74	$53.31	$20.65
STATE: VIRGINIA				
ALBEMARLE	$93.15	$47.21	$137.24	$84.45
ALLEGHANY	$124.95	$47.58	$187.24	$68.74
AMHERST	$71.48	$29.48	$89.83	$38.81
ARLINGTON	$150.72	$78.42	$206.12	$110.44
BATH	$171.02	$45.79	$159.12	$60.20
BEDFORD	$86.41	$33.22	$99.08	$55.09
BOTETOURT	$110.28	$39.26	$86.26	$42.37
BRUNSWICK	$102.21	$39.07	$112.21	$49.73
BUCKINGHAM	$100.53	$45.57	$102.43	$63.58
CAMPBELL	$78.59	$29.90	$78.86	$38.94
CARROLL	$96.49	$33.27	$100.55	$45.53

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
CHARLES CITY.....	$123.28	$39.83	$68.69	$44.98
CHARLOTTESVILLE CITY	$94.61	$50.22	$145.11	$97.13
CHESTERFIELD.....	$130.07	$52.81	$140.45	$69.79
CLIFTON FORGE CITY..	$121.41	$46.37	$137.71	$62.39
COVINGTON CITY.....	$133.59	$45.33	$104.18	$46.31
CULPEPER.....	$89.77	$44.90	$82.42	$48.35
DANVILLE CITY.....	$78.43	$36.48	$95.66	$51.85
DINWIDDIE.....	$101.77	$36.97	$94.24	$34.29
ESSEX.....	$121.06	$48.45	$133.58	$57.02
FAIRFAX.....	$132.60	$76.11	$173.95	$105.26
FAUQUIER.....	$122.85	$49.45	$124.41	$59.71
FLUVANNA.....	$96.18	$45.16	$99.12	$60.66
FRANKLIN.....	$112.23	$32.92	$94.28	$39.74
FREDERICKSBURG CITY.	$106.86	$47.33	$127.48	$63.62
GILES.....	$109.46	$42.09	$89.41	$46.94
GOOCHLAND.....	$109.61	$43.60	$118.74	$56.61
GREENE.....	$87.56	$41.93	$148.83	$75.83
HALIFAX.....	$81.27	$32.56	$102.75	$47.38
HANOVER.....	$129.51	$48.51	$166.46	$76.37
HENRICO.....	$129.24	$54.63	$190.04	$79.93
HIGHLAND.....	$94.51	$32.82	$85.01	$41.05
ISLE OF WIGHT.....	$111.45	$50.61	$102.30	$57.79
KING AND QUEEN.....	$142.35	$48.85	$115.97	$61.92
KING WILLIAM.....	$132.51	$48.42	$158.23	$61.79
LEE.....	$104.86	$46.12	$88.24	$46.25
LOUDOUN.....	$119.39	$56.31	$166.16	$86.11
LUNENBURG.....	$94.36	$36.39	$83.52	$39.25
MADISON.....	$87.76	$41.79	$78.62	$48.50
MANASSAS CITY.....	$164.40	$72.62	$200.89	$98.94
MECKLENBURG.....	$90.04	$37.93	$100.67	$44.74
MONTGOMERY.....	$104.12	$40.14	$116.39	$53.08
NEW KENT.....	$136.17	$45.60	$147.54	$72.19
NORFOLK CITY.....	$153.43	$63.20	$179.46	$81.21
NORTHUMBERLAND.....	$115.94	$44.82	$132.86	$63.88
NOTTOWAY.....	$96.86	$41.82	$97.78	$47.43
PAGE.....	$111.24	$37.02	$99.89	$49.43
PETERSBURG CITY.....	$119.49	$42.31	$123.09	$51.13
PORTSMOUTH CITY.....	$127.96	$59.69	$145.27	$82.76
POWHATAN.....	$115.07	$43.72	$100.26	$45.44
PRINCE GEORGE.....	$110.85	$44.77	$138.44	$57.12
PULASKI.....	$144.43	$47.10	$164.26	$73.77
RAPPAHANNOCK.....	$101.84	$42.51	$83.07	$45.81
RICHMOND CITY.....	$138.70	$55.66	$159.19	$68.78
ROANOKE CITY.....	$116.94	$43.13	$129.90	$54.45
ROCKINGHAM.....	$71.09	$30.73	$82.78	$44.55
SALEM.....	$94.05	$44.05	$129.14	$56.77
SHENANDOAH.....	$79.88	$32.37	$84.80	$45.82
SOUTH BOSTON CITY...	$84.30	$33.84	$118.56	$52.73
SPOTSYLVANIA.....	$92.18	$40.84	$109.56	$56.67

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
CHARLOTTE.....	$73.37	$27.39	$71.13	$30.48
CHESAPEAKE.....	$159.19	$63.52	$165.44	$82.23
CLARKE.....	$87.67	$34.95	$115.69	$46.16
COLONIAL HGTS CITY..	$120.95	$49.93	$124.01	$59.48
CRAIG.....	$103.29	$37.35	$145.04	$60.76
CUMBERLAND.....	$101.98	$39.46	$56.83	$34.16
DICKENSON.....	$121.23	$52.95	$80.73	$51.19
EMPORIA.....	$125.20	$54.13	$158.68	$69.47
FAIRFAX CITY.....	$142.66	$74.90	$165.77	$91.84
FALLS CHURCH CITY...	$144.39	$82.72	$204.77	$116.96
FLOYD.....	$85.36	$32.36	$109.32	$47.40
FRANKLIN CITY.....	$123.70	$63.64	$144.01	$76.89
FREDERICK.....	$80.99	$32.76	$86.95	$51.39
GALAX CITY.....	$100.94	$36.66	$92.94	$41.74
GLOUCESTER.....	$105.01	$44.53	$122.89	$60.64
GRAYSON.....	$84.86	$29.32	$81.99	$33.79
GREENSVILLE.....	$129.48	$60.17	$122.04	$58.32
HAMPTON CITY.....	$101.11	$51.58	$119.94	$69.33
HARRISONBURG CITY...	$66.78	$31.54	$89.59	$47.88
HENRY.....	$103.37	$38.53	$108.00	$51.42
HOPEWELL CITY.....	$134.17	$55.91	$158.74	$80.22
JAMES CITY.....	$86.26	$50.91	$111.95	$48.05
KING GEORGE.....	$125.17	$49.80	$129.71	$65.46
LANCASTER.....	$93.63	$39.67	$131.49	$64.25
LEXINGTON.....	$70.43	$31.89	$52.02	$39.40
LOUISA.....	$107.39	$46.64	$127.01	$62.67
LYNCHBURG CITY.....	$83.47	$34.07	$91.92	$45.28
MARTINSVILLE CITY...	$91.92	$38.87	$105.87	$57.89
MATHEWS.....	$100.88	$4 .88	$117.26	$54.15
MIDDLESEX.....	$105.42	$40.48	$124.56	$53.15
NELSON.....	$94.24	$38.23	$89.97	$55.08
NEWPORT NEWS CITY...	$96.59	$50.37	$109.10	$64.33
NORTHAMPTON.....	$83.89	$33.77	$95.36	$42.22
NORTON CITY.....	$161.15	$58.37	$132.17	$57.07
ORANGE.....	$104.37	$46.49	$93.16	$59.10
PATRICK.....	$106.97	$34.76	$132.05	$51.87
PITTSYLVANIA.....	$68.67	$30.13	$77.56	$39.21
POQUOSON CITY.....	$102.67	$51.64	$127.89	$80.36
PRINCE EDWARD.....	$90.33	$32.37	$104.24	$40.26
PRINCE WILLIAM.....	$153.37	$77.44	$209.00	$116.29
RADFORD CITY.....	$136.43	$46.26	$162.90	$60.97
RICHMOND.....	$142.11	$50.77	$115.65	$69.57
ROANOKE.....	$86.02	$36.91	$122.99	$59.78
ROCKBRIDGE.....	$73.76	$32.11	$98.74	$47.61
RUSSELL.....	$115.90	$44.50	$97.71	$50.91
SCOTT.....	$122.19	$41.19	$98.90	$48.46
SMYTH.....	$80.38	$30.29	$84.72	$38.76
SOUTHAMPTON.....	$111.06	$52.73	$129.57	$64.98
STAFFORD.....	$109.66	$48.39	$150.21	$75.71

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
STAUNTON CITY.....	$95.07	$35.83	$107.79	$49.55
SURRY.....	$104.94	$43.86	$98.67	$40.94
TAZEWELL.....	$126.74	$55.61	$117.21	$64.76
WARREN.....	$117.46	$45.62	$157.65	$76.56
WAYNESBORO CITY.....	$121.31	$44.67	$141.07	$66.90
WILLIAMSBURG CITY...	$112.33	$56.41	$149.50	$71.41
WISE.....	$137.01	$53.64	$109.50	$52.47
YORK.....	$104.65	$52.44	$102.46	$59.31
STATE: WASHINGTON				
ADAMS.....	$126.44	$57.94	$120.48	$62.97
BENTON.....	$95.55	$50.94	$107.13	$64.88
CLALLAM.....	$95.59	$51.77	$109.11	$64.75
COLUMBIA.....	$114.62	$47.20	$92.69	$48.13
DOUGLAS.....	$98.17	$57.99	$88.03	$60.71
FRANKLIN.....	$111.77	$51.58	$124.47	$60.31
GRANT.....	$105.98	$53.65	$103.10	$58.17
ISLAND.....	$98.51	$49.86	$88.42	$53.12
KING.....	$129.05	$60.57	$152.80	$77.84
KITTITAS.....	$99.65	$48.44	$103.33	$55.98
LEWIS.....	$104.45	$52.05	$89.95	$57.25
MASON.....	$112.02	$54.89	$89.68	$53.21
PACIFIC.....	$137.85	$51.79	$135.16	$61.90
PIERCE.....	$101.22	$58.29	$97.93	$69.54
SKAGIT.....	$124.91	$57.83	$128.32	$69.25
SNOHOMISH.....	$120.67	$54.79	$132.13	$70.94
STEVENS.....	$110.05	$47.98	$108.88	$60.78
WAHKIAKUM.....	$99.16	$43.01	$119.29	$62.81
WHATCOM.....	$86.30	$49.66	$85.42	$58.33
YAKIMA.....	$107.14	$48.47	$115.52	$61.63
STATE: W. VIRGINIA				
BARBOUR.....	$126.04	$32.96	$91.10	$40.14
BOONE.....	$120.91	$43.67	$83.46	$40.23
BROOKE.....	$163.72	$45.29	$196.60	$59.94
CALHOUN.....	$117.83	$38.48	$83.50	$28.12
DODDRIDGE.....	$95.12	$34.82	$60.50	$27.27
GILMER.....	$96.88	$33.67	$88.50	$36.71
GREENBRIER.....	$102.24	$47.73	$88.21	$46.62
HANCOCK.....	$194.97	$52.60	$214.84	$70.49
HARRISON.....	$110.73	$42.85	$86.29	$43.14
JEFFERSON.....	$104.49	$36.29	$102.68	$43.59
LEWIS.....	$94.42	$33.80	$80.39	$35.36
LOGAN.....	$132.42	$57.82	$96.37	$56.67
MARION.....	$94.93	$32.10	$98.03	$41.85
MASON.....	$122.69	$39.50	$116.51	$46.62
MINERAL.....	$135.92	$39.38	$113.33	$40.74
MONONGALIA.....	$121.94	$48.67	$120.36	$54.65
MORGAN.....	$90.58	$35.22	$97.61	$49.03

STATE: VIRGINIA COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
SUFFOLK CITY.....	$115.16	$50.26	$136.51	$66.55
SUSSEX.....	$126.22	$46.11	$113.93	$55.26
VIRGINIA BEACH CITY.	$143.91	$69.18	$182.04	$95.48
WASHINGTON.....	$71.64	$31.35	$78.72	$40.55
WESTMORELAND.....	$130.34	$51.75	$150.38	$65.71
WINCHESTER CITY.....	$86.68	$36.70	$101.34	$45.51
WYTHE.....	$141.21	$41.53	$127.73	$49.52
STATE: WASHINGTON				
ASOTIN.....	$104.38	$50.00	$94.94	$53.70
CHELAN.....	$95.86	$56.51	$107.72	$69.64
CLARK.....	$100.92	$53.55	$100.06	$56.24
COWLITZ.....	$116.10	$49.93	$117.92	$64.69
FERRY.....	$137.51	$53.02	$100.87	$49.10
GARFIELD.....	$119.59	$48.46	$94.79	$72.80
GRAYS HARBOR.....	$112.10	$53.40	$106.78	$60.39
JEFFERSON.....	$101.41	$52.38	$86.84	$55.82
KITSAP.....	$88.51	$57.24	$96.17	$69.74
KLICKITAT.....	$124.67	$46.00	$122.12	$56.89
LINCOLN.....	$102.58	$54.13	$125.54	$87.12
OKANOGAN.....	$110.20	$50.98	$131.69	$70.60
PEND OREILLE.....	$110.79	$48.31	$93.56	$55.78
SAN JUAN.....	$88.78	$48.01	$133.02	$77.58
SKAMANIA.....	$126.04	$49.29	$143.35	$73.03
SPOKANE.....	$111.36	$56.73	$111.14	$71.47
THURSTON.....	$88.19	$54.16	$84.74	$58.55
WALLA WALLA.....	$117.50	$54.77	$128.06	$66.48
WHITMAN.....	$108.76	$49.58	$102.83	$53.79
STATE: W. VIRGINIA				
BERKELEY.....	$107.26	$40.53	$106.99	$48.85
BRAXTON.....	$81.98	$32.67	$57.56	$24.01
CABELL.....	$85.52	$39.19	$76.83	$43.55
CLAY.....	$96.82	$36.14	$66.52	$35.62
FAYETTE.....	$118.44	$40.27	$94.05	$51.63
GRANT.....	$98.17	$36.62	$81.07	$35.99
HAMPSHIRE.....	$96.80	$38.56	$84.49	$40.09
HARDY.....	$77.29	$32.49	$72.82	$29.73
JACKSON.....	$79.65	$30.42	$84.86	$39.76
KANAWHA.....	$137.54	$47.72	$137.52	$54.51
LINCOLN.....	$84.06	$38.30	$62.19	$35.09
MC DOWELL.....	$121.35	$59.63	$79.08	$48.06
MARSHALL.....	$185.79	$45.93	$190.54	$58.56
MERCER.....	$124.91	$57.89	$114.92	$61.57
MINGO.....	$119.95	$52.18	$81.59	$48.98
MONROE.....	$98.02	$47.99	$71.59	$53.13
NICHOLAS.....	$94.01	$45.25	$80.55	$42.90

TABLE 2

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: W. VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
OHIO	$146.59	$41.93	$207.44	$59.78
PLEASANTS	$124.62	$37.74	$74.96	$34.15
PRESTON	$91.83	$34.92	$73.64	$37.31
RALEIGH	$91.32	$43.74	$69.00	$37.69
RITCHIE	$94.46	$32.14	$87.47	$40.45
SUMMERS	$109.17	$47.90	$109.72	$52.53
TUCKER	$110.25	$42.41	$74.75	$42.69
UPSHUR	$67.79	$31.31	$59.31	$30.43
WEBSTER	$84.78	$38.24	$61.31	$37.69
WIRT	$100.52	$35.22	$103.31	$34.03
WYOMING	$129.44	$40.71	$76.03	$43.16
STATE: WISCONSIN				
ADAMS	$138.95	$46.00	$145.69	$55.08
BARRON	$104.71	$38.06	$102.18	$45.57
BROWN	$108.84	$38.34	$127.74	$60.86
BURNETT	$127.53	$37.88	$137.97	$46.70
CHIPPEWA	$117.49	$44.30	$116.16	$60.25
COLUMBIA	$118.73	$42.49	$133.70	$58.16
DANE	$105.72	$47.16	$133.98	$69.67
DOOR	$117.77	$43.40	$116.46	$55.32
DUNN	$89.75	$38.95	$90.64	$50.18
FLORENCE	$105.32	$36.63	$111.04	$51.86
FOREST	$97.84	$38.14	$88.61	$51.55
GREEN	$90.58	$33.46	$114.20	$56.39
IOWA	$87.79	$33.38	$98.32	$47.34
JACKSON	$124.86	$40.04	$99.06	$43.89
JUNEAU	$106.68	$40.08	$98.51	$47.85
KEWAUNEE	$117.35	$36.83	$128.27	$47.09
LAFAYETTE	$115.33	$38.24	$132.92	$55.40
LINCOLN	$126.67	$42.92	$154.46	$63.92
MARATHON	$102.45	$42.22	$99.70	$50.48
MARQUETTE	$106.19	$41.77	$112.25	$57.07
MILWAUKEE	$181.44	$63.45	$201.15	$88.41
OCONTO	$102.99	$35.48	$101.84	$42.20
OUTAGAMIE	$118.24	$41.53	$135.19	$60.83
PEPIN	$89.32	$40.85	$107.66	$61.33
POLK	$130.27	$40.93	$128.64	$53.92
PRICE	$107.91	$39.44	$117.91	$48.77
RICHLAND	$85.87	$34.63	$85.24	$45.51
ROCK	$106.86	$44.46	$119.03	$55.48
SAUK	$111.34	$44.43	$119.22	$54.32
SHAWANO	$84.77	$36.04	$101.50	$49.47
TAYLOR	$109.39	$39.90	$98.36	$48.21
VERNON	$80.50	$34.07	$88.23	$44.18
WALWORTH	$126.03	$42.20	$170.69	$57.42
WASHINGTON	$124.17	$47.59	$124.00	$61.88
WAUPACA	$91.36	$33.42	$94.26	$44.83
WINNEBAGO	$129.99	$43.74	$147.77	$72.42

STATE: W. VIRGINIA COUNTY NAME	****** AGED ****** PART A	PART B	*** DISABLED *** PART A	PART B
PENDLETON	$69.34	$30.37	$82.74	$28.28
POCAHONTAS	$91.47	$34.00	$90.43	$40.42
PUTNAM	$113.96	$40.85	$105.62	$44.56
RANDOLPH	$95.13	$40.08	$85.80	$42.24
ROANE	$98.64	$30.43	$70.48	$27.37
TAYLOR	$100.29	$37.27	$112.37	$46.06
TYLER	$96.41	$30.17	$75.72	$34.76
WAYNE	$82.52	$35.60	$65.44	$35.95
WETZEL	$110.93	$34.72	$108.89	$37.97
WOOD	$122.84	$41.55	$121.32	$51.06
STATE: WISCONSIN				
ASHLAND	$102.65	$36.34	$131.53	$52.45
BAYFIELD	$114.76	$39.10	$114.87	$45.66
BUFFALO	$89.60	$41.74	$81.53	$48.87
CALUMET	$109.67	$35.79	$105.02	$58.37
CLARK	$95.96	$36.27	$76.66	$41.74
CRAWFORD	$100.53	$38.67	$127.40	$54.05
DODGE	$105.82	$41.19	$103.09	$51.57
DOUGLAS	$146.50	$44.97	$141.98	$49.18
EAU CLAIRE	$120.88	$48.76	$139.60	$62.07
FOND DU LAC	$109.03	$42.59	$123.10	$56.28
GRANT	$109.43	$37.44	$116.41	$49.26
GREEN LAKE	$119.63	$41.77	$129.81	$61.48
IRON	$120.38	$38.16	$85.93	$36.98
JEFFERSON	$109.66	$41.53	$107.31	$48.76
KENOSHA	$164.08	$54.87	$187.94	$76.74
LA CROSSE	$99.46	$49.06	$127.20	$73.49
LANGLADE	$105.89	$42.97	$87.14	$56.23
MANITOWOC	$117.87	$41.33	$147.21	$62.96
MARINETTE	$93.12	$30.89	$80.84	$37.47
MENOMINEE	$101.10	$47.98	$111.00	$57.69
MONROE	$91.95	$37.52	$86.62	$45.09
ONEIDA	$119.65	$44.49	$120.39	$54.78
OZAUKEE	$147.18	$50.58	$188.82	$73.50
PIERCE	$102.17	$39.47	$108.00	$56.21
PORTAGE	$116.39	$39.41	$116.99	$49.96
RACINE	$124.15	$49.83	$150.31	$78.80
ROCK	$117.71	$46.78	$128.50	$63.79
ST CROIX	$117.69	$39.35	$111.68	$48.08
SAWYER	$122.91	$41.65	$125.92	$53.64
SHEBOYGAN	$113.39	$35.83	$148.42	$60.32
TREMPEALEAU	$87.38	$38.80	$91.46	$45.80
VILAS	$131.38	$45.45	$158.62	$61.66
WASHBURN	$152.03	$43.00	$126.50	$42.18
WAUKESHA	$144.76	$52.46	$178.65	$76.94
WAUSHARA	$126.49	$41.01	$110.26	$49.81
WOOD	$106.73	$44.09	$106.45	$55.11

STANDARDIZED PER CAPITA RATES OF PAYMENT

STATE: WYOMING COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
ALBANY	$121.19	$50.73	$171.95	$69.23
CAMPBELL	$135.35	$52.16	$151.54	$57.17
CONVERSE	$99.39	$40.07	$111.00	$91.86
FREMONT	$144.35	$50.69	$108.21	$50.82
HOT SPRINGS	$129.70	$46.97	$113.48	$49.01
LARAMIE	$112.05	$49.16	$105.23	$62.29
NATRONA	$115.12	$46.93	$141.29	$72.71
PARK	$86.65	$46.66	$103.99	$79.28
SHERIDAN	$81.38	$36.46	$75.36	$41.24
SWEETWATER	$117.77	$49.08	$151.47	$62.01
UINTA	$112.67	$49.92	$103.70	$64.80
WESTON	$105.32	$41.66	$126.91	$62.02
STATE: GUAM				
AGANA	$53.81	$14.95	$105.30	$49.96
AGAT	$53.81	$14.95	$104.52	$52.18
BARRIGADA	$53.81	$14.95	$112.17	$58.05
DEDEDO	$53.81	$14.95	$99.37	$45.19
MAITE	$53.81	$14.95	$116.31	$54.03
MERIZO	$53.81	$14.95	$126.00	$54.03
ORDOT	$53.81	$14.95	$60.48	$29.27
SANTA RITA	$53.81	$14.95	$100.80	$46.83
TALOFOFO	$53.81	$14.95	$98.61	$49.01
TOTO	$53.81	$14.95	$117.82	$47.46
YIGO	$53.81	$14.95	$108.00	$51.86

STATE: WYOMING COUNTY NAME	****** AGED ****** PART A	 PART B	*** DISABLED *** PART A	 PART B
BIG HORN	$118.32	$47.41	$109.40	$56.48
CARBON	$142.17	$44.36	$173.37	$76.01
CROOK	$143.92	$41.70	$92.04	$32.15
GOSHEN	$116.38	$39.41	$119.14	$48.63
JOHNSON	$104.91	$41.42	$135.78	$47.70
LINCOLN	$104.93	$42.87	$145.37	$54.71
NIOBRARA	$96.44	$36.80	$144.95	$49.04
PLATTE	$112.67	$42.99	$133.22	$66.33
SUBLETTE	$124.64	$46.26	$120.50	$46.89
TETON	$128.79	$59.35	$181.88	$119.80
WASHAKIE	$109.67	$46.24	$106.99	$54.12
STATE: GUAM				
AGANA HEIGHTS	$53.81	$14.95	$108.78	$52.25
ASAN	$53.81	$14.95	$75.60	$49.19
CHALAN PAGO	$53.81	$14.95	$119.37	$63.86
INARAJAN	$53.81	$14.95	$91.64	$39.57
MANGILAO	$53.81	$14.95	$100.80	$45.32
MONGMONG	$53.81	$14.95	$94.50	$47.89
PITI	$53.81	$14.95	$137.46	$70.24
SINAJANA	$53.81	$14.95	$99.69	$43.90
TAMUNING	$53.81	$14.95	$103.77	$47.89
UMATAC	$53.81	$14.95	$98.61	$45.81
YONA	$53.81	$14.95	$100.19	$51.51

TABLE 3

PER CAPITA RATES OF PAYMENT FOR MEDICARE ENROLLEES

WITH

END-STAGE RENAL DISEASE

STATE	PART A	PART B
ALABAMA	$496.19	$1,084.21
ALASKA	$1,004.21	$1,686.60
ARIZONA	$699.71	$1,740.21
ARKANSAS	$445.29	$1,202.31
CALIFORNIA	$843.36	$1,725.98
COLORADO	$596.32	$1,543.55
CONNECTICUT	$756.81	$1,582.24
DELAWARE	$898.63	$1,563.54
DIST. OF COL.	$1,207.57	$1,732.26
FLORIDA	$656.96	$1,598.61
GEORGIA	$584.89	$1,495.69
HAWAII	$957.16	$1,917.67
IDAHO	$696.87	$1,144.78
ILLINOIS	$784.63	$1,673.74
INDIANA	$839.14	$1,532.16
IOWA	$643.34	$1,073.69
KANSAS	$896.87	$1,500.25
KENTUCKY	$879.29	$1,237.96
LOUISIANA	$588.14	$1,556.44
MAINE	$982.93	$1,317.65
MARYLAND	$1,190.24	$1,698.65
MASSACHUSETTS	$775.67	$1,252.04
MICHIGAN	$1,055.65	$1,485.79
MINNESOTA	$1,515.73	$1,383.51
MISSISSIPPI	$380.06	$1,633.12
MISSOURI	$706.44	$1,314.64
MONTANA	$790.73	$1,214.12
NEBRASKA	$662.32	$1,145.43
NEVADA	$799.68	$1,870.87
NEW HAMPSHIRE	$1,007.77	$1,529.95
NEW JERSEY	$671.35	$1,685.83
NEW MEXICO	$714.94	$1,280.65
NEW YORK	$651.68	$1,530.15
N. CAROLINA	$603.12	$1,406.36
N. DAKOTA	$1,294.64	$1,348.39
OHIO	$768.00	$1,426.83
OKLAHOMA	$618.80	$1,153.85
OREGON	$1,331.94	$1,536.13
PENNSYLVANIA	$793.28	$1,707.26
PUERTO RICO	$245.77	$1,437.06
RHODE ISLAND	$969.39	$1,748.52
S. CAROLINA	$613.34	$1,590.69
S. DAKOTA	$1,469.46	$1,350.27
TENNESSEE	$545.63	$1,388.73
TEXAS	$649.94	$1,523.82
UTAH	$571.47	$1,359.38
VERMONT	$987.80	$1,359.04
VIRGIN ISLANDS	$285.66	$1,639.76
VIRGINIA	$624.85	$1,542.18
WASHINGTON	$784.05	$1,188.74
W. VIRGINIA	$645.28	$1,453.97
WISCONSIN	$1,176.03	$1,327.92
WYOMING	$484.31	$1,158.19
GUAM	$740.23	$1,856.95

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BILLING CODE 4120-01-C

federal register

Thursday
January 10, 1985

Part VI

Office of Management and Budget

Budget Deferrals; Notice

OFFICE OF MANAGEMENT AND BUDGET

Budget Deferrals

To the Congress of the United States:

In accordance with the Impoundment Control Act of 1974, I herewith report two new deferrals of budget authority for 1985 totaling $11,000,000 and five revised deferrals now totaling $5,405,581,139. The deferrals affect International Security Assistance, the Departments of Defense, Health and Human Services, State, Transportation, and the United States Institute of Peace.

The details of these deferrals are contained in the attached report.

Ronald Reagan.

The White House,
January 4, 1985.

BILLING CODE 3110-01-M

CONTENTS OF SPECIAL MESSAGE
(in thousands of dollars)

DEFERRAL #	ITEM	BUDGET AUTHORITY
	Funds Appropriated to the President	
	International Security Assistance	
D85-2B	Economic support fund	4,179,733
D85-3B	Peacekeeping operations	7,000
	Department of Defense - Civil	
	Wildlife Conservation, Military Reservations	
D85-7A	Wildlife conservation	1,192
	Department of Health and Human Services	
	Assistant Secretary for Health	
	Scientific activities overseas	
D85-8A	(special foreign currency program)	1,013
	Department of State	
	Bureau for Refugee Programs	
	United States emergency refugee and	
D85-20A	migration assistance fund	33,081
	Department of Transportation	
	Federal Aviation Administration	
	Facilities and equipment (airport	
D85-11A	and airway trust fund)	1,190,162
	United States Institute of Peace	
D85-39	United States Institute of Peace	4,000
	Total, deferrals	5,416,181

SUMMARY OF SPECIAL MESSAGES
FOR FY 1985
(in thousands of dollars)

	RESCISSIONS	DEFERRALS
Fourth special message:		
New items	---	11,000
Revisions to previous special messages	---	726,996
Effects of fourth special message	---	737,996
Amounts from previous special messages that are changed by this message (changes noted above)	---	4,678,185
Subtotal, rescissions and deferrals	---	5,416,181
Amounts from previous special messages that are not changed by this message	---	7,529,203
Total amount proposed to date in all special messages	---	12,945,384

D85-2B

SUPPLEMENTARY REPORT

Report pursuant to Section 1014(c) of P.L. 93-344

This report updates Deferral No. D85-2A transmitted to the Congress on November 29, 1984.

This revision to a deferral of Funds Appropriated to the President for Economic support increases the amount previously reported as deferred from $4,106,500,000 to $4,179,732,508. This net increase of $73,232,508 is attributable to unanticipated carryover of unobligated balances from 1984.

Deferral No:*D85-2B

DEFERRAL OF BUDGET AUTHORITY
Report Pursuant to Section 1013 of P.L. 93-344

AGENCY:
Funds Appropriated to the President

Bureau:
International Security Assistance

Appropriation title and symbol:

Economic Support Fund 1/

114/51037
1151037
*11X1037

OMB Identification code:
11-1037-0-1-152

Grant program:
[X] Yes [ ] No

Type of account or fund:

[X] Annual

[X] Multiple-year March 31, 1985 (expiration date)

[*X] No-Year

New budget authority.....$3,826,000,000
(P.L. 98-473)
Other budgetary resources *371,765,053

Total budgetary resources*$4,197,765,053

Amount to be deferred:
Part of year *$4,179,732,508

Entire year 0

Legal authority (in addition to sec. 1013):
[X] Antideficiency Act
[ ] Other

Type of budget authority:
[X] Appropriation
[ ] Contract authority
[ ] Other

Coverage Appropriation	Symbol	Amount Deferred
Economic Support Fund, 1984-85	114/51037	$ 280,500,000
Economic Support Fund, 1985	1151037	3,826,000,000
*Economic Support Fund, No Year	11X1037	73,232,508
		$4,179,732,508

Justification: Pursuant to the Foreign Assistance Act (FAA) of 1961, as amended, the President is authorized to furnish assistance to promote economic or political stability in foreign countries on such terms and conditions as he may determine. Under Part II, Chapter 4, of the Foreign Assistance Act, the Secretary of State is responsible for policy decisions and justifications for such economic support programs, including the countries and amounts to be provided. Executive Order 12163 of September 29, 1979, further delegates the President's responsibilities under Chapter 4, related to policy decisions and justifications for economic support programs, to the Secretary of State. These functions will be exercised in cooperation with the Administrator of the Agency for International Development. These funds are deferred pending approval of specific loans and grants to eligible countries by the Secretary of State. This will insure that each approved program is consistent with the foreign, national security and financial policies of the U.S. and will not exceed the limits of available funds. This action is taken pursuant to the Antideficiency Act (31 U.S.C. 1512).

1/ This account was the subject of similar deferrals in 1984 (D84-24A, D84-60, and D84-66).

*Revised from previous report

Estimated Program Effect: None

Outlay Effect: None

Deferral No: D85-38

D85-7A

DEFERRAL OF BUDGET AUTHORITY
Report Pursuant to Section 1013 of P.L. 93-344

AGENCY:
Funds Appropriated to the President
Bureau:
International Security Assistance
Appropriation title and symbol:

Peacekeeping Operations

1151032

OMB identification code:
11-1032-0-1-152
Grant program:
[ ] Yes [X] No

Type of account or fund:
[X] Annual
[ ] Multiple-year _____ (expiration date)
[ ] No-Year

New budget authority..... $44,000,000
(P.L. 98-473)
Other budgetary resources _____
Total budgetary resources 44,000,000

Amount to be deferred:
Part of year $ 7,000,000
Entire year _____

Legal authority (in addition to sec. 1013):
[X] Antideficiency Act
[ ] Other _____

Type of budget authority:
[X] Appropriation
[ ] Contract authority
[ ] Other _____

Justification: Pursuant to the Foreign Assistance Act of 1961, as amended (Part II, Chapter 6), the President is authorized to furnish assistance to friendly countries and international organizations, on such terms and conditions as he may determine, for Peacekeeping Operations and other programs carried out in furtherance of the national security interests of the United States. The funds are deferred pending review and approval of program requirements by the President. This will insure that each approved program is consistent with the foreign and national security policies of the United States. This action is taken pursuant to the Antideficiency Act (31 U.S.C. 1512).

Estimated Program Effect: None

Outlay Effect: None

SUPPLEMENTARY REPORT

Report Pursuant to Section 1014(c) of Public Law 93-344

This report updates Deferral No. D85-7 transmitted to the Congress on October 1, 1984.

This revision to a deferral of Department of Defense wildlife conservation funds increases the amount previously reported as deferred from $1,127,197 to $1,191,677. This increase of $64,480 is attributable to increased estimates of receipts and adjustments in unobligated balances brought forward on October 1, 1984.

Deferral No: *D85-7A

DEFERRAL OF BUDGET AUTHORITY
Report Pursuant to Section 1013 of P.L. 93-344

AGENCY:
Department of Defense - Civil
Bureau: Wildlife Conservation, Military Reservations
Appropriation title and symbol:
Wildlife Conservation, Army - 21X5095
Wildlife Conservation, Navy - 17X5095
Wildlife Conservation, Air Force - 57X5095

OMB Identification code:
97-5095-0-2-303
Grant program:
[ ] Yes [X] No

Type of account or fund:
[ ] Annual
[ ] Multiple-year (expiration date)
[X] No-Year

New budget authority..... $1,721,000
(P.L. 16 USC 670F)
Other budgetary resources * 1,430,059
Total budgetary resources * 3,151,059

Amount to be deferred:
Part of year * $ 14,618
Entire year * 1,177,059

Legal authority (in addition to sec. 1013):
[X] Antideficiency Act
[ ] Other

Type of budget authority:
[X] Appropriation
[ ] Contract authority
[ ] Other

Coverage: 1/

Appropriation	Symbol	OMB Identification Code	Amount Deferred
Wildlife Conservation, Army....	21X5095	21-5095-0-2-303	$ 825,000
Wildlife Conservation, Navy....	17X5095	17-5095-0-2-303	* 161,428
Wildlife Conservation, Air Force	57X5095	57-5095-0-2-303	* 205,249
			*$1,191,677

Justification: These are permanent appropriations of receipts generated from hunting and fishing fees in accordance with the purpose of the law--to carry out a program of natural resource conservation. These funds are being deferred because: (1) installations may be accumulating funds over a period of time to fund a major project, (2) the installation may be designing and obtaining approval for the project, and (3) there is a seasonal relationship between the collection of fees and their subsequent expenditure. Most of the fees are collected during the winter and spring months, while most of the program work is performed during the summer and fall months. This necessitates that funds collected in a prior year be deferred in order to be available to finance the program during summer and fall months or in subsequent years. Additional amounts will be apportioned if program requirements are identified. This deferral is made under the provisions of the Antideficiency Act (31 U.S.C. 1512).

1/ These accounts were the subject of a similar deferral in 1984 (D84-7).

* Revised from previous report.

Estimated Program Effect: None

Outlay Effect: None

D85-8A

SUPPLEMENTARY REPORT

Report Pursuant to Section 1014(c) of P.L. 93-344

This report updates Deferral No. D85-8 transmitted to the Congress on October 1, 1984.

This revision of a deferral for the Scientific Activities Overseas Program of the Department of Health and Human Services increases the previously reported deferral amount from $423,762 to $1,013,378. This increase results from a higher level of unobligated balance actually brought forward into fiscal year 1985 than previously estimated.

Deferral No: *D85-8A

DEFERRAL OF BUDGET AUTHORITY
Report Pursuant to Section 1013 of P.L. 93-344

AGENCY: Department of Health and Human Services **Bureau:** Assistant Secretary for Health **Appropriation title and symbol:** Scientific activities overseas (special foreign currency program) 1/ 75X1102 **OMB identification code:** 75-1102-0-1-552 **Grant program:** | | Yes | X | No	**New budget authority.....** $ _____ (P.L. _____) **Other budgetary resources** *7,252,451 **Total budgetary resources** *7,252,451 **Amount to be deferred:** **Part of year** $ _____ **Entire year** *1,013,378 **Legal authority** (in addition to sec. 1013): | X | Antideficiency Act | | Other _____
Type of account or fund: | | Annual | | Multiple-year _____ (expiration date) | X | No-Year	**Type of budget authority:** | X | Appropriation | | Contract authority | | Other _____

Justification: The Scientific activities overseas program is funded with appropriations of excess foreign currencies owned by the United States. The currencies of Burma, Guinea, India, and Pakistan held by the Treasury have been designated as excess to normal U.S. needs in 1984 and are expected to be excess in 1985. Funds for this program, which remain available until expended, are used for scientific research projects in those countries.

The amount of funds to be obligated during 1985 and the amount to be deferred for the entire year were determined after a careful review of the scientific merit of project proposals in the countries for which excess currency is available. The research projects in those countries that will contribute toward meeting U.S. scientific needs have been selected for funding in 1985. The amount being deferred is excess to current program requirements and is being reserved under the provisions of the Antideficiency Act (31 U.S.C. 1512).

Estimated Program Effect: None

Outlay Effect: None

1/ This account was the subject of a similar deferral in 1984 (D84-9A).

* Revised from previous report.

D85-20A

SUPPLEMENTARY REPORT

Report Pursuant to Section 1014(c) of P.L. 93-344

This report updates Deferral No. D85-20 transmitted to the Congress on October 31, 1984.

This revision to a deferral of State Department funds for emergency refugee and migration assistance increases the amount previously reported as deferred from $32,928,000 to $33,080,636. This net increase of $152,636 results from an unanticipated deobligation for the Cuban/Haitian program.

Deferral No: *D85-20A

DEFERRAL OF BUDGET AUTHORITY
Report Pursuant to Section 1013 of P.L. 93-344

AGENCY: Department of State	New budget authority..... $ (P.L.)
Bureau: Bureau for Refugee Programs	Other budgetary resources *33,175,201
Appropriation title and symbol: United States emergency refugee and migration assistance fund, executive 1/ 11X0040	Total budgetary resources *33,175,201
	Amount to be deferred: Part of year $*33,080,636
	Entire year
OMB identification code: 11-0040-0-1-151	Legal authority (in addition to sec. 1013): [X] Antideficiency Act
Grant program: [ ] Yes [X] No	[ ] Other
Type of account or fund: [ ] Annual	**Type of budget authority:** [X] Appropriation
[ ] Multiple-year (expiration date)	[ ] Contract authority
[X] No-Year	[ ] Other

Justification: Section 501(a) of the Foreign Relations Authorization Act, 1976 (Public Law 94-141) and Section 414 (b) (1) of the Refugee Act of 1980 (Public Law 96-212) amended Section 2 (c) of the Migration and Refugee Assistance Act of 1962 (22 U.S.C. 2601) by authorizing a fund not to exceed $50,000,000 to enable the President to provide emergency assistance for unexpected urgent refugee and migration needs.

Executive Order No. 11922 of June 16, 1976, allocated all funds appropriated to the President for the Emergency Fund to the Secretary of State but reserved for the President the determination of assistance to be furnished and the designation of refugees to be assisted by the Fund.

*The Emergency Fund contains $33,175,201 in unobligated balances from prior-year authority. Of this amount, $33,080,636 has been deferred pending Presidential decisions required by Executive Order No. 11922 and to achieve the most economical use of appropriations. Funds will be released as the President determines assistance to be furnished and designates refugees to be assisted by the Fund. This deferral action is taken under the provisions of the Antideficiency Act (31 U.S.C. 1512).

Estimated Program Effect: None

Outlay Effect: None

1/ This account was the subject of a similar deferral during 1984 (D84-12A).

* Revised from previous report.

D85-11A

Deferral No:*D85-11A

SUPPLEMENTARY REPORT

Report Pursuant to Section 1014(c) of P.L. 93-344

This report updates Deferral No. D85-11 transmitted to the Congress on October 1, 1984.

This revision to a deferral of Department of Transportation funds for Federal Aviation Administration facilities and equipment, increases the amount previously reported as deferred from $537,205,361 to $1,190,162,400 of which $163,000,000 has already been released. The net increase of $652,957,039 is attributable to amounts appropriated in the Department of Transportation and Related Agencies Appropriation Act, 1985.

Deferral No: *D85-11A

DEFERRAL OF BUDGET AUTHORITY

Report Pursuant to Section 1013 of P.L. 93-344

AGENCY:

Department of Transportation

Bureau:

Federal Aviation Administration

Appropriation title and symbol:

Facilities and equipment (Airport and airway trust fund) 1/

69X8107 693/78107 *695/98107
692/68107 694/88107

OMB identification code:

69-8107-0-7-402

Grant program:

[ ] Yes [X] No

Type of account or fund:

[ ] Annual — 692/68107 9/30/86; 693/78107 9/30/87; 694/88107 9/30/88

[X] Multiple-year — *695/98107 9/30/89 (expiration date)

[X] No-Year

New budget authority..... $*1,370,000,000
(P.L. 98-473)

Other budgetary resources *1,158,292,000

Total budgetary resources *2,528,292,000

Amount to be deferred:

Part of year $* 163,000,000

Entire year *1,027,162,400

Legal authority (in addition to sec. 1013):

[X] Antideficiency Act

[ ] Other

Type of budget authority:

[X] Appropriation

[ ] Contract authority

[ ] Other

Justification: Funds from this account are used to continue to procure specific Congressionally-approved facilities and equipment for the expansion and modernization of the National Airspace System. The projects financed from this account include construction of buildings and the purchase of new equipment for new or improved air traffic control towers, automation of the en route airway control system, and expansion and improvement in the navigational and landing aid systems. These activities were justified and provided for in the Department's regular budget submissions and were appropriated by Congress for the year in which requested. Due to the lengthy procurement and construction time for interrelated facilities and complex equipment systems, it is not possible to obligate all the funds necessary to complete each project in the year funds were appropriated. Therefore, it is necessary to defer these funds. This action is consistent with FAA's full funding approach and Congressional intent to provide multi-year funding for the total costs of projects. This action is taken under provisions of the Antideficiency Act (31 U.S.C. 1512), which authorizes the establishment of reserves for contingencies.

Estimated Program Effect: None

Outlay Effect: None

1/ This account was the subject of a similar deferral in 1984 (D84-14).

*Revised from previous report.

Deferral No: D85-39

DEFERRAL OF BUDGET AUTHORITY
Report Pursuant to Section 1013 of P.L. 93-344

AGENCY: United States Institute of Peace **Bureau:**	**New budget authority.....** $4,000,000 (P.L. 98-473) **Other budgetary resources** **Total budgetary resources**
Appropriation title and symbol: United States Institute of Peace 955/61300	**Amount to be deferred:** **Part of year** $4,000,000 **Entire year**
OMB identification code: 95-1300-0-1-153 **Grant program:** [ ] Yes [X] No	**Legal authority (in addition to sec. 1013):** [X] Antideficiency Act [ ] Other
Type of account or fund: [ ] Annual [X] Multiple-year September 30, 1986 (expiration date) [ ] No-Year	**Type of budget authority:** [X] Appropriation [ ] Contract authority [ ] Other

Justification: Pursuant to the United States Institute of Peace Act, P.L. 98-525, Title XVII, the U. S. Institute of Peace will provide education and training, basic and applied research opportunities, and information services on the means to promote international peace and conflict resolution. The Board of Directors of the Institute may transfer to the Endowment of the Institute any funds not obligated or expended from appropriations to the Institute for a fiscal year. Such funds shall remain available for the purposes of such legal entity (the Endowment) without regard to fiscal year limitations. Funds are deferred pending organization of the Institute, appointment of its Board of Directors, selection of a location, and designation of its legal entity (the Endowment). This will insure that necessary legal and organizational efforts are made to establish the Institute as a legal entity capable of properly administering the funds appropriated by Congress. This action is taken pursuant to the Antideficiency Act (31 U.S.C. 1512).

Estimated Program Effect: None

Outlay Effect: None

[FR Doc. 85-811 Filed 1-9-85; 8:45 am]
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Thursday, January 10, 1985

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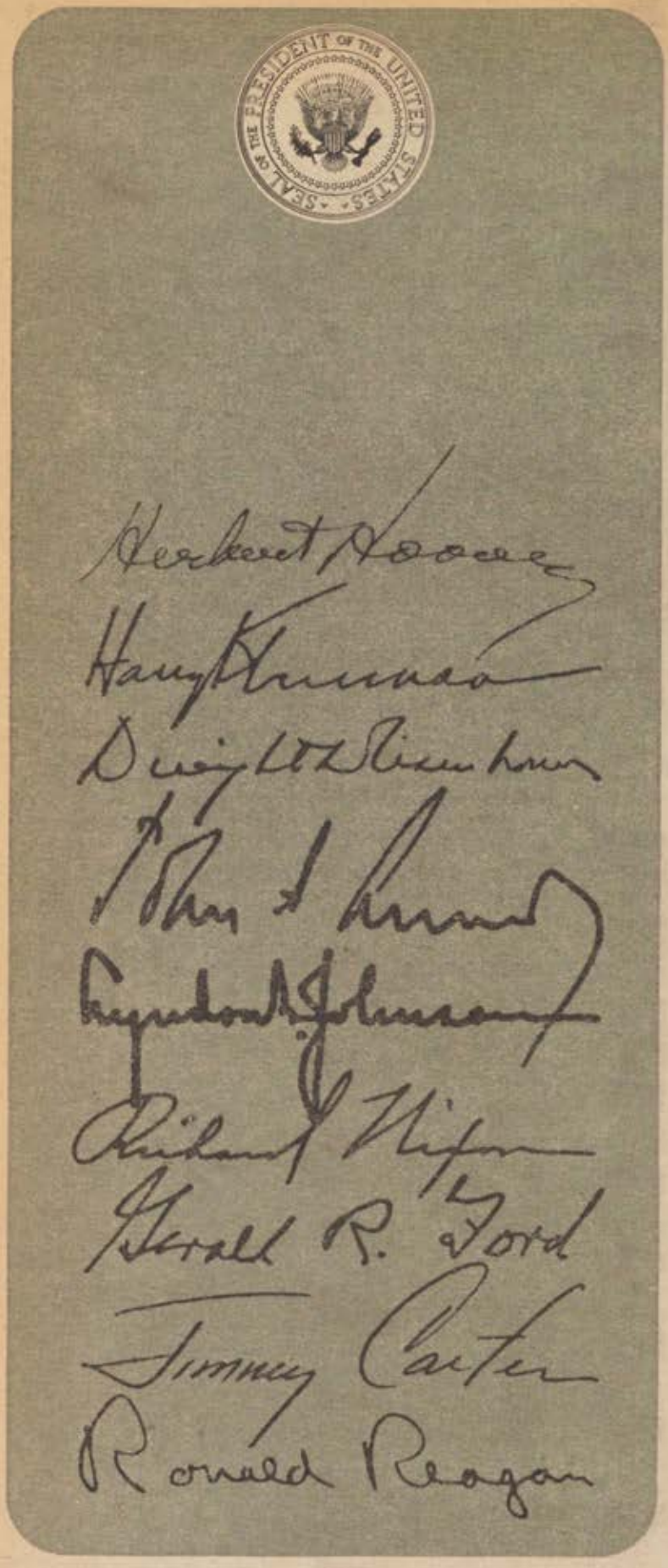
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