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June 26, 1998

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WHY: To provide the public with access to information necessary to research Federal agency regulations which directly affect them. There will be no discussion of specific agency regulations.

WASHINGTON, DC

WHEN: July 14, 1998 at 9:00 am

WHERE: Office of the Federal Register
Conference Room
800 North Capitol Street, NW.
Washington, DC
(3 blocks north of Union Station Metro)

RESERVATIONS: 202–523–4538

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Separate Parts In This Issue

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

CFR PARTS AFFECTED IN THIS ISSUE

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

Rules and Regulations

Federal Register

Vol. 63, No. 123

Friday, June 26, 1998

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 581 and 582

RIN 3206–AH43

Processing Garnishment Orders for Child Support and Alimony and Commercial Garnishment of Federal Employees' Pay

AGENCY: Office of Personnel Management.

ACTION: Final rule; correction.

SUMMARY: This document corrects errors that appeared in the list of agents designated to accept legal process for child support and alimony and the list of agents designated to facilitate the service of legal process on Federal employees (Appendices A and B to Part 581) that were published on March 26, 1998 (63 FR 14756).

EFFECTIVE DATE: The final regulations were effective on April 27, 1998.

FOR FURTHER INFORMATION CONTACT: Murray M. Meeker, Senior Attorney, Office of the General Counsel, (202) 606–1700.

U.S. Office of Personnel Management.

Janice R. Lachance,

Director.

Accordingly, OPM amends 5 CFR part 581 as follows:

PART 581—PROCESSING GARNISHMENT ORDERS FOR CHILD SUPPORT AND ALIMONY

1. The authority citation for Part 581 continues to read as follows:

Authority: 42 U.S.C. 659; 15 U.S.C. 1673; E.O. 12105 (43 FR 59465 and 3 CFR 262).

2. The listing for the Department of Agriculture's Marketing and Regulatory Programs, including the Agricultural Marketing Service (except for employees of the Milk Marketing Administration); the Animal and Plant Health Inspection Service; and the Grain Inspection, Packers and Stockyards Administration, on page 14760, column 1, is corrected as follows:

Marketing and Regulatory Programs
  Agricultural Marketing Service (except for employees of the Milk Marketing Administration)
  Animal and Plant Health Inspection Service
  Grain Inspection, Packers and Stockyards Administration
Chief, Human Resources, USDA, APHIS, Butler Square West, 5th Floor, 100 North 6th Street, Minneapolis, MN 55403, (612) 370–2107

3. The listing for what were formerly the Department of Agriculture's Rural Economic and Community Development, the Rural Housing and Community Development Service, and the Rural Business and Cooperative Development Service, on page 14760, column 2, is corrected as follows:

Rural Development
  Rural Housing Service
  Rural Business-Cooperative Service
  Rural Utilities Service
Chief, Human Resources Programs Branch, Human Resources, Rural Development, 1400 Independence Avenue, SW., Stop 0730, Washington, DC 20250–0730, (202) 692–0194

4. The listing for the Department of Agriculture's Research, Education, and Economics, including the Agricultural Research Service; the Cooperative State Research, Education, and Extension Service; the National Agricultural Statistics Service; and the Economic Research Service, on page 14763, column 2, is corrected as follows:

Research, Education, and Economics
  Agricultural Research Service
  Cooperative State Research, Education, and Extension Service
  Economic Research Service
  National Agricultural Statistics Service
Director, Human Resources Division, Administrative and Financial Management Staff, Agricultural Research Service, 5601 Sunnyside Avenue, Room 3–1145A, Beltsville, MD 20705–5101, (301) 504–1478

5. The listing for the Federal Bureau of Investigation of the Department of Justice on page 14766, column 2, is corrected as follows: Chief, Payroll Administration and Processing Unit, Room 1885, 935 Pennsylvania Avenue, NW., Washington, DC 20535, (202) 324–5881.

6. The listing for the Department of Veterans Affairs' Huntington Regional Office, on page 14774, column 3, is corrected as follows: Fiscal Officer, Huntington Regional Office, 640 Fourth Avenue, Huntington, WV 25701, (304) 529–5477.

7. The listing for the International Trade Commission is added in alphabetical order on page 14775, column 3, as follows:

International Trade Commission

Director, Office of Finance and Budget, 500 E Street, SW., Suite 316, Washington, DC 20436, (202) 205–2678

8. The listing for the Trade and Development Agency is added in alphabetical order on page 14777, column 2, as follows:

Trade and Development Agency

Effective August 3, 1998, garnishment orders for employees of the United States Trade and Development Agency should be sent to: Chief, Payroll Operations Division, Attn.: Code D–2640, Bureau of Reclamation, Administrative Services Center, Department of the Interior, P.O. Box 272030, Denver, CO 80227–9030, (303) 969–7739.

9. The listing for the Executive Office of the President, on page 14777, column 3, is corrected as follows:

Garnishment orders for civilian employees of the Executive Office of the President should be sent to: Assistant General Counsel for Garnishment Operations, Defense Finance and Accounting Service, Cleveland Center—Code L (DFAS–CL/L), P.O. Box 998002, Cleveland, OH 44199–8002, (216) 522–5301.

10. The listing for the Federal Bureau of Investigation of the Department of Justice on page 14778, column 3, is removed.

[FR Doc. 98–17134 Filed 6–25–98; 8:45 am]

BILLING CODE 6325–01–U

DEPARTMENT OF AGRICULTURE

Federal Crop Insurance Corporation

7 CFR Parts 435 and 457

RIN 0563–AB47

Tobacco (Quota Plan) Crop Insurance Regulations; and Common Crop Insurance Regulations; Quota Tobacco Crop Insurance Provisions

AGENCY: Federal Crop Insurance Corporation, USDA.

ACTION: Final rule.

SUMMARY: The Federal Crop Insurance Corporation (FCIC) finalizes specific crop provisions for the insurance of quota tobacco. The provisions will be used in conjunction with the Common Crop Insurance Policy, Basic Provisions, which contain standard terms and conditions common to most crops. The intended effect of this action is to provide policy changes to better meet the needs of the insured, include the current tobacco (quota plan) crop insurance regulations with the Common Crop Insurance Policy for ease of use and consistency of terms, and to restrict the effect of the current tobacco (quota plan) crop insurance regulation to the 1998 and prior crop years.

EFFECTIVE DATE: July 27, 1998.

FOR FURTHER INFORMATION CONTACT: Gary Johnson, Insurance Management Specialist, Research and Development, Product Development Division, Federal Crop Insurance Corporation, United States Department of Agriculture, 9435 Holmes Road, Kansas City, MO, 64131, telephone (816) 926–7730.

SUPPLEMENTARY INFORMATION:

Executive Order 12866

This rule has been determined to be exempt for the purposes of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget (OMB).

Paperwork Reduction Act of 1995

Pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35), the collections of information for this rule have been approved by the Office of Management and Budget (OMB) under control number 0563–0053 through October 31, 2000.

Unfunded Mandates Reform Act of 1995

Title II of the Unfunded Mandates Reform Act of 1995 (UMRA), Public Law 104–4, establishes requirements for Federal agencies to assess the effects of their regulatory actions on State, local, and tribal governments and the private sector. This rule contains no Federal mandates (under the regulatory provisions of title II of the UMRA) for State, local, and tribal governments or the private sector. Thus, this rule is not subject to the requirements of sections 202 and 205 of the UMRA.

Executive Order 12612

It has been determined under section 6(a) of Executive Order 12612, Federalism, that this rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment. The provisions contained in this rule will not have a substantial direct effect on States or their political subdivisions, or on the distribution of power and responsibilities among the various levels of government.

Regulatory Flexibility Act

This regulation will not have a significant economic impact on a substantial number of small entities. New provisions included in this rule will not impact small entities to a greater extent than large entities. Under the current regulations, a producer is required to complete an application and acreage report. If the crop is damaged or destroyed, the insured is required to give notice of loss and provide the necessary information to complete a claim for indemnity.

The amount of work required of insurance companies delivering and servicing these policies will not increase significantly from the amount of work currently required. The rule does not have any greater or lesser impact on the producer. Therefore, this action is determined to be exempt from the provisions of the Regulatory Flexibility Act (5 U.S.C. 605), and no Regulatory Flexibility Analysis was prepared.

Federal Assistance Program

This program is listed in the Catalog of Federal Domestic Assistance under No. 10.450.

Executive Order 12372

This program is not subject to the provisions of Executive Order 12372 which require intergovernmental consultation with State and local officials. See the Notice related to 7 CFR part 3015, subpart V, published at 48 FR 29115, June 24, 1983.

Executive Order 12988

This rule has been reviewed in accordance with Executive Order 12988 on civil justice reform. The provisions of this rule will not have a retroactive effect. The provisions of this rule will preempt State and local laws to the extent such State and local laws are inconsistent herewith. The administrative appeal provisions published at 7 CFR part 11 must be exhausted before any action for judicial review of any determination made by FCIC may be brought.

Environmental Evaluation

This action is not expected to have a significant impact on the quality of the human environment, health, and safety. Therefore, neither an Environmental Assessment nor an Environmental Impact Statement is needed.

National Performance Review

This regulatory action is being taken as part of the National Performance Review Initiative to eliminate unnecessary or duplicative regulations and improve those that remain in force.

Background

On Tuesday, May 13, 1997, FCIC published a notice of proposed rulemaking in the **Federal Register** at 62 FR 26248–26252 to add to the Common Crop Insurance Regulations (7 CFR part 457), a new section, 7 CFR 457.156, Quota Tobacco Crop Insurance Provisions. The new provisions will be effective for the 1999 and succeeding crop years. These provisions will replace and supersede the current provisions for insuring quota tobacco found at 7 CFR part 435 (Tobacco (Quota Plan) Crop Insurance Regulations). FCIC also amends 7 CFR part 435 to limit its effect to the 1985 through 1998 crop years.

Following publication of the proposed rule, the public was afforded 30 days to submit written comments and opinions. A total of 510 signed petitions were received from North Carolina and Virginia tobacco producers, and 88 comments were received from an insurance service organization and reinsured companies. The comments received and FCIC's responses are as follows:

Comment: Two reinsured companies and an insurance service organization recommended that the definition of ''amount of insurance'' be revised to read, ''the dollar amount determined by multiplying the insured poundage quota by the current year's support price or the percentage of the current year's support price you select.'' This revision addresses the possibility of insureds selecting price elections of less than 100 percent.

Response: FCIC agrees with the comment and has amended the definition accordingly. FCIC also has revised this definition to address the possible reduction in the amount of

insurance for late planted acreage in accordance with section 14.

Comment: An insurance service organization recommended that FCIC either revise or delete the definition of ''approved yield.'' The commenter mentioned that since quota tobacco currently is not an Actual Production History (APH) crop, the definition will be questioned by insureds who do not receive a copy of the Code of Federal Regulations with their crop insurance policies.

Response: ''Approved yield'' is referenced in section 3 of the crop provisions, so it must be defined. Section 3 clearly indicates that an approved yield is not necessary unless required by the Special Provisions. As written, if the FSA quota tobacco support price program is discontinued and quota tobacco becomes an APH crop in the future, the Special Provisions could be amended easily to require an approved yield. Therefore, no changes have been made.

Comment: A reinsured company and an insurance service organization made the following recommendations to revise the definition of ''effective poundage marketing quota'': (1) Remove the words ''minus the amount of any carryover tobacco'' because crop insurance is designed to cover the tobacco crop actually grown the current crop year, and the restriction of yield times acres in the definition of ''insured poundage quota'' would take care of any allowance the producer made for carryover tobacco; (2) Clarify whether any additional poundage the producer intends to produce must be leased or if it can be grown without any marketing quota; (3) Add language to the definition of ''effective poundage marketing quota'' from section 7(b), which states that effective poundage marketing quota may not include any tobacco that would be subject to a marketing quota penalty under the United States Department of Agriculture (USDA) Tobacco Marketing Quota Regulations; and (4) Revise the definition to exclude the word ''county'' because the farm marketing quota is established by the Farm Service Agency (FSA) on a Farm Serial Number (FSN) basis.

Response: (1) Although, producers will normally reduce the number of acres grown in the current crop year to account for carryover production from the prior years, they may instead elect to reduce inputs (fertilizer, etc.), thereby producing fewer pounds per acre. To maintain the appropriate relationship between the number of planted acres and the effective poundage marketing quota, the amount of any carryover production should be removed from the effective poundage marketing quota. Therefore, no change has been made. (2) FCIC agrees with the recommendation and has clarified the definition of ''effective poundage marketing quota'' to include any additional (above quota) poundage as allowed by the USDA Tobacco Marketing Quota Regulations. Under current (FSA) procedures, a minimal percentage of additional poundage is allowed to be marketed. (3) FCIC agrees and has revised the definition of ''effective poundage marketing quota'' accordingly. (4) The definition has been clarified to refer to the FSA office for the county and the effective poundage marketing quota for the FSN.

Comments: A reinsured company and an insurance service organization expressed concerns with the definition of ''good farming practices,'' which makes reference to ''cultural practices generally in use in the county * * *'' recognized by the Cooperative State Research, Education, and Extension Service as compatible with agronomic and weather conditions in the county.'' The commenters questioned whether cultural practices exist that are not necessarily recognized (or possibly not known) by the Cooperative State Research, Education, and Extension Service. The commenters also indicated that the term ''county'' in the definition of ''good farming practices'' should be changed to ''area.''

Response: FCIC believes that the Cooperative State Research, Education, and Extension Service (CSREES) recognizes farming practices that are considered acceptable for producing quota tobacco. If a producer is following practices currently not recognized as acceptable by CSREES, there is no reason why such recognition cannot be sought by interested parties. The term ''area'' is less definitive than the term ''county'' and would cause insurance providers to make determinations more subjective in nature. Therefore, no change has been made in response to this comment, except that the definition of ''good farming practices'' has been moved to the Basic Provisions.

Comments: A reinsured company and an insurance service organization recommended revising the definition of ''harvest'' to include a requirement that at least 20 percent of the production guarantee must be cut on each acre to qualify as harvested. Commenters also recommended that a minimum appraisal of 35 percent of the amount of insurance be established to encourage producers to harvest damaged tobacco. In some cases, it will be difficult to verify unharvested production due to deterioration of the leaves before the adjuster works the final claim. The commenters believe that removal of these requirements from the current crop provisions will result in a significant increase in premium rates. Commenters expressed concern that FCIC may have overreacted if the changes were made because of one lawsuit.

Response: FCIC has determined that the requirement that at least 20 percent of the production guarantee be cut on each acre to qualify as harvested and the 35 percent minimum appraisal for unharvested acreage is too severe. Producers should not be forced to incur the costs associated with harvesting tobacco acres that may not be marketable. In addition, FCIC cannot ignore a court ruling that such provisions are unenforceable. Therefore, no change has been made in the final rule provisions.

Comments: A reinsured company and an insurance service organization noted that the definition of ''harvest'' refers to the phrase ''removing tobacco from the field.'' They believe this is a determination of when coverage ceases, which is already included in section 9(c) of these provisions.

Response: Definitions are included in the crop provisions for clarification of policy provisions. The definition of harvest is needed because this term and its opposite ''unharvested'' are used repeatedly in section 12 (Settlement of Claim) (redesignated as section 13). The insurance period is defined in section 9 (redesignated as section 10). When the crop is harvested does not solely determine when coverage ceases. Therefore, no change has been made.

Comments: An insurance service organization asked why the phrase ''the average auction price * * *'' in the definition of ''market price'' was changed to ''the previous years' season average price published by National Agricultural Statistics Service * * *''

Response: The phrase was changed for clarification. In practice the ''average auction price'' has been interpreted consistently as the previous years'' season average price published by National Agriculture Statistics under the current crop provisions. Therefore, no change has been made.

Comments: An insurance service organization recommended deleting ''marketing window'' from the definition of ''practical to replant.'' The commenters stated that quota tobacco is unlike other crops, such as processor and fresh market crops, where the producer only has a certain amount of time to market the crop.

Response: FCIC agrees that the concept of a ''marketing window'' is

most applicable to processor and fresh market crops and recognizes that quota tobacco is unlike these crops. However, the Federal Agriculture Improvement and Reform Act of 1996 mandated that FCIC consider marketing windows in determining whether it is feasible to require planting during a crop year. Therefore, no change has been made, except that the definition of ''practical to replant'' has been moved to the Basic Provisions.

Comments: A reinsured company and an insurance service organization expressed concern about the terms ''replace'' and ''replacing'' in the definition of ''replanting.'' Commenters stated that the terms, as used, seem awkward and cumbersome.

Response: FCIC believes that the definition of ''replanting'' clearly describes the steps required to replant the crop. However, FCIC has replaced the phrase ''growing a successful tobacco crop'' with ''producing at least the quota,'' for clarity.

Comments: An insurance service organization recommended that the definition of ''support price'' be amended to read ''type 31 tobacco'' since type 31 is the only type of tobacco that is insurable under these provisions.

Response: FCIC believes that the definition is clearly stated. The term ''type'' is written for the flexibility of insuring other types of tobacco if designated in the Special Provisions.

Comment: A reinsured company and an insurance service organization recommended moving the definition of ''unit'' to section 2 for consistency.

Response: All policy definitions are contained in section 1 for uniformity. Therefore, no change has been made in this regard. FCIC has changed the term ''unit'' to ''Basic Unit,'' however, to conform to recent changes in the Basic Provisions.

Comments: An insurance service organization and 510 growers recommended that the unit division guidelines of these provisions be the same as currently specified for Guaranteed Tobacco. Those provisions define basic units by share and optional units by Farm Serial Number (FSN). Commenters believe that this change would resolve the current conflict between basic units (by share) as defined for Catastrophic Risk Protection (CAT) and basic units (by FSN) for buy-up policyholders.

Response: FCIC acknowledges that adopting the unit division rules contained in the Common Crop Insurance Policy for quota tobacco would resolve the conflict between unit definition for catastrophic coverage and additional coverage that now exists. However, the current unit definition for quota tobacco was adopted beginning with the 1985 crop year to resolve a vulnerability that exists in this program. Prior to that time, units were defined similarly for guaranteed and quota tobacco. Consider a landlord who share rents a portion of the quota to a tenant and also produces quota tobacco on the Farm Serial Number (FSN). Under the basic unit definition of the Common Crop Insurance Policy, two basic units are established for the landlord (a 100 percent share and the share with the tenant). One basic unit is established for the tenant. Under the definition contained in the Quota Tobacco Crop Provisions, one basic unit is established for each producer by FSN.

The insured quantity under these provisions is the insured marketing quota, a quantity that is independent of acreage if a sufficient number of acres are planted. Premium is charged only on the amount of insured marketing quota. Under the ''Basic unit'' definition contained in the Quota Tobacco Crop Provisions, the landlord's share of all production from the FSN is counted against the landlord's share of the quota. Under the ''Basic unit'' definition contained in the Common Crop Insurance Provisions, there is greater opportunity to plant additional acreage and manipulate production within the FSN so that the entire quota may be produced and sold, yet a loss be paid on one unit. However, premium will not be collected on the additional acreage.

Due to a large number of comments on this particular issue, FCIC will review any additional information that may support a different approach to establishing units for quota tobacco. All such information must specifically address the concern described herein and demonstrate how it will be alleviated by the proposed unit definition. Pending the submission of such information, FCIC will implement the basic unit definition contained in the proposed rule and will consider any changes at such date as the information may be available. If warranted, the unit definition can be changed for the 2000 or a subsequent crop year.

Comment: A reinsured company and an insurance service organization recommended removing any references to ''annual production reports'' for the APH plan. The commenters contend that if the FSA quota tobacco support program is changed or eliminated, it will be necessary to revise several provisions of the policy.

Response: Section 3 of these provisions requires annual production reports only when required by the Special Provisions. The current method of establishing farm yields will continue for the 1998 crop year. If the quota tobacco support price program is discontinued or modified in future years, these provisions provide an alternative method for establishing the production guarantee. Therefore, no change has been made. However, FCIC has amended the definition of ''support price'' to include the possibility that the tobacco support program may be changed. If there is no tobacco support program, FCIC will announce the average price per pound for the type of tobacco.

Comments: A reinsured company and an insurance service organization recommended deleting the word ''carryover'' in section 6(a). Commenters stated that the basic premise of multiple peril crop insurance coverage is to insure actual planted acreage of the crop. Subtracting the carryover poundage would take coverage away from a planted crop which is legally insurable (i.e., the carryover poundage has value and is exposed to perils). This could have additional unwanted consequences by making the insurance providers responsible for tracking and placing value on carryover poundage.

Response: Although producers normally reduce the number of acres grown in the current crop year to account for carryover production from the prior year, they may instead elect to reduce inputs (fertilizer, etc.), thereby producing fewer pounds per acre. Further, to maintain the appropriate relationship between the number of planted acres and the effective poundage marketing quota, the amount of any carryover production should be removed from the effective poundage marketing quota. Therefore, no change has been made.

Comments: A reinsured company and an insurance service organization recommended that section 6(a) be revised to remove the phrase, ''once submitted, you may not revise the acreage report,'' because section 6(c), now 6(d), of the Basic Provisions already states, ''* * *you may not revise this report after the acreage reporting date without our consent.'' The commenter inquired about the impact of changes in information between the time an acreage report is submitted and the actual acreage reporting date. The commenter stated that, if this sentence remains in the crop provisions, tobacco insureds will wait until the last day to report acreage.

Response: FCIC agrees that section 6(d) of the Basic Provisions is adequate and has deleted this language from the Crop Provisions.

Comments: A reinsured company and an insurance service organization recommended revising section 7(a) to read ''type 31 tobacco designated in the Special Provisions, in which you have a share.'' Commenters noted that the current quota policy refers to only type 31 tobacco.

Response: FCIC agrees that the current quota tobacco policy only refers to type 31 tobacco. However, section 7(a) (redesignated as section 8(c)) is intended to allow the flexibility of insuring other types of tobacco if they are designated in the Special Provisions. Therefore, FCIC has not revised section 7(a). FCIC has changed section 12(d) (redesignated as section 13(d)) to refer to ''U.S. Official Standard Grades for the insured type of tobacco,'' rather than ''U.S. Official Standard Grades, Burley Tobacco, U.S. Type 31,'' for consistency.

Comments: A reinsured company and an insurance service organization asked if the provisions in section 8(c) are intended to allow written agreement requests for a type not rated in the actuarial documents.

Response: Section 8(c) (redesignated as section 9(c)) only references a method of planting. Therefore, section 9(c) does not authorize written agreements for types not rated.

Comments: A reinsured company and an insurance service organization questioned why section 9(a) is not as precise as section 11(a) of the Basic Provisions, which specifies ''total destruction * * * on the unit.''

Response: FCIC has revised section 9(a) (redesignated as section 10(a)) to refer to total destruction of the tobacco on the unit.

Comment: A reinsured company and an insurance service organization asked if the current requirement that notice be given without delay if any tobacco is damaged and will not be sold through an auction warehouse was removed intentionally from section 11.

Response: Section 14(a)(2) of the Basic Provisions states ''* * *you must * * *give us notice within 72 hours of your initial discovery of damage* * *'' FCIC believes this requirement is substantially the same as requiring a notice ''without delay,'' so the latter requirement of section 11 was removed in the proposed rule.

Comment: Two reinsured companies and an insurance service organization recommended that section 12(b)(1) reference price elections less than 100 percent of the support price. The commenters indicated that the language as written could be taken to mean that the insured poundage quota will be multiplied by 100 percent of the support price even for CAT policies.

Response: FCIC agrees with the recommendation and has amended section 12(b)(1) (redesignated as section 13(b)(1)) to read ''multiplying the insured poundage quota by your elected percentage of the current year's support price.''

Comments: Two reinsured companies and an insurance service organization recommended the following: (1) Add the word ''resulting'' in section 12 (b)(2); and (2) Remove the reference to ''section 12(b)(2)'' from section 12(b)(3) because it is not necessary to reference the previous item by number.

Response: The recommendations do not add any additional clarification to the provision. Therefore, no changes have been made.

Comments: Two reinsured companies and an insurance service organization recommend removing the words ''acceptable production records'' from section 12(c)(1)(D), if these words relate to other APH references in these provisions.

Response: As stated in earlier responses, section 12(c)(1)(D) (redesignated as section 13(c)(1)(D)) will only apply if annual production reports are required by the Special Provisions, and the provision has been so clarified.

Comments: Two reinsured companies and an insurance service organization expressed concern that section 12(c)(1)(iii) of these provisions allows the insured to defer settlement and wait for a later, generally lower appraisal.

Response: Section 12(c)(1)(iii) (redesignated as section 13(c)(1)(iii)) allows deferment of a claim only if the insurance provider agrees that representative samples can be left or if the insured elects to continue to care for the entire crop. In either case, if the insured does not provide sufficient care for the remaining crop, appraisals for uninsured causes of loss may be made. Therefore, no change has been made.

Comments: Two reinsured companies and an insurance service organization expressed concern that there are no instructions in section 12(c) and (d) on how to value appraised production.

Response: Section 12(c)(1)(iv) (redesignated as section 13(c)(1)(iii)(A)) has been rewritten to more clearly specify the valuation of harvested and appraised production.

Comments: Two reinsured companies and an insurance service organization opposed any reference to the word ''carryover'' in section 12(h).

Response: Section 12(h) (redesignated as section 13(h)) eliminates the adjustment of next year's quota when the insurance provider agrees that any carryover or current years' tobacco has no market value due to an insured cause of loss. It also eliminates the opportunity to falsely report that carryover and current years' tobacco has no value and thus increase the indemnity payment. This provision is consistent with FSA's requirement that tobacco having no value be destroyed. Therefore, no change has been made.

Comments: Two reinsured companies and an insurance service organization suggested that requiring a written agreement to be renewed each year should be removed in section 14(d). Terms of the agreement should be stated in the agreement to fit the particular situation for the policy, or if no substantive changes occur from one year to the next, allow the written agreement to be continuous.

Response: Written agreements are temporary and intended to address unusual situations. If the condition creating a need for written agreement remains from year to year among producers it should be incorporated into the policy, the Special Provisions, or the actuarial documents. Therefore, no change has been made, except the provisions for written agreements have been moved to the Basic Provisions.

Comments: Two reinsured companies and an insurance service organization asked: (1) Is the Late Planting Agreement Option no longer available; and (2) Why are the late and prevented planting language provisions not included in the proposed rule as they have been in other crops?

Response: A new section 14 has been added to provide for late planting coverage. Under the new section 15, prevented planting coverage will not be provided for quota tobacco as set out in the Basic Provisions because the high cash value per acre and the hand labor required to transplant tobacco on relatively small acreage enables producers to plant sufficient acreage to maintain their effective poundage marketing quota even under extremely adverse conditions that would prevent planting of most other crops.

In addition to the changes indicated above, FCIC has made the following changes:

1. Section 1. Removed definitions of ''days,'' ''FSA,'' ''final planting date,'' and ''USDA,'' because these definitions were moved to the Basic Provisions. Changed the definition of ''unit'' to ''basic unit.''

2. Section 7 (Annual Premium). Added to modify section 7 of the Basic Provisions to calculate premium, in part, based on the producer's amount of insurance. As defined in these crop provisions, the definition of ''amount of insurance'' takes into consideration the insured poundage quota, current year's

support price, and late planting adjustments unique to quota tobacco.

3. Section 12(b) (redesignated as Section 13(b)). Revised for clarification. Also, added an example of an indemnity calculation for illustration purposes.

List of Subjects in 7 CFR Parts 435 and 457

Crop insurance, Quota tobacco, Tobacco (quota plan) crop insurance regulations.

Final Rule

Accordingly, as set forth in the preamble, the Federal Crop Insurance Corporation hereby amends the Tobacco (Quota Plan) Crop Insurance Regulations (7 CFR part 435) and the Common Crop Insurance Regulations (7 CFR part 457) as follows:

PART 435—TOBACCO (QUOTA PLAN) CROP INSURANCE REGULATIONS; REGULATIONS FOR THE 1985 THROUGH 1998 CROP YEARS

1. The authority citation for 7 CFR part 435 is revised to read as follows:

Authority: 7 U.S.C. 1506(1), 1506(p).

2. The part heading is revised as set forth above.

Subpart Heading [Removed]

3. The subpart heading ''Subpart—Regulations for the 1985 and Succeeding Crop Years'' is removed.

4. Section 435.7 is amended by revising the introductory text of paragraph (d) to read as follows:

§ 435.7 The application and policy.

* * * * *

(d) The application is found at subpart D of part 400—General Administrative Regulations (7 CFR 400.37, 400.38). The provisions of the Tobacco (Quota Plan) Insurance Policy for the 1985 through 1998 crop years are as follows:

* * * * *

PART 457—COMMON CROP INSURANCE REGULATIONS; REGULATIONS FOR THE 1998 AND SUBSEQUENT CONTRACT YEARS

5. The authority citation for 7 CFR part 457 continues to read as follows:

Authority: 7 U.S.C. 1506(1), 1506(p).

6. Section 457.156 is added to read as follows:

§ 457.156 Quota tobacco crop insurance provisions.

The Quota Tobacco Crop Insurance Provisions for the 1999 and succeeding crop years are as follows:

FCIC policies:

United States Department of Agriculture

Federal Crop Insurance Corporation

Reinsured policies:

(Appropriate title for insurance provider)

Both FCIC and reinsured policies:

Quota Tobacco Crop Insurance Provisions

If a conflict exists among the policy provisions, the order of priority is as follows: (1) the Catastrophic Risk Protection Endorsement, if applicable; (2) the Special Provisions; (3) these Crop Provisions; and (4) the Basic Provisions with (1) controlling (2), etc.

1. Definitions.

Amount of insurance. The dollar amount determined by multiplying the insured poundage quota by the current year's support price or the percentage of the current year's support price you select less any adjustments for late planting as specified in section 14.

Approved yield. The yield calculated in accordance with 7 CFR part 400, subpart G, if required by the Special Provisions.

Basic unit. In lieu of the definition in the Basic Provisions, a basic unit is all insurable acreage of an insurable type of tobacco in the county in which you have a share on the date of planting for the crop year and that is identified by a single FSA farm serial number at the time insurance first attaches under these provisions for the crop year.

Carryover tobacco. Any tobacco produced on the land identified by a FSA farm serial number in previous years that remained unsold at the end of the most recent marketing year.

County. In lieu of the definition in the Basic Provisions, county is defined as the county or other political subdivision of a state shown on your accepted application including any land identified by a FSA farm serial number for such county but physically located in another county.

Discount variety. Tobacco defined as such under the provisions of the United States Department of Agriculture tobacco price support program.

Effective poundage marketing quota. The farm marketing quota as established and recorded by the local FSA office for the land identified by the FSA farm serial number plus any additional poundage, as allowed by the USDA Tobacco Marketing Quota Regulations, that you intend to produce for each unit in that crop year minus the amount of any carryover tobacco. The term may not include any tobacco that would be subject to a marketing quota penalty under USDA Tobacco Marketing Quota Regulations. For any crop year in which there are no effective USDA Tobacco Marketing Quota Regulations, the effective poundage marketing quota will be the pounds obtained by multiplying the applicable approved yield per acre by the lower of the reported or insured acreage on the basic unit, unless otherwise provided by the actuarial documents.

Fair market value. The current year's tobacco season average price for the applicable type of tobacco obtained from the sale of the tobacco through a market other than an auction warehouse.

Farm yield. The yield per acre used by FSA to establish the effective poundage marketing quota for land identified by a FSA farm serial number, unless we have estab lished a yield for that land in the actuarial documents.

Harvest. Cutting and removing all insured tobacco from the field in which it was grown.

Hydroponic plants. Seedlings grown in liquid nutrient solutions.

Insured poundage quota. The lesser of:

(1) The product (in pounds) obtained by multiplying the effective poundage marketing quota for the land identified by a FSA farm serial number by your selected coverage level; or

(2) The farm yield or approved yield, as applicable, adjusted for late planting in accordance with section 14, if applicable, multiplied by the appropriate number of insured acres and by your selected coverage level.

Late planting period. In lieu of the definition in section 1 of the Basic Provisions, the period that begins the day after the final planting date for the insured crop and ends 15 days after the final planting date, unless otherwise specified in the Special Provisions.

Market price. The previous years' season average price published by National Agricultural Statistics Service for the applicable type of tobacco in the area.

Marketing year. The marketing year published by National Agricultural Statistics Service for the applicable type of tobacco in the area.

Planted acreage. Land in which tobacco seedlings, including hydroponic plants, have been transplanted by hand or machine from the tobacco bed to the field.

Pound. Sixteen ounces avoirdupois.

Replanting. In lieu of the definition in section 1 of the Basic Provisions, performing the cultural practices necessary to replace the tobacco plant, and then replacing the tobacco plant in the insured acreage with the expectation of producing at least the quota.

Support price. The average price per pound for the type of tobacco as announced by the USDA under its tobacco price support program, or, if there is no such program, as announced by FCIC.

Tobacco bed. An area protected from adverse weather, in which tobacco seeds are sown and seedlings are grown until transplanted into the tobacco field by hand or machine.

2. Unit Division.

A unit will be determined in accordance with the definition of basic unit contained in section 1 of these Crop Provisions. The provision in the Basic Provisions regarding optional units are not applicable, unless specified by the Special Provisions.

3. Insurance Guarantees, Coverage Levels, and Prices for Determining Indemnities.

In addition to section 3 of the Basic Provisions, a production report, if required by the Special Provisions, must be filed in accordance with section 3(c) of the Basic Provisions.

4. Contract Changes.

In accordance with section 4 of the Basic Provisions, the contract change date is November 30 preceding the cancellation date.

5. Cancellation and Termination Dates.

In accordance with section 2 of the Basic Provisions, the cancellation and termination dates are March 15.

6. Report of Acreage.

In addition to the requirements of section 6 of the Basic Provisions:

(a) You must report the effective poundage marketing quota and specify any amount of carryover tobacco, if applicable.

(b) You must provide a copy of any written lease agreement between you and any landlord or tenant showing the amount of the effective poundage marketing quota allocated to you. The written lease agreement must:

(1) Identify all other persons sharing in the effective poundage marketing quota; and

(2) Be submitted to your local insurance provider's office on or before the acreage reporting date.

(c) In the event of a loss, if the written lease agreement has been submitted timely, we will distribute the effective poundage marketing quota in accordance with the terms of the written lease agreement. If the written lease agreement is not submitted timely, we will prorate the effective poundage marketing quota across the FSA farm serial number to all insured and uninsured persons based on planted acres within land identified by the FSA farm serial number.

7. Annual Premium.

In lieu of paragraph (c) of section 7 of the Basic Provisions, your annual premium amount is determined by either:

(a) Multiplying the amount of insurance by the rate, your share, and any premium adjustment percentages that may apply; or

(b) If no support price program exists, multiplying the approved yield by the coverage level, the support price, the acres, your share, and any premium adjustment percentages that may apply.

8. Insured Crop.

(a) In accordance with section 8 of the Basic Provisions, the crop insured will be any of the tobacco types designated in the Special Provisions for the county, in which you have a share, that you elect to insure, and for which a premium rate is provided by the actuarial documents.

(b) In addition to section 8 of the Basic Provisions, the crop insured will not include any poundage above the effective poundage marketing quota or the insured poundage quota.

9. Insurable Acreage.

In addition to the provisions of section 9 of the Basic Provisions, we will not insure any acreage under these crop provisions that is:

(a) Planted to a discount variety;

(b) Planted to a tobacco type for which no premium rate is provided by the actuarial documents;

(c) Planted in any manner other than as provided in the definition of ''planted acreage'' in section 1 of these Crop Provisions, unless otherwise provided by the Special Provisions or by written agreement; or

(d) Damaged before the final planting date to the extent that most of the producers of tobacco acreage with similar characteristics in the area would normally not further care for the crop, unless such crop is replanted or we agree that replanting is not practical.

10. Insurance Period.

In accordance with the provisions of section 11(b) of the Basic Provisions, insurance ceases at the earliest of:

(a) Total destruction of the tobacco on the unit;

(b) Weighing-in at the tobacco warehouse;

(c) Removal of the tobacco from the field where grown except for curing, grading, packing, or immediate delivery to the tobacco warehouse; or

(d) The February 28 immediately following the normal harvest period.

11. Causes of Loss.

In accordance with the provisions of section 12 of the Basic Provisions, insurance is provided only against the following causes of loss that occur during the insurance period:

(a) Adverse weather conditions;

(b) Fire;

(c) Insects, but not damage due to insufficient or improper application of pest control measures;

(d) Plant disease, but not damage due to insufficient or improper application of disease control measures;

(e) Wildlife;

(f) Earthquake;

(g) Volcanic eruption; or

(h) Failure of the irrigation water supply, if caused by a peril specified in section 11 (a) through (g) that occurs during the insurance period.

12. Duties In The Event of Damage or Loss.

In accordance with the requirements of section 14 of the Basic Provisions, any representative samples we may require of each unharvested tobacco type must be at least 5 feet wide (at least two rows) and extend the entire length of each field in the unit. The samples must not be harvested or destroyed until after our inspection.

13. Settlement of Claim.

(a) We will determine your loss on a unit basis. In the event you are unable to provide separate acceptable production records, we will allocate any commingled production to such units in proportion to our liability on the harvested acreage for each unit.

(b) In the event of loss or damage covered by this policy, we will settle your claim by:

(1) Multiplying the insured poundage quota by your elected percentage of the current year's support price.

(2) Subtracting the total value of the production to be counted (see section 13(c)) from the amount of insurance; and

(3) Multiplying the result in section 13(b)(1) by your share. For example:

You have 100 percent share of type 31 quota tobacco in the unit, with an insurable poundage quota of 1,000 pounds and a support price of $1.73 per pound. The amount of insurance equals $1730.00 (1,000 insurable poundage quota × $1.73 support price). You are only able to harvest 600 pounds. The value of the total production to count equals $1038.00 (600 harvested pounds × $1.73 support price). Your indemnity would be calculated as follows:

(1) $1730.00 (amount of insurance) − $1038.00 (value of the total production to count) = $692.00 loss

(2) $692.00 loss x 100 percent = $692.00 indemnity payment

(c) The value of the total production to count (pounds of appraised or harvested production) for all insurable acreage on the unit will include:

(1) All appraised production as follows:

(i) Not less than the amount of insurance per insured acre for the unit for any acreage:

(A) That is abandoned;

(B) Put to another use without our consent;

(C) That is damaged solely by uninsured causes; or

(D) For which you fail to provide acceptable production records, if required by the Special Provisions;

(ii) The value of production lost due to uninsured causes which is the number of pounds of such production multiplied by the support price;

(iii) The value of potential production on unharvested insured acreage that you intend to put to another use with our consent, if you and we agree on the number of pounds of such production to count which will be multiplied by the support price. Upon such agreement, the insurance period for that acreage will end when you put the acreage to another use or abandon the crop. If agreement on the appraised amount of production is not reached:

(A) If you do not elect to continue to care for the crop, we may allow you to put the acreage to another use if you agree to leave intact, and provide sufficient care for, representative samples of the crop in locations acceptable to us (The value of production to count for such acreage will be the number of pounds of harvested or appraised production taken from samples at the time harvest should have occurred multiplied by the support price. If you do not leave the required samples intact, or you fail to provide sufficient care for the samples, the value of production to count will be our appraisal made prior to giving you consent to put the acreage to another use multiplied by the support price); or

(B) If you elect to continue to care for the crop, the value of production to count for the acreage will be the harvested production, or our reappraisal multiplied by the support price if additional damage occurs and the crop is not harvested;

(2) All harvested production from insurable acreage multiplied by:

(i) The average price for any tobacco sold on a warehouse floor; and

(ii) Fair market value for all other tobacco sold or not sold.

(d) Mature tobacco production that is damaged by insurable causes will be adjusted for quality based on the USDA Official Standard Grades for the insured type of tobacco.

(e) To enable us to determine the fair market value of tobacco not sold through auction warehouses, you must give us the opportunity to inspect such tobacco before it is sold, contracted to be sold, or otherwise disposed. Failure to provide us the opportunity to inspect such tobacco may result in rejection of any claim for indemnity.

(f) If we consider the best offer you receive for such tobacco to be inadequate, we may obtain additional offers on your behalf.

(g) Once we agree that any carryover or current year's tobacco has no market value

due to insured causes, you must destroy it. If you disagree and refuse to destroy the tobacco with no value, we will determine the value and count it as production to count.

14. Late Planting.

(a) In lieu of late planting provisions in the Basic Provisions regarding acreage initially planted after the final planting date, insurance will be provided for acreage planted to the insured crop after the final planting date as follows:

(1) For each acre or portion thereof planted during the first 10 days after the final planting date, the farm yield will be reduced by 1 percent per day; and

(2) For each acre or portion thereof planted during the 11th through the 15th day after the final planting date, the farm yield will be reduced by 2 percent per day.

(b) If you plant enough acreage to fulfill the effective poundage marketing quota, there will be no reduction in the insured poundage quota as a result of any late planted acreage.

15. Prevented Planting.

The prevented planting provisions in the Basic Provisions are not applicable to quota tobacco.

Signed in Washington, D.C., on June 19, 1998.

Kenneth D. Ackerman,

Manager, Federal Crop Insurance Corporation.

[FR Doc. 98–16968 Filed 6–25–98; 8:45 am]

BILLING CODE 3410–08–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Parts 21 and 29

[Docket No. SW002; Special Condition No. 29–002–SC]

Special Conditions: Eurocopter France Model AS–365 N3 ''Dauphin'' Helicopters, Full Authority Digital Engine Control (FADEC)

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special condition; request for comments.

SUMMARY: This special condition is issued for the Eurocopter France Model AS–365 N3 ''Dauphin'' helicopters. These helicopters will have a novel or unusual design feature associated with the Full Authority Digital Engine Control (FADEC). The applicable airworthiness regulations do not contain adequate or appropriate safety standards to protect systems that perform critical functions from the effects of high-intensity radiated fields (HIRF). This special condition contains the additional safety standards that the Administrator considers necessary to ensure that critical functions of systems will be maintained when exposed to HIRF.

DATES: The effective date of this special condition is June 17, 1998. Comments must be received on or before August 25, 1998.

ADDRESSES: Comments on this special condition may be mailed in duplicate to: Federal Aviation Administration, Office of the Regional Counsel, Southwest Region, Attention: Rules Docket No. SW002, Fort Worth, Texas 76193–0007 or deliver in duplicate to the Office of the Regional Counsel, Southwest Region, at 2601 Meacham Blvd., Fort Worth, Texas 76137. Comments must be marked: Rules Docket No. SW002. Comments may be inspected in the Rules Docket weekdays, except Federal holidays, between 8:30 a.m. and 4:00 p.m.

FOR FURTHER INFORMATION CONTACT: Carroll Wright, FAA, Rotorcraft Directorate, Regulations Group, Fort Worth, Texas 76193–0111; telephone 817–222–5120, fax 817–222–5961.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice and opportunity for prior public comment hereon are impracticable because these procedures would significantly delay issuance of the approval design and thus delivery of the affected aircraft. In addition, notice and opportunity for prior public comment are unnecessary since the substance of this special condition has been subject to the public comment process in several prior instances with no substantive comments received. The FAA therefore finds that good cause exists for making this special condition effective upon issuance.

Comments Invited

Interested persons are invited to submit such written data, views, or arguments as they may desire. Communications should identify the regulatory docket and be submitted in duplicate to the address specified above. All communications received on or before the closing date for comments will be considered by the Administrator. The special condition may be changed in light of the comments received. All comments received will be available in the Rules Docket for examination by interested persons, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerning this rulemaking will be filed in the docket. Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this Special Condition must include a self-addressed, stamped postcard on which the following statement is made: ''Comments to Rules Docket No. SW002'' The postcard will be date stamped and returned to the commenter.

Background

On September 1, 1997, Eurocopter France applied for an amendment to Type Certificate (TC) No. H10EU to include the new Model AS–365 N3 ''Dauphin'' helicopter. The Model AS–365 N3 ''Dauphin'' helicopter, which is a derivative of the Model AS–365 N2 helicopter that is currently approved under TC No. H10EU, is a transport category A and B helicopter powered by two Turbomeca Arriel 2C engines with FADEC. The Turbomeca Arriel 1C2 engine has been replaced with the Turbomeca Arriel 2C engine, which includes a digital engine control system.

Type Certification Basis

Under the provisions of 14 CFR § 21.101, Eurocopter France must show that the Model AS–365 N3 ''Dauphin'' helicopter meets the applicable provisions of the regulations incorporated by reference in TC No. H10EU or the applicable regulations in effect on the date of application for the change to the Model No. AS–365 N3. The regulations incorporated by reference in the type certificate are commonly referred to as the ''original type certification basis.'' The regulations incorporated by reference in H10EU are as follows: § 21.29 and 14 CFR part 29, effective February 1, 1965, plus Amendments 29–1 through 29–11. In addition, the applicant elected to comply with 14 CFR part 29 amendments 29–12 through 29–16, except for 14 CFR part 29.397 concerning the rotorbrake. The certification basis also includes certain special conditions and equivalent safety findings that are not relevant to this special condition.

If the Administrator finds that the applicable airworthiness regulations do not contain adequate or appropriate safety standards for these helicopters because of a novel or unusual design feature, special conditions are prescribed under the provisions of § 21.16.

In addition to the applicable airworthiness regulations and special conditions, the Model AS–365 N3 helicopter must comply with the noise certification requirements of 14 CFR part 36; and the FAA must issue a finding of regulatory adequacy pursuant to § 611 of Public Law 92–574, the ''Noise Control Act of 1972.''

Special conditions, as appropriate, are issued in accordance with § 11.49, as required by §§ 11.28 and 11.29(b), and become part of the type certification basis in accordance with § 21.101(b)(2).

Special conditions are initially applicable to the model for which they are issued. Should the type certificate for that model be amended later to include any other model that incorporates the same novel or unusual design feature, or should any other model already included on the same type certificate be modified to incorporate the same novel or unusual design feature, the special conditions would also apply to the other model under the provisions of § 21.101(a)(1).

Novel or Unusual Design Features

The Eurocopter France Model AS–365 N3 ''Dauphin'' helicopter will incorporate the following novel or unusual design features: Electrical, electronic, or combination of electrical electronic (electrical/electronic) systems, such as FADEC, that will be performing functions critical to the continued safe flight and landing of the helicopter. FADEC is an electronic device that performs the functions of engine control.

Discussion

The Eurocopter France Model AS–365 N3 ''Dauphin'' helicopter, at the time of application, was identified as having modifications that incorporate one and possibly more electrical/electronic systems, such as FADEC. After the design is finalized, Eurocopter France will provide the FAA with a preliminary hazard analysis that will identify any other critical functions required for safe flight and landing that are performed by the electrical/ electronic systems.

Recent advances in technology have given rise to the application in aircraft designs of advanced electrical/ electronic systems that perform critical functions. These advanced systems respond to the transient effects of induced electrical current and voltage caused by HIRF incident on the external surface of the helicopter. These induced transient currents and voltages can degrade the performance of the electrical/ electronic systems by damaging the components or by upsetting the systems' functions.

Furthermore, the electromagnetic environment has undergone a transformation not envisioned by the current application of 14 CFR § 29.1309(a). Higher energy levels radiate from operational transmitters currently used for radar, radio, and television. Also, the number of HIRF transmitters has increased significantly.

Existing aircraft certification requirements are inappropriate in view of these technological advances. In addition, the FAA has received reports of some significant safety incidents and accidents involving military aircraft equipped with advanced electrical/ electronic systems when they were exposed to electromagnetic radiation.

The combined effects of the technological advances in helicopter design and the changing environment have resulted in an increased level of vulnerability of the electrical/electronic systems required for the continued safe flight and landing of the helicopter. Effective measures to protect these helicopters against the adverse effects of exposure to HIRF will be provided by the design and installation of these systems. The following primary factors contributed to the current conditions: (1) increased use of sensitive electronics that perform critical functions; (2) reduced electromagnetic shielding afforded helicopter systems by advanced technology airframe materials; (3) adverse service experience of military aircraft using these technologies; and (4) an increase in the number and power of radio frequency transmitters and the expected increase in the future.

The FAA recognizes the need for aircraft certification standards to keep pace with the developments in technology and environment and, in 1986, initiated a high-priority program to (1) determine and define electromagnetic energy levels; (2) develop and describe guidance material for design, test, and analysis; and (3) prescribe and promulgate regulatory standards.

The FAA participated with industry and airworthiness authorities of other countries to develop internationally recognized standards for certification.

The FAA and airworthiness authorities of other countries have identified two levels of the HIRF environment to which a helicopter could be exposed, one environment for VFR operations and a different environment for IFR operations. While the HIRF rulemaking requirements are being finalized, the FAA is adopting a special condition for the certification of aircraft that employ electrical/electronic systems that perform critical functions. The accepted maximum energy levels that civilian helicopter system installations must withstand for safe operation are based on surveys and analysis of existing radio frequency transmitters. This special condition will require the helicopters' electrical/ electronic systems and associated wiring to be protected from these energy levels. These external threat levels are believed to represent the worst-case exposure for a helicopter operating under VFR or IFR.

Compliance with HIRF requirements will be demonstrated by tests, analysis, computer models, similarity with existing systems, or a combination of these methods. Service experience alone will not be acceptable since such experience in normal flight operations may not include an exposure to HIRF. Reliance on a system with similar design features for redundancy, as a means of protection against the effects of external HIRF, is generally insufficient because all elements of a redundant system are likely to be concurrently exposed to the radiated fields.

This special condition will require the systems that perform critical control functions, or provide critical displays as installed in the aircraft, to meet certain standards based on either a defined HIRF environment or a fixed value using laboratory tests. Control system failures and malfunctions can more directly and abruptly contribute to a catastrophic event than display system failures and malfunctions. Therefore, it is considered appropriate to require more rigorous HIRF verification methods for critical control systems than for critical display systems.

The applicant may demonstrate that the operation and operational capabilities of the installed electrical/ electronic systems that perform critical functions are not adversely affected when the aircraft is exposed to the defined HIRF test environment. The FAA has determined that the test environment defined in Table 1 is acceptable for critical control functions in helicopters. The test environment defined in Table 2 is acceptable for critical display systems in helicopters.

The applicant may also demonstrate by a laboratory test that the electrical/ electronic systems that perform critical control, or provide critical displays, can withstand a peak electromagnetic field strength in a frequency range of 10 KH_z to 18 GH_z. If a laboratory test is used to show compliance with the defined HIRF environment, no credit will be given for signal attenuation due to installation. A level of 100 volts per meter (v/m) is appropriate for critical displays systems. A level of 200 v/m is appropriate for critical control functions. Laboratory test levels are defined according to RTCA/DO–160D Section 20 Category W (100 v/m and 150 mA) and Category Y (200 v/m and 300 mA). As defined in DO–160D Section 20, the test levels are defined as the peak of the root mean square (rms) envelope. As a minimum, the modulations required for RTCA/ DO–160D Section 20 Categories W and Y will be used. Other modulations should be selected for the signal most

likely to disrupt the operation of the system under test, based on its design characteristics. For example, flight control systems may be susceptible to 3 H_z square wave modulation while the video signals for electronic display systems may be susceptible to 400 H_z sinusoidal modulation. If the worst-case modulation is unknown or cannot be determined, default modulations may be used. Suggested default values are a 1 KH_z sine wave with 80 percent depth of modulation in the frequency range from 10 KH_z to 400 MH_z and 1 KH_z square wave with greater than 90 percent depth of modulation from 400 MH_z to 18 GH_z. For frequencies where the unmodulated signal would cause deviations from normal operation, several different modulating signals with various waveforms and frequencies should be applied.

Applicants must perform a preliminary hazard analysis to identify electrical/electronic systems that perform critical functions. The term ''critical'' means those functions whose failure would contribute to or cause an unsafe condition that would prevent the continued safe flight and landing of the helicopter. The systems identified by the hazard analysis as performing critical functions are required to have HIRF protection. A system may perform both critical and noncritical functions. Primary electronic flight display systems and their associated components perform critical functions such as attitude, altitude, and airspeed indications. HIRF requirements would apply only to the systems that perform critical functions.

Acceptable system performance would be attained by demonstrating that the critical function components of the system under consideration continue to perform their intended function during and after exposure to required electromagnetic fields. Deviations from system specifications may be acceptable but must be independently assessed by the FAA on a case-by-case basis.

TABLE 1.—VFR ROTORCRAFT FIELD STRENGTH VOLTS/METER

Frequency	Peak	Average
10–100 KHz	150	150
100–500	200	200
500–2000	200	200
2–30 MHz	200	200
30–100	200	200
100–200	200	200
200–400	200	200
400–700	730	200
700–1000	1400	240
1–2 GHz	5000	250
2–4	6000	490
4–6	7200	400
6–8	1100	170
8–12	5000	330
12–18	2000	330
18–40	1000	420

TABLE 2.—IFR ROTORCRAFT FIELD STRENGTH VOLTS/METER

Frequency	Peak	Average
10–100 KHz	50	50
100–500	50	50
500–2000	50	50
2–30 MHz	100	100
30–70	50	50
70–100	50	50
100–200	100	100
200–400	100	100
400–700	700	50
700–1000	700	100
1–2 GHz	2000	200
2–4	3000	200
4–6	3000	200
6–8	1000	200
8–12	3000	300
12–18	2000	200
18–40	600	200

Applicability

As previously discussed, this special condition is applicable to Model AS–365 N3 helicopters. Should Eurocopter France apply at a later date for a change to the type certificate to include another model incorporating the same novel or unusual design feature, the special condition would apply to that model as well under the provisions of § 21.101(a)(1).

Conclusion

This action affects only certain novel or unusual design features on one model series of helicopters. It is not a rule of general applicability and affects only the applicant who applied to the FAA for approval of these features on the helicopters.

The substance of this special condition has been subjected to the notice and comment procedures in several prior instances and has been derived without substantive change from those previously issued. It is unlikely that prior public comment would result in a significant change from the substance contained herein. For this reason and because a delay would significantly affect the certification of the helicopter, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting this special condition upon issuance. The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Part 21 and 29

Aircraft, Air transportation, Aviation safety, Rotorcraft, Safety.

The authority citation for these special conditions is as follows: 42 USC 7572; 49 USC. 106(g), 40105, 40113, 44701–44702, 44704, 44709, 44711, 44713, 44715, 45303.

The Special Condition

Accordingly, pursuant to the authority delegated to me by the Administrator, the following special condition is issued as part of the type certification basis for Eurocopter France Model AS 365 N3 ''Dauphin'' helicopters.

Protection for Electrical and Electronic Systems From High Intensity Radiated Fields

Each system that performs critical functions must be designed and installed to ensure that the operation and operational capabilities of these critical functions are not adversely affected when the helicopter is exposed to high intensity radiated fields external to the helicopter.

Issued in Fort Worth, Texas, on June 17, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate Aircraft Certification Service, ASW–100.

[FR Doc. 98–16960 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 27

[Docket No. SW001; Special Conditions No. 27–001–SC]

Special Conditions: Eurocopter Model AS–350 B3 ''Ecureuil'' Helicopters, Full Authority Digital Engine Control (FADEC)

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special condition; request for comments.

SUMMARY: This special condition is issued for the Eurocopter Model AS–350 B3 ''Ecureuil'' helicopters. These helicopters will have a novel or unusual design feature associated with the Full Authority Digital Engine Control

(FADEC). The applicable airworthiness regulations do not contain adequate or appropriate safety standards to protect systems that perform critical control functions, or provide critical displays, from the effects of high-intensity radiated fields (HIRF). This special condition contains the additional safety standards that the Administrator considers necessary to ensure that critical functions of systems will be maintained when exposed to HIRF.

DATES: The effective date of this special condition is April 30, 1998. Comments must be received on or before August 25, 1998.

ADDRESSES: Comments on this special condition may be mailed in duplicate to: Federal Aviation Administration, Office of the Regional Counsel, Attention: Rules Docket No. SW001, Fort Worth, Texas 76193–0007 or deliver in duplicate to the Office of the Regional Counsel at 2601 Meacham Blvd., Fort Worth, Texas 76137. Comments must be marked: Rules Docket No. SW001. Comments may be inspected in the Rules Docket weekdays, except Federal holidays, between 8:30 a.m. and 4:00 p.m.

FOR FURTHER INFORMATION CONTACT: Carroll Wright, FAA, Rotorcraft Directorate, Regulations Group, Fort Worth, Texas 76193–0111; telephone 817–222–5120, fax 817–222–5961.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice and opportunity for prior public comment hereon are impracticable because these procedures would significantly delay issuance of the design approval and thus delivery of the affected aircraft. In addition, notice and opportunity for prior public comment are unnecessary since the substance of these special conditions has been subject to the public comment process in several prior instances with no substantive comments received. The FAA therefore finds that good cause exists for making this special condition effective upon issuance.

Comments Invited

Interested persons are invited to submit such written data, views, or arguments as they may desire. Communications should identify the regulatory docket or special condition number and be submitted in duplicate to the address specified above. All communications received on or before the closing date for comments will be considered by the Administrator. The special condition may be changed in light of the comments received. All comments received will be available in the Rules Docket for examination by interested persons, both before and after the closing date for comments. A report summarizing each substantive public contact with FAA personnel concerning this rulemaking will be filed in the docket. Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this special condition must include a self-addressed, stamped postcard on which the following statement is made: ''Comments to Rules Docket No. SW001.'' The postcard will be date stamped and returned to the commenter.

Background

On June 18, 1997, Eurocopter applied for an amendment to Type Certificate (TC) No. H9EU to include the new Model AS–350 B3 ''Ecureuil'' helicopter. The Model AS–350 B3 ''Ecureuil'' helicopter, which is a derivative of the AS–350 B/B1/B2 versions currently approved under TC No. H9EU, is a normal category five-passenger helicopter powered by a Turbomeca Arriel 2B engine with FADEC. The Model AS–350 B3 is derived from the Model AS–350 B2 with the following main modifications: (1) Turbomeca Arriel 2B engine with digital engine control system; (2) Powerplant instruments on Liquid Crystal Display; and (3) AS–355 N type tail rotor.

Type Certification Basis

Under the provisions of 14 CFR 21.101, Eurocopter must show that the Model AS–350 B3 ''Ecureuil'' helicopter meets the applicable provisions of the regulations incorporated by reference in TC No. H9EU or the applicable regulations in effect on the date of application for the change to the Model AS–350 B3. The regulations incorporated by reference in the type certificate are commonly referred to as the ''original type certification basis.'' The regulations incorporated by reference in H9EU are as follows: § 21.29 and 14 CFR part 27, effective February 1, 1965, plus Amendments 27–1 through 27–10. In addition, the certification basis includes certain special conditions and equivalent safety findings that are not relevant to this special condition.

If the Administrator finds that the applicable airworthiness regulations do not contain adequate or appropriate safety standards for these helicopters because of a novel or unusual design feature, special conditions are prescribed under the provisions of § 21.16.

In addition to the applicable airworthiness regulations and special conditions, the Model AS–350 B3 must comply with the noise certification requirements of 14 CFR part 36; and the FAA must issue a finding of regulatory adequacy pursuant to section 611 of Public Law 92–574, the ''Noise Control Act of 1972.''

Special conditions, as appropriate, are issued in accordance with § 11.49, as required by §§ 11.28 and 11.29(b), and become part of the type certification basis in accordance with § 21.101(b)(2).

Special conditions are initially applicable to the model for which they are issued. Should the type certificate for that model be amended later to include any other model that incorporates the same novel or unusual design feature, or should any other model already included on the same type certificate be modified to incorporate the same novel or unusual design feature, the special conditions would also apply to the other model under the provisions of § 21.101(a)(1).

Novel or Unusual Design Features

The Eurocopter Model AS–350 B3 ''Ecureuil'' helicopters will incorporate the following novel or unusual design features: Electrical, electronic, or combination of electrical electronic (electrical/electronic) systems, such as FADEC, that will be performing functions critical to the continued safe flight and landing of the helicopter. FADEC is an electronic device that performs the functions of engine control.

Discussion

The Eurocopter Model AS–350 B3 ''Ecureuil'' helicopter, at the time of application, was identified as having modifications that incorporate one and possibly more electrical/electronic systems, such as FADEC. After the design is finalized, Eurocopter will provide the FAA with a preliminary hazard analysis that will identify any other critical functions, required for safe flight and landing, performed by the electrical/electronic systems.

Recent advances in technology have given rise to the application in aircraft designs of advanced electrical/electronic systems that perform critical functions. These advanced systems respond to the transient effects of induced electrical current and voltage caused by HIRF incident on the external surface of the helicopter. These induced transient currents and voltages can degrade the performance of the electrical/ electronic systems by damaging the components or by upsetting the systems' functions.

Furthermore, the electromagnetic environment has undergone a transformation not envisioned by the current application of § 27.1309(a).

Higher energy levels radiate from operational transmitters currently used for radar, radio, and television. Also, the number of transmitters has increased significantly.

Existing aircraft certification requirements are inappropriate in view of these technological advances. In addition, the FAA has received reports of some significant safety incidents and accidents involving military aircraft equipped with advanced electrical/electronic systems when they were exposed to electromagnetic radiation.

The combined effects of the technological advances in helicopter design and the changing environment have resulted in an increased level of vulnerability of the electrical/electronic systems required for the continued safe flight and landing of the helicopter. Effective measures to protect these helicopters against the adverse effects of exposure to HIRF will be provided by the design and installation of these systems. The following primary factors contributed to the current conditions: (1) increased use of sensitive electronics that perform critical functions, (2) reduced electromagnetic shielding afforded helicopter systems by advanced technology airframe materials, (3) adverse service experience of military aircraft using these technologies, and (4) an increase in the number and power of radio frequency emitters and the expected increase in the future.

The FAA recognizes the need for aircraft certification standards to keep pace with the developments in technology and environment and, in 1986, initiated a high priority program to (1) determine and define electromagnetic energy levels; (2) develop and describe guidance material for design, test, and analysis; and (3) prescribe and promulgate regulatory standards.

The FAA participated with industry and airworthiness authorities of other countries to develop internationally recognized standards for certification.

The FAA and airworthiness authorities of other countries have identified two levels of the HIRF environment that a helicopter could be exposed to, one environment for VFR operations and a different environment for IFR operations. While the HIRF rulemaking requirements are being finalized, the FAA is adopting a special condition for the certification of aircraft that employ electrical/electronic systems that perform critical control functions, or provide critical displays. The accepted maximum energy levels that civilian helicopter system installations must withstand for safe operation are based on surveys and analysis of existing radio frequency emitters. This special condition will require the helicopters' electrical/electronic systems and associated wiring to be protected from these energy levels. These external threat levels are believed to represent the worst-case exposure for a helicopter operating under VFR or IFR.

Compliance with HIRF requirements will be demonstrated by tests, analysis, models, similarity with existing systems, or a combination of these methods. Service experience alone will not be acceptable since such experience in normal flight operations may not include an exposure to HIRF. Reliance on a system with similar design features for redundancy, as a means of protection against the effects of external HIRF, is generally insufficient because all elements of a redundant system are likely to be concurrently exposed to the radiated fields.

This special condition will require the systems that perform critical control functions, or provide critical displays as installed in the aircraft, to meet certain standards based on either a defined HIRF environment or a fixed value using laboratory tests. Control system failures and malfunctions can more directly and abruptly contribute to a catastrophic event than display system failures and malfunctions. Therefore it is considered appropriate to require more rigorous HIRF verification methods for critical control systems than for critical display systems.

The applicant may demonstrate that the operation and operational capabilities of the installed electrical/electronic systems that perform critical functions are not adversely affected when the aircraft is exposed to the defined HIRF test environment.

The FAA has determined that the test environment defined in Table 1 is acceptable for critical control functions in helicopters. The test environment defined in Table 2 is acceptable for critical display systems in helicopters.

The applicant may also demonstrate by a laboratory test that the electrical/electronic systems that perform critical control, or provide critical displays can withstand a peak electromagnetic field strength in a frequency range of 10 KH_z to 18 GH_z. If a laboratory test is used to show compliance with the defined HIRF environment, no credit will be given for signal attenuation due to installation. A level of 100 volts per meter (v/m) is appropriate for critical display systems. A level of 200 v/m is appropriate for critical control functions. Laboratory test levels are defined according to RTCA/DO–160D Section 20 Category W (100 v/m and 150 mA) and Category Y (200 v/m and 300 mA). As defined in DO–160D Section 20, the test levels are defined as the peak of the root means squared (rms) envelope. As a minimum, the modulations required for RTCA/DO–160D Section 20 Categories W and Y will be used. Other modulations should be selected for the signal most likely to disrupt the operation of the system under test, based on its design characteristics. For example, flight control systems may be susceptible to 3 H_z square wave modulation while the video signals for electronic display systems may be susceptible to 400 H_z sinusoidal modulation. If the worst-case modulation is unknown or cannot be determined, default modulations may be used. Suggested default values are a 1 KH_z sine wave with 80 percent depth of modulation in the frequency range from 10 KH_z to 400 MH_z and 1 KH_z square wave with greater than 90 percent depth of modulation from 400 MH_z to 18 GH_z. For frequencies where the unmodulated signal would cause deviations from normal operation, several different modulating signals with various waveforms and frequencies should be applied.

Applicants must perform a preliminary hazard analysis to identify electrical/electronic systems that perform critical functions. The term ''critical'' means those functions whose failure would contribute to or cause an unsafe condition that would prevent the continued safe flight and landing of the helicopters. The systems identified by the hazard analysis as performing critical functions are required to have HIRF protection. A system may perform both critical and noncritical functions. Primary electronic flight display systems and their associated components perform critical functions such as attitude, altitude, and airspeed indications. HIRF requirements would apply only to the systems that perform critical functions, including control and display.

Acceptable system performance would be attained by demonstrating that the critical function components of the system under consideration continue to perform their intended function during and after exposure to required electromagnetic fields. Deviations from system specifications may be acceptable but must be independently assessed by the FAA on a case-by-case basis.

TABLE 1.—VFR ROTORCRAFT FIELD STRENGTH VOLTS/METER

Frequency	Peak	Average
10–100 KHz	150	150

TABLE 1.—VFR ROTORCRAFT FIELD STRENGTH VOLTS/METER—Continued

Frequency	Peak	Average
100–500	200	200
500–2000	200	200
2–30 MHz	200	200
30–100	200	200
100–200	200	200
200–400	200	200
400–700	730	200
700–1000	1400	240
1–2 GHz	5000	250
2–4	6000	490
4–6	7200	400
6–8	1100	170
8–12	5000	330
12–18	2000	330
18–40	1000	420

TABLE 2.—IFR ROTORCRAFT FIELD STRENGTH VOLTS/METER

Frequency	Peak	Average
10–100 KHz	50	50
100–500	50	50
500–2000	50	50
2–30 MHz	100	100
30–70	50	50
70–100	50	50
100–200	100	100
200–400	100	100
400–700	700	50
700–1000	700	100
1–2 GHz	2000	200
2–4	3000	200
4–6	3000	200
6–8	1000	200
8–12	3000	300
12–18	2000	200
18–40	600	200

Applicability

As previously discussed, this special condition is applicable to the Model AS–350 B3 helicopter. Should Eurocopter apply at a later date for a change to the type certificate to include another model incorporating the same novel or unusual design feature, the special condition would apply to that model as well under the provisions of § 21.101(a)(1).

Conclusion

This action affects only certain novel or unusual design features on one model helicopter. It is not a rule of general applicability and affects only the applicant who applied to the FAA for approval of these features on the helicopter.

The substance of this special condition has been subjected to the notice and comment procedure in several prior instances and has been derived without substantive change from those previously issued. It is unlikely that prior public comment would result in a significant change from the substance contained herein. For this reason and because a delay would significantly affect the certification of the helicopter, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable, and good cause exists for adopting this special condition upon issuance. The FAA is requesting comments to allow interested persons to submit views that may not have been submitted in response to the prior opportunities for comment described above.

List of Subjects in 14 CFR Parts 21 and 27

Aircraft, Air transportation, Aviation safety, Rotorcraft, Safety.

The authority citation for this special condition is as follows: 42 U.S.C. 7572; 49 U.S.C. 106(g), 40105, 40113, 44701–44702, 44704, 44709, 44711, 44713, 44715, 45303.

The Special Condition

Accordingly, pursuant to the authority delegated to me by the Administrator, the following special condition is issued as part of the type certification basis for Eurocopter Model AS–350 B3 ''Ecureuil'' helicopters.

Protection for Electrical and Electronic Systems from High Intensity Radiated Fields

Each system that performs critical functions must be designed and installed to ensure that the operation and operational capabilities of these critical functions are not adversely affected when the helicopter is exposed to high intensity radiated fields external to the helicopter.

Issued in Fort Worth, Texas, on April 30, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 98–16959 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 97–SW–39–AD; Amendment 39–10630; AD 98–13–39]

RIN 2120–AA64

Airworthiness Directives; Eurocopter France Model AS 332C, L, and L1 Helicopters

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to Eurocopter France Model AS 332C, L, and L1 helicopters that requires initial and repetitive inspections of the tail rotor shaft flapping hinge retainers (retainers) for cracks. This amendment is prompted by a report of high vibrations occurring on a helicopter while in service due to a cracked retainer. The actions specified by this AD are intended to detect cracks on the retainers that could lead to high tail rotor vibrations, loss of tail rotor control, and subsequent loss of control of the helicopter.

EFFECTIVE DATE: July 31, 1998.

FOR FURTHER INFORMATION CONTACT: Mr. Mike Mathias, Aerospace Engineer, FAA, Rotorcraft Directorate, Rotorcraft Standards Staff, 2601 Meacham Blvd., Fort Worth, Texas 76137, telephone (817) 222–5123, fax (817) 222–5961.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an airworthiness directive (AD) that is applicable to Eurocopter France Model AS 332C, L, and L1 helicopters was published in the **Federal Register** on April 1, 1998 (63 FR 15791). That action proposed to require initial and repetitive inspections of the retainers for cracks.

Interested persons have been afforded an opportunity to participate in the making of this amendment. No comments were received on the proposal or the FAA's determination of the cost to the public. The FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

The FAA estimates that 4 helicopters of U.S. registry will be affected by this AD, that it will take approximately 0.5 work hours per helicopter to accomplish the required actions, and that the average labor rate is $60 per work hour. Required parts, if replacement of the retainers on the tail rotor blades is necessary, would cost approximately $56,900 per helicopter. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be $252,080, assuming that the retainers on the tail rotor blades are replaced on all 4 helicopters and each helicopter is dye penetrant inspected 200 times per year.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in

accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive to read as follows:

AD 98–13–39 Eurocopter France: Amendment 39–10630. Docket No. 97–SW–39–AD.

Applicability: AS 332C, L, and L1 helicopters, with tail rotor shaft flapping hinge retainer, part number 330A33.3165.00, installed, certificated in any category.

Note 1: This AD applies to each helicopter identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For helicopters that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must use the authority provided in paragraph (c) to request approval from the FAA. This approval may address either no action, if the current configuration eliminates the unsafe condition, or different actions necessary to address the unsafe condition described in this AD. Such a request should include an assessment of the effect of the changed configuration on the unsafe condition addressed by this AD. In no case does the presence of any modification, alteration, or repair remove any helicopter from the applicability of this AD.

Compliance: Required as indicated, unless accomplished previously.

To detect cracks on a tail rotor shaft flapping hinge retainer (retainer) that could lead to high tail rotor vibrations, loss of tail rotor control, and subsequent loss of control of the helicopter, accomplish the following:

(a) Prior to further flight, and thereafter before the first flight of each day, perform a dye penetrant inspection of each retainer for cracks.

(b) If a crack is found on any retainer, replace it with an airworthy retainer.

Note 2: Eurocopter Service Bulletin No. 05.00.41, dated January 29, 1996, pertains to the subject of this AD.

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Rotorcraft Standards Staff, Rotorcraft Directorate, FAA. Operators shall submit their requests through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Rotorcraft Standards Staff.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Rotorcraft Standards Staff.

(d) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the helicopter to a location where the requirements of this AD can be accomplished.

(e) This amendment becomes effective on July 31, 1998.

Note 4: The subject of this AD is addressed in Direction Generale De L'Aviation Civile (France) AD 96–074–057(B), dated March 27, 1996.

Issued in Fort Worth, Texas, on June 18, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 98–17041 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98–SW–11–AD; Amendment 39–10633; AD 98–06–04]

RIN 2120–AA64

Airworthiness Directives; Eurocopter France Model AS332C, L, and L1 and Model SA330F, G, and J Helicopters

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This document publishes in the **Federal Register** an amendment adopting Airworthiness Directive (AD) 98–06–04 which was sent previously to all known U.S. owners and operators of Eurocopter France Model AS332C, L, and L1 and Model SA330F, G, and J helicopters by individual letters. This AD requires performing a procedure to determine the angular play of the tail rotor gearbox, and repeating the procedure at certain intervals. This amendment is prompted by an accident involving a Model SA330 helicopter which resulted from the loss of the tail rotor drive. An investigation determined that the loss of the tail rotor drive was caused by excessive play between the tail rotor gearbox bevel gear and the bevel wheel. This condition, if not corrected, could result in failure of the tail rotor gearbox, loss of tail rotor drive, and subsequent loss of control of the helicopter.

DATES: Effective July 13, 1998, to all persons except those persons to whom it was made immediately effective by priority letter AD 98–06–04, issued on March 4, 1998, which contained the requirements of this amendment.

Comments for inclusion in the Rules Docket must be received on or before August 25, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Office of the Regional Counsel, Southwest Region, Attention: Rules Docket No. 98–SW–11–AD, 2601 Meacham Blvd., Room 663, Fort Worth, Texas 76137.

FOR FURTHER INFORMATION CONTACT: Mr. Scott Horn, Aerospace Engineer, FAA, Rotorcraft Directorate, Rotorcraft Standards Staff, 2601 Meacham Blvd., Fort Worth, Texas 76137, telephone (817) 222–5125, fax (817) 222–5961.

SUPPLEMENTARY INFORMATION: On March 4, 1998, the FAA issued priority letter AD 98–06–04, applicable to Eurocopter France Model AS332C, L, and L1 and Model SA330F, G, and J helicopters, which requires performing a procedure to determine the play of the tail rotor gearbox within 25 hours time-in-service (TIS), and repeating the procedure at intervals of 100 hours TIS or 520 hours TIS depending on the amount of play that is detected. That action was prompted by an accident involving a Model SA330 helicopter that occurred on October 21, 1997, which resulted from the loss of the tail rotor drive. An investigation determined that the loss of tail rotor drive was caused by excessive play between the tail rotor gearbox bevel gear and the bevel wheel. This condition, if not corrected, could result in failure of the tail rotor gearbox, loss

of tail rotor drive and subsequent loss of control of the helicopter.

Since the unsafe condition described is likely to exist or develop on other Eurocopter France Model AS332C, L, and L1 and Model SA330F, G, and J helicopters of the same type design, the FAA issued priority letter AD 98–06–04 to prevent failure of the tail rotor gearbox, loss of tail rotor drive and subsequent loss of control of the helicopter. The AD requires, within 25 hours TIS after the effective date of this AD, and thereafter at specified intervals, performing a procedure to determine the angular play of the tail rotor gearbox and replacing the tail rotor gearbox with an airworthy gearbox if the specified angular play limit is exceeded. The short compliance time involved is required because the previously described critical unsafe condition can adversely affect the controllability of the helicopter. Therefore, inspections of the tail rotor gearbox for excessive play is required within 25 hours TIS or upon or before attaining 520 hours TIS and this AD must be issued immediately.

Since it was found that immediate corrective action was required, notice and opportunity for prior public comment thereon were impracticable and contrary to the public interest, and good cause existed to make the AD effective immediately by individual letters issued on March 4, 1998 to all known U.S. owners and operators of Eurocopter France Model AS332C, L, and L1 and Model SA330F, G, and J helicopters. These conditions still exist, and the AD is hereby published in the **Federal Register** as an amendment to section 39.13 of the Federal Aviation Regulations (14 CFR 39.13) to make it effective to all persons. However, the FAA has made several nonsubstantive editorial changes since the issuance of Priority Letter AD 98–06–04; the word ''excess'' was changed to ''excessive,'' the incorrect placement of the number ''12'' in Figure 1 has been corrected, and a new paragraph was added to clarify that brackets and mounts installed during the required inspection are to be removed between inspections. The FAA has determined that these changes will neither increase the economic burden on an operator nor increase the scope of the AD.

The FAA estimates that 4 helicopters of U.S. registry will be affected by this AD, that it will take approximately 3 work hours per helicopter to accomplish the required actions, and that the average labor rate is $60 per work hour. Required parts will cost approximately $100 per helicopter to create the necessary tools and $45,000 to replace the gearbox, if necessary. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be $45,280 per helicopter.

Comments Invited

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

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this rule must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 98–SW–11–AD.'' The postcard will be date stamped and returned to the commenter.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation is an emergency regulation that must be issued immediately to correct an unsafe condition in aircraft, and that it is not a ''significant regulatory action'' under Executive Order 12866. It has been determined further that this action involves an emergency regulation under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket. A copy of it, if filed, may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive to read as follows:

98–06–04 Eurocopter France: Amendment 39–10633. Docket No. 98–SW–11–AD.

Applicability: Model AS332C, L, and L1 and Model SA330F, G, and J helicopters, certificated in any category.

Note 1: This AD applies to each helicopter identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For helicopters that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must use the authority provided in paragraph (e) to request approval from the FAA. This approval may address either no action, if the current configuration eliminates the unsafe condition, or different actions necessary to address the unsafe condition described in this AD. Such a request should include an assessment of the effect of the changed configuration on the unsafe condition addressed by this AD. In no case does the presence of any modification, alteration, or repair remove any helicopter from the applicability of this AD.

Compliance: Required within the next 25 hours time-in-service (TIS) for tail rotor gearboxes (TGB) with 495 or more hours TIS since manufacture or overhaul; or, for TGB with less than 495 hours TIS since manufacture or overhaul, required upon or before attaining 520 hours TIS, unless accomplished previously.

To detect excessive play between the splines of the TGB bevel gear and the bevel wheel and to prevent failure of the TGB, which could result in loss of tail rotor drive and subsequent loss of control of the helicopter, accomplish the following:

(a) For TGB that are not equipped with a tail rotor blade deicing system as shown in Figure 1, fabricate a steel angle bracket (angle bracket) (No. 1 of Figure 1) and an aluminum mount (No. 2 of Figure 1).

(1) Place a tail rotor blade in the horizontal position with the blade's tip facing forward.

(2) Immobilize the TGB input flange by placing a wooden block between the TGB input flange and the deck.

(3) Secure the angle bracket on the TGB output casing with a nut (No. 3 of Figure 1) and a washer (No. 5 of Figure 1).

(4) Secure the mount on the rotor shaft.

(5) Secure the dial indicator gage (No. 4 of Figure 1) on the angle bracket.

(6) Install the feeler of the dial indicator on the mount at the index mark which is 120 mm from the rotor shaft center line.

(7) Using a dynamometer, apply a 1 daN (2.25 lbs.) load in both directions (indicated by letter ''F'' in Figure 1), 30 mm from the blade tip, to measure the total play.

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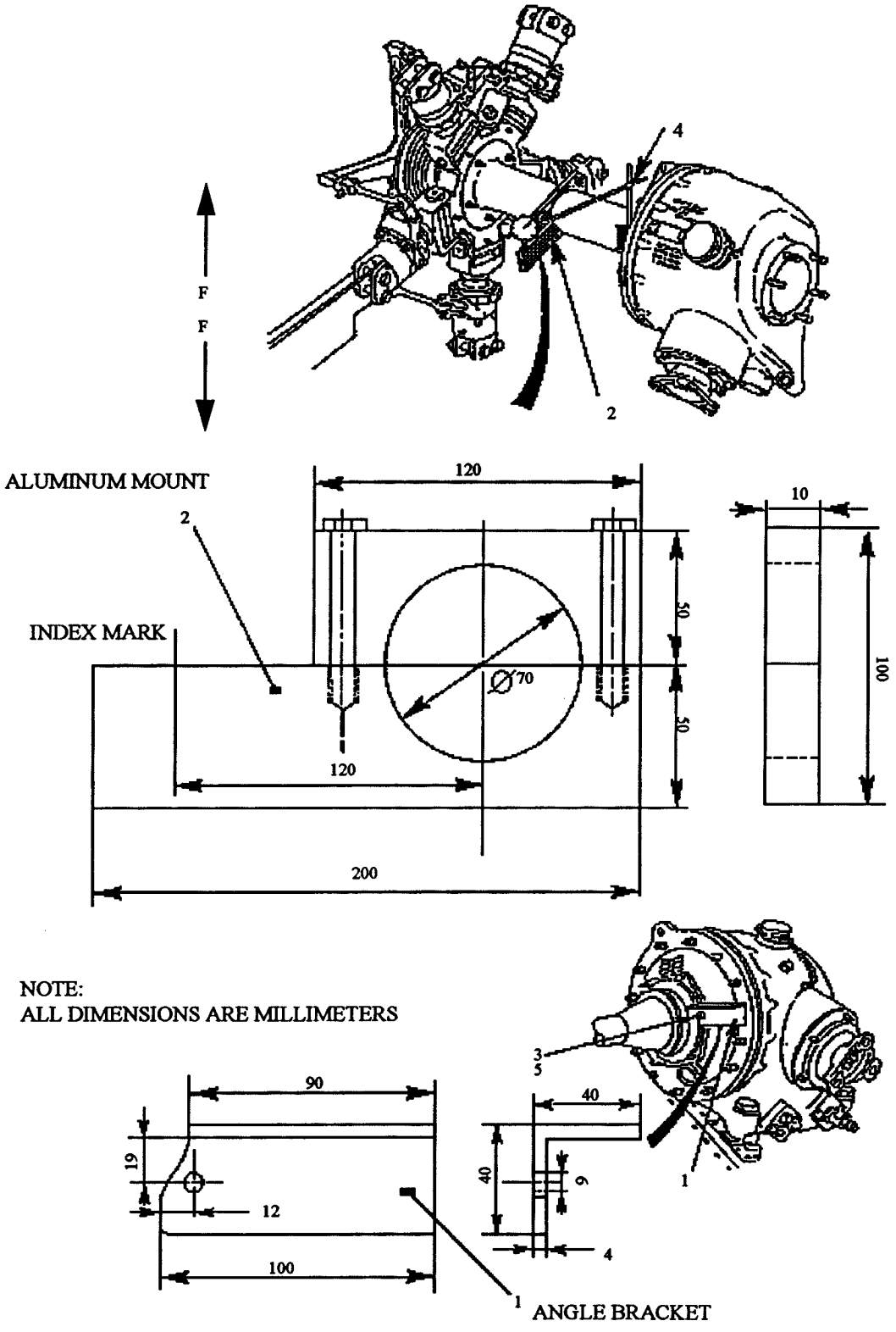

4
F
F
2
ALUMINUM MOUNT
2
INDEX MARK
120
10
50
50
100
Ø70
120
200
NOTE:
ALL DIMENSIONS ARE MILLIMETERS
3
5
90
40
19
40
9
12
100
4
1
1
ANGLE BRACKET

FIGURE 1

(b) For TGB that are equipped with a tail rotor blade deicing system as shown in Figure 2, fabricate a steel angle bracket (angle bracket) (No. 6 of Figure 2) from a 90° formed steel sheet.

(1) Place a tail rotor blade in the horizontal position with the blade's tip facing forward.

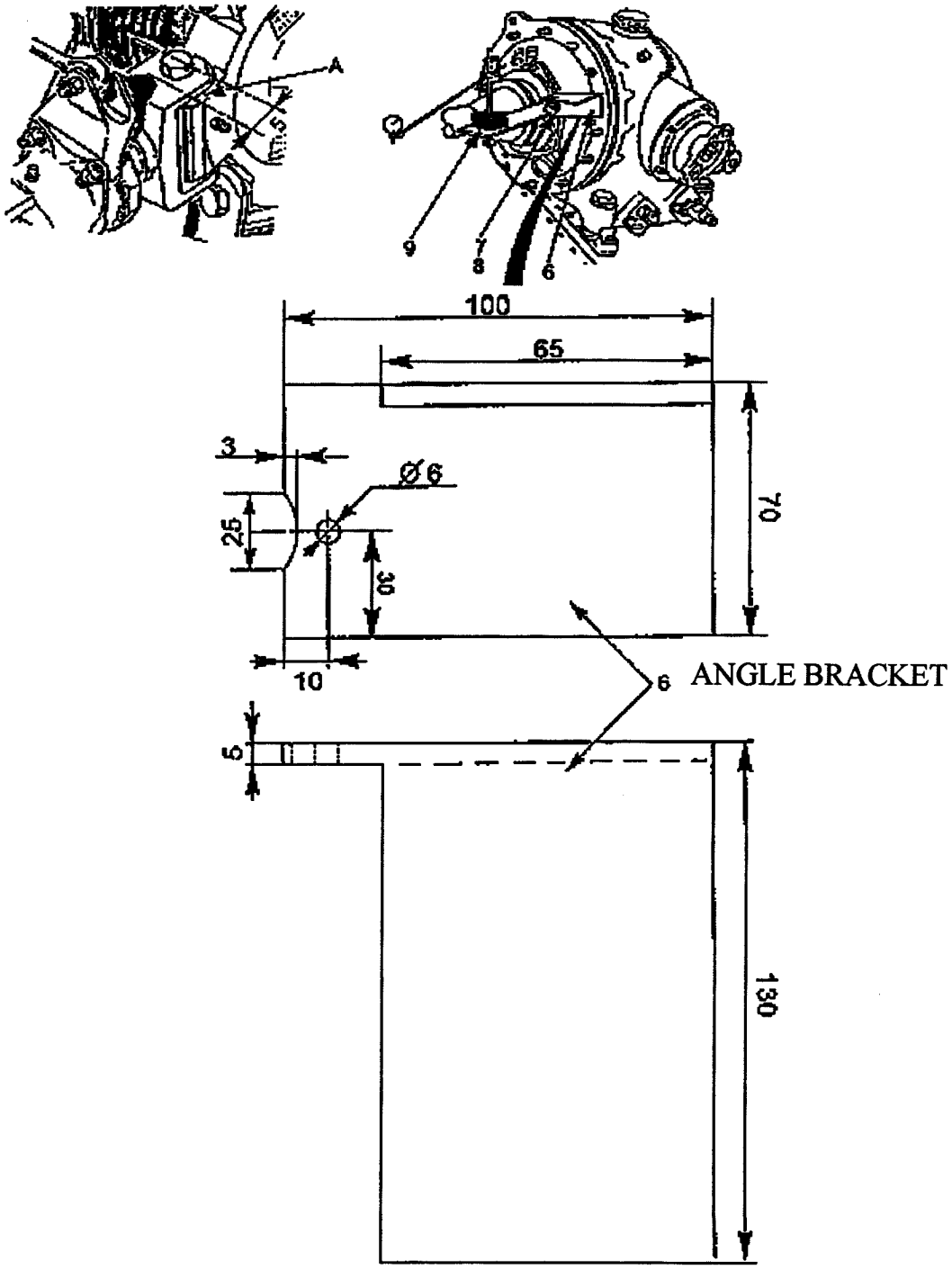
(2) Immobilize the TGB input flange by placing a wooden block between the TGB input flange and the deck.

(3) Secure the angle bracket on the TGB output casing with a nut (No. 7 of Figure 2) and a washer (No. 8 of Figure 2).

(4) Secure the dial indicator gage (No. 9 of Figure 2) on the angle bracket.

(5) Install the feeler of the dial indicator on the tail rotor hub, 5 mm from the spindle attachment bolt (Item A of Figure 2).

(6) Using a dynamometer, apply a 1 daN (2.25 lbs.) load in both directions (indicated by letter ''F'' in Figure 1), 30 mm from the blade tip, to measure the total play.



NOTE:
ALL DIMENSIONS ARE MILLIMETERS

FIGURE 2

BILLING CODE 4910–13–C

(c) Record the play measurement on the equipment log card or equivalent record.

(1) If the play is 0.37 mm or less, comply with paragraphs (a) or (b) of this AD, as applicable, at intervals not to exceed 520 hours TIS.

(2) If the play is greater than 0.37 mm and less than 0.52 mm, comply with paragraphs (a) or (b) of this AD, as applicable, at intervals not to exceed 100 hours TIS.

(3) If the play is equal to or greater than 0.52 mm, remove the TGB and replace it with an airworthy TGB.

(d) Brackets and mounts installed to perform the requirements of this AD, as applicable, are to be removed prior to flight.

(e) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Rotorcraft Standards Staff, FAA. Operators shall submit their requests through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Rotorcraft Standards Staff.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Rotorcraft Standards Staff.

(f) Special flight permits will not be issued.

(g) This amendment becomes effective on July 13, 1998, to all persons except those persons to whom it was made immediately effective by Priority Letter AD 98–06–04, issued March 4, 1998, which contained the requirements of this amendment.

Note 3: The subject of this AD is addressed in Direction Generale De L'Aviation Civile (France) AD 97–322–067(AB) and AD 97–323–079(AB), both dated November 19, 1997.

Issued in Fort Worth, Texas, on June 18, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 98–17043 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98–SW–18–AD; Amendment 39–10632; AD 98–09–11]

RIN 2120–AA64

Airworthiness Directives; Eurocopter Deutschland GmbH Model EC 135 Helicopters

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This document publishes in the **Federal Register** an amendment adopting Airworthiness Directive (AD) 98–09–11 which was sent previously to all known U.S. owners and operators of Eurocopter Deutschland GmbH (Eurocopter) Model EC 135 helicopters by individual letters. This AD requires, before further flight, a review of aircraft records to determine if a tail rotor drive shaft vibration survey and installation of a Fenestron Shaft Retrofit Kit have been accomplished; before further flight, and thereafter at intervals not to exceed 15 hours time-in-service, inspecting the tail rotor drive shaft bearing (bearing) attaching lock plates for bent-open tabs, and broken or missing slippage marks; and visually inspecting each bearing support for cracks. This amendment is prompted by three reports of loose bearings and attachment bolts, and one report of a cracked bearing support. Excessive vibrations in the tail rotor drive shaft can loosen attachment bolts or cause cracking in the bearing supports. This condition, if not corrected, could result in loss of drive to the tail rotor and subsequent loss of control of the helicopter.

DATES: Effective July 13, 1998, to all persons except those persons to whom it was made immediately effective by priority letter AD 98–09–11, issued on April 17, 1998, which contained the requirements of this amendment.

Comments for inclusion in the Rules Docket must be received on or before August 25, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Office of the Regional Counsel, Southwest Region, Attention: Rules Docket No. 98–SW–18–AD, 2601 Meacham Blvd., Room 663, Fort Worth, Texas 76137.

FOR FURTHER INFORMATION CONTACT: Mr. Scott Horn, Aerospace Engineer, FAA, Rotorcraft Directorate, Rotorcraft Standards Staff, 2601 Meacham Blvd., Fort Worth, Texas 76137, telephone (817) 222–5125, fax (817) 222–5961.

SUPPLEMENTARY INFORMATION: On April 17, 1998, the FAA issued priority letter AD 98–09–11, applicable to Eurocopter Model EC 135 helicopters, which requires, before further flight, a review of aircraft records to determine if a tail rotor drive shaft vibration survey and installation of a Fenestron Shaft Retrofit Kit L 535M3002 882 have been accomplished. If a tail rotor vibration survey has not been accomplished or if a Fenestron Shaft Retrofit Kit has not been installed, the FAA must be contacted. Also, before further flight, and thereafter at intervals not to exceed 15 hours time-in-service, the AD requires inspecting the bearing attaching lock plates at each bearing support for bent-open tabs, and inspecting for broken or missing slippage marks. If a bearing attaching lock plate tab is bent open, or if a slippage mark is broken or missing, the FAA must be notified. Finally, the AD requires visually inspecting each bearing support for cracks, and if a crack is found, replacing the bearing support with an airworthy bearing support. That action was prompted by three reports of loose bearings and attachment bolts, and one report of a cracked bearing support. Excessive vibrations in the tail rotor drive shaft can loosen attachment bolts or cause cracking in the bearing supports. This condition, if not corrected, could result in loss of drive to the tail rotor and subsequent loss of control of the helicopter.

The Luttfahrt-Bundesamt (LBA), which is the airworthiness authority for the Federal Republic of Germany, recently notified the FAA that an unsafe condition may exist on Eurocopter Deutschland GmbH (ECD) Model EC 135 helicopters. The LBA advises that the loosening of bolt connections at the bearing supports may lead to a tail rotor failure and thus to the loss of the helicopter. The LBA issued AD 1998–033/5, dated April 6, 1998, applicable to ECD Model EC 135 helicopters.

The FAA has reviewed Eurocopter EC 135 Alert Service Bulletin No. EC 135–53A–002, dated December 12, 1997, which describes procedures for visually inspecting the bearing supports, and Eurocopter EC 135 Alert Service Bulletin No. EC 135–53A–005, Revision 1, dated April 6, 1998, which describes procedures for measuring vibrations on the tail rotor drive shaft and replacement of roller bearing attaching hardware at bearing locations.

This helicopter model is manufactured in the Federal Republic of Germany and is type certificated for operation in the United States under the provision of section 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the LBA has kept the FAA informed of the situation described above. The FAA has examined the findings of the LBA, reviewed all available information, and determined that AD action is necessary for products of this type design that are certificated for operations in the United States.

Since the unsafe condition described is likely to exist or develop on other Eurocopter Model EC 135 helicopters of the same type design, the FAA issued priority letter AD 98–09–11 to detect loose bearing attachment bolts, or cracked bearing supports, which could result in loss of drive to the tail rotor and subsequent loss of control of the helicopter. The AD requires, before

further flight, a review of aircraft records to determine if a tail rotor drive shaft vibration survey and installation of a Fenestron Shaft Retrofit Kit L 535M3002 882 have been accomplished. If a tail rotor vibration survey has not been accomplished or if a Fenestron Shaft Retrofit Kit has not been installed, the FAA must be contacted. Also, before further flight, and thereafter at intervals not to exceed 15 hours time-in-service, the AD requires inspecting the bearing attaching lock plates at each bearing support for bent-open tabs, and inspecting for broken or missing slippage marks. If a bearing attaching lock plate tab is bent open, or if a slippage mark is broken or missing, the FAA must be notified. Finally, the AD requires visually inspecting each bearing support for cracks, and if a crack is found, replacing the bearing support with an airworthy bearing support.

The short compliance time involved is required because the previously described critical unsafe condition can adversely affect the controllability of the helicopter. Therefore, reviewing aircraft records, inspecting the bearing attaching lock plates, and visually inspecting each bearing support for cracks are required before further flight and this AD must be issued immediately.

Since it was found that immediate corrective action was required, notice and opportunity for prior public comment thereon were impracticable and contrary to the public interest, and good cause existed to make the AD effective immediately by individual letters issued on April 17, 1998 to all known U.S. owners and operators of Eurocopter Model EC 135 helicopters. These conditions still exist, and the AD is hereby published in the **Federal Register** as an amendment to section 39.13 of the Federal Aviation Regulations (14 CFR 39.13) to make it effective to all persons.

The FAA estimates that 6 helicopters of U.S. registry will be affected by this AD, that it will take approximately .5 work hour per helicopter to review aircraft records and 1 work hour per helicopter to conduct the required inspections, and that the average labor rate is $60 per work hour. Required parts will be provided at no cost by the manufacturer. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be $540 to review the aircraft records and perform the inspections once on each helicopter in the U.S. fleet.

Comments Invited

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

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this rule must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 98–SW–18–AD.'' The postcard will be date stamped and returned to the commenter.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation is an emergency regulation that must be issued immediately to correct an unsafe condition in aircraft, and that it is not a ''significant regulatory action'' under Executive Order 12866. It has been determined further that this action involves an emergency regulation under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket. A copy of it, if filed, may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive to read as follows:

AD 98–09–11 Eurocopter Deutschland GmbH: Amendment 39–10632. Docket No. 98–SW–18–AD.

Applicability: Model EC 135 helicopters, serial numbers 0005 through 0048, certificated in any category.

Note 1: This AD applies to each helicopter identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For helicopters that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must use the authority provided in paragraph (d) to request approval from the FAA. This approval may address either no action, if the current configuration eliminates the unsafe condition, or different actions necessary to address the unsafe condition described in this AD. Such a request should include an assessment of the effect of the changed configuration on the unsafe condition addressed by this AD. In no case does the presence of any modification, alteration, or repair remove any helicopter from the applicability of this AD.

Compliance: Required as indicated, unless accomplished previously.

To detect loose tail rotor drive shaft bearing (bearing) attachment bolts, or cracked bearing supports, which could result in loss of drive to the tail rotor and subsequent loss of control of the helicopter, accomplish the following:

(a) Before further flight, review the helicopter's historical records to determine if a tail rotor drive shaft vibration survey and the installation of Fenestron Shaft Retrofit Kit L 535M3002 882 have been accomplished. If either action has not been accomplished, contact the Manager, Rotorcraft Standards Staff, FAA, telephone (817) 222–5110, fax (817) 222–5961.

(b) Before further flight, and thereafter at intervals not to exceed 15 hours time-in-service (TIS), at each bearing support:

(1) Inspect each bearing attaching lock plate that was installed with the Fenestron Shaft Retrofit Kit L 535M3002 882 for bent-open tabs.

(2) Inspect for broken or missing slippage marks that may indicate looseness or rotation of attaching hardware.

(3) If a lock plate tab is bent open on bearing supports A, B, or C (shown in Figure 1), or if slippage marks are broken or missing, contact the Manager, Rotorcraft Standards Staff.

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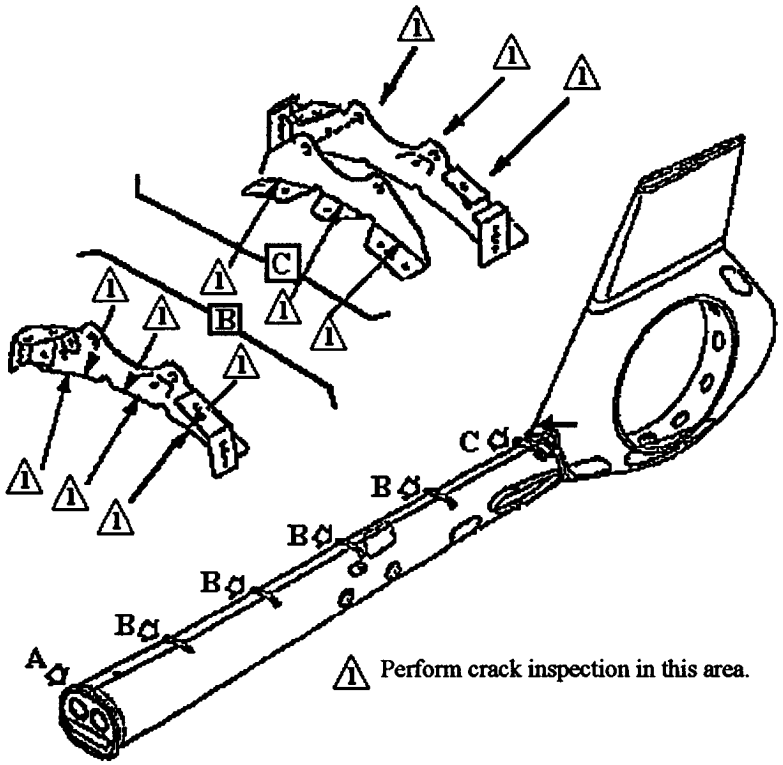

Inspection of Bearing Supports
Figure 1

BILLING CODE 4910–13–C

(c) Before further flight, and thereafter at intervals not to exceed 15 hours TIS, using a 6-power or higher magnifying glass and a bright light, visually inspect bearing supports B and C as shown in Figure 1 for cracks. If a crack is found, replace the bearing support with an airworthy bearing support.

(d) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Rotorcraft Standards Staff, FAA. Operators shall submit their requests through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Rotorcraft Standards Staff.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Rotorcraft Standards Staff.

(e) Special flight permits will not be issued.

(f) This amendment becomes effective on July 13, 1998, to all persons except those persons to whom it was made immediately effective by Priority Letter AD 98–09–11, issued April 17, 1998, which contained the requirements of this amendment.

Note 3: The subject of this AD is addressed in Luftfahrt-Bundesamt (Federal Republic of Germany) AD 1998–033/5, dated April 6, 1998.

Issued in Fort Worth, Texas, on June 18, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 98–17023 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 97–SW–65–AD; Amendment 39–10619; AD 98–13–28]

RIN 2120–AA64

Airworthiness Directives; Agusta S.p.A. Model A109C and A109K2 Helicopters

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that is applicable to Agusta S.p.A. (Agusta) Model A109C and A109K2 helicopters. This action requires a one-time inspection of each tail rotor blade (blade) for debonding, and if debonding exists which exceeds certain limits,

replacement of the blade with an airworthy blade. This amendment is prompted by two incidents in which helicopters lost a blade tip fairing during ground run-up. The actions specified in this AD are intended to prevent loss of the tip fairing on a blade, which could result in increased vibrations, loss of the tail rotor assembly, and subsequent loss of control of the helicopter.

DATES: Effective July 13, 1998.

Comments for inclusion in the Rules Docket must be received on or before August 25, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Office of the Regional Counsel, Southwest Region, Attention: Rules Docket No. 97–SW–65–AD, 2601 Meacham Blvd., Room 663, Fort Worth, Texas 76137.

FOR FURTHER INFORMATION CONTACT: Mr. Shep Blackman, Aerospace Engineer, FAA, Rotorcraft Directorate, Rotorcraft Standards Staff, 2601 Meacham Blvd., Fort Worth, Texas 76137, telephone (817) 222–5296, fax (817) 222–5961.

SUPPLEMENTARY INFORMATION: The Registro Aeronautico Italiano (RAI) which is the airworthiness authority for Italy, recently notified the FAA that an unsafe condition may exist on Agusta Model A109C and A109K2 helicopters. The RAI advises that a number of blades may have been incorrectly manufactured.

These helicopter models are manufactured in Italy and are type certificated for operation in the United States under the provisions of section 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the RAI has kept the FAA informed of the situation described above. The FAA has examined the findings of the RAI, reviewed all available information, and determined that AD action is necessary for products of this type design that are certificated for operation in the United States.

Since an unsafe condition has been identified that is likely to exist or develop on other Agusta Model A109C and A109K2 of the same type design registered in the United States, this AD is being issued to prevent loss of the tip fairing on the blade, which could result in increased vibrations, loss of the tail rotor assembly, and subsequent loss of control of the helicopter.

The short compliance time involved is required because the previously described critical unsafe condition can adversely affect the controllability of the helicopter. Therefore, inspection of the blades is required prior to further flight, and this AD must be issued immediately.

Since a situation exists that requires the immediate adoption of this regulation, it is found that notice and opportunity for prior public comment hereon are impracticable, and that good cause exists for making this amendment effective in less than 30 days.

The FAA estimates that 22 helicopters of U.S. registry will be affected by this AD, that it will take approximately 3 hours to accomplish the inspection and replacement, if necessary, and that the average labor rate is $60 per work hour. Required parts will cost approximately $11,000 per helicopter. Based on these figures, the total cost impact of the AD on U.S. operators is estimated to be $245,960.

Comments Invited

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

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this rule must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 97–SW–65–AD.'' The postcard will be date stamped and returned to the commenter.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation is an emergency regulation that must be issued immediately to correct an unsafe condition in aircraft, and that it is not a ''significant regulatory action'' under Executive Order 12866. It has been determined further that this action involves an emergency regulation under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket. A copy of it, if filed, may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive to read as follows:

AD 98–13–28 AGUSTA S.p.A.: Amendment 39–10619. Docket No. 97–SW–65–AD.

Applicability: Model A109C and A109K2 helicopters, with tail rotor blades (blades), part number (P/N) 109–8132–01–107, serial number A5-all dash numbers, installed, certificated in any category.

Note 1: This AD applies to each helicopter identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For helicopters that have been modified, altered, or repaired so that the performance of the

requirements of this AD is affected, the owner/operator must use the authority provided in paragraph (d) to request approval from the FAA. This approval may address either no action, if the current configuration eliminates the unsafe condition, or different actions necessary to address the unsafe condition described in this AD. Such a request should include an assessment of the effect of the changed configuration on the unsafe condition addressed by this AD. In no case does the presence of any modification, alteration, or repair remove any helicopter from the applicability of this AD.

Compliance: Required before further flight, unless accomplished previously.

To prevent loss of the tip fairing on the blade, which could result in increased vibrations, loss of the tail rotor assembly, and subsequent loss of control of the helicopter, accomplish the following:

(a) Perform a one-time inspection of each tail rotor blade for debonds. The area to be inspected is located in a spanwise band from 620.0 mm to 670.0 mm (24.4 to 26.4 inches), as measured outboard from the blade retention bolt centerline. Inspect the entire blade surface on both sides of each blade within this band (see Figure 1).

Note 2: Agusta Bollettino Tecnico (Technical Bulletin) Number 109K–15, Revision A, dated April 18, 1997, pertains to the subject of this AD.

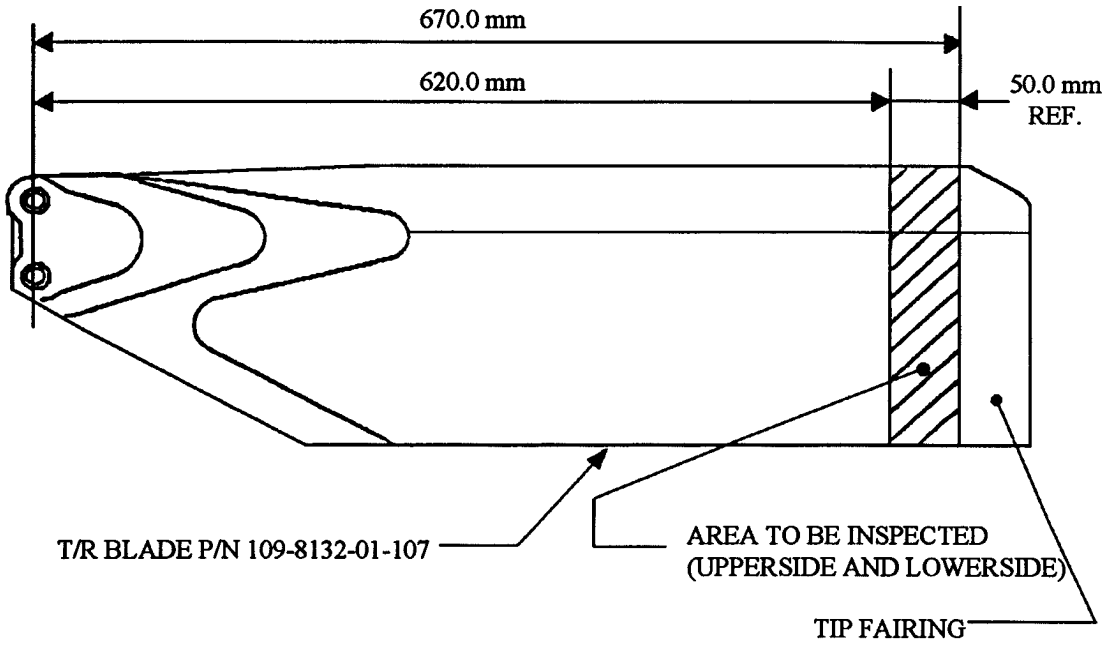

Figure 1

(b) Perform a tapping inspection to detect debonds within the blade surface area identified in paragraph (a) of this AD, using an aluminum hammer, P/N 109–3101–58–2, or equivalent. The presence of paint cracks on the tail rotor blade upper or lower surface in the tip fairing area at the 670.0 mm spanwise location (see Figure 1) may indicate that debonds exist.

(c) Any blade that does not meet the allowable debond criteria specified in the applicable maintenance manual must be replaced with an airworthy blade before further flight.

(d) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, FAA, Rotorcraft Directorate, Rotorcraft Standards Staff. Operators shall submit their requests through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Rotorcraft Standards Staff.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Rotorcraft Standards Staff.

(e) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the helicopter to a location where the requirements of this AD can be accomplished.

(f) This amendment becomes effective on July 13, 1998.

Note 4: The subject of this AD is addressed in Registro Aeronautico Italiano (Italy) AD 97–124 and AD 97–125, both dated April 30, 1997.

Issued in Fort Worth, Texas, on June 15, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 98–16612 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98–CE–60–AD; Amendment 39–10634; AD 98–13–41]

RIN 2120–AA64

Airworthiness Directives; Cessna Aircraft Company Model 172R Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule; request for comments.

SUMMARY: This amendment adopts a new airworthiness directive (AD) that applies to certain Cessna Aircraft Company (Cessna) Model 172R airplanes. This action requires: inspecting for incorrectly routed aileron control cables in the center console area; inspecting for incorrectly routed aileron control cables in the right-hand (RH)

wing area; inspecting for a loose or improperly installed center lock clamp on the forward aileron control cable drum; and inspecting for loose or missing elevator trim actuator mounting screws, loose rudder circuit pulleys, missing rudder cable guard pins, incorrect elevator trim cable routing, aileron control cable clearance, and flight control cable tension or rigging outside specification. If any of the above conditions are found, this AD requires correcting, repairing, or replacing any damaged or missing part, and reporting any of the above conditions found to the Wichita Aircraft Certification Office. Notification by the manufacturer, service difficulty reports (SDR's), and an FAA surveillance audit at the manufacturing facility identifying potential deficiencies on the affected airplanes prompted the action. The actions specified by this AD are intended to prevent loss of aileron and elevator control, which could result in loss of directional control of the airplane.

DATES: Effective July 20, 1998.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the Federal Register as of July 20, 1998.

Comments for inclusion in the Rules Docket must be received on or before August 18, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 98–CE–60–AD, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106.

Service information that applies to this AD may be obtained from The Cessna Aircraft Company, P.O. Box 7706, Wichita, Kansas 67277, telephone: (316) 941–7550, facsimile: (316) 942–9008. This information may also be examined at the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 98–CE–60–AD, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mr. Joel M. Ligon, Aerospace Engineer, FAA, Wichita Aircraft Certification Office, 1801 Airport Road, Rm. 100, Mid-Continent Airport, Wichita, Kansas, 67209, telephone: (316) 946–4138; facsimile: (316) 946–4407.

SUPPLEMENTARY INFORMATION:

Discussion

The FAA has recently been notified by Cessna Aircraft Company of a quality control problem in the aileron and elevator control systems on certain Cessna Model 172R airplanes. In addition to this disclosure, the FAA has received service difficulty reports (SDR's) from the field regarding aileron cable control malfunction. The FAA also completed a surveillance audit revealing airplanes having incorrectly routed aileron cables, mis-rigged aileron and elevator control cables, and missing parts in the aileron and elevator systems.

Relevant Service Information

Cessna has issued the following service bulletins applicable to certain Cessna Model 172R airplanes:

—SB98–27–02, dated May 11, 1998, which specifies procedures for inspecting for incorrect routing of the aileron cable over the cable guard in the center console area, or fraying of the cable. If incorrect routing is found and the cable is frayed, the service bulletin specifies replacing the cable with a new cable. If incorrect routing is found, but no evidence of fraying is found, the service bulletin specifies re-routing the cable to its correct position;

—SB98–27–05, dated June 1, 1998, which specifies procedures for inspecting the aileron control cable in the right-hand (RH) wing for routing over an aileron autopilot actuator pulley instead of the aileron flight control pulley in the adjacent location and contains instructions to remove the aileron autopilot actuator pulley. If the aileron control cable is routed over the autopilot actuator pulley and the cable is frayed or damaged, replace the aileron control cable. If mis-routing is found, but no evidence of fraying is found, the service bulletin specifies re-routing the cable to its proper position;

—SB98–27–03, dated June 1, 1998, which specifies procedures for inspecting for a loose or incorrectly installed aileron control cable centering and retainer lock clamp on the forward aileron control cable drum. This condition can result in the primary aileron cable dislodging on the drum which could cause damage to the drum and/or partial or complete loss of aileron control. If this condition is found, repair or replace any damaged part; and,

—SB98–27–06, dated June 15, 1998, which specifies procedures for inspecting for loose or missing elevator trim actuator mounting screws, loose rudder circuit pulleys, missing rudder cable guard pins, incorrect routing of the elevator trim cable, incorrect aileron crossover cable clearance, and incorrect specifications of the flight control cable tension and rigging. If any of the above conditions are found, the service bulletin specifies repairing, replacing, or correcting the part that is damaged, out of alignment, or mis-rigged.

The FAA's Determination

After examining the circumstances and reviewing all available information related to the incidents described above, including the relevant service information, the FAA has determined that AD action should be taken to prevent loss of aileron and elevator control, which could result in loss of directional control of the airplane.

Explanation of the Provisions of the AD

Since an unsafe condition has been identified that is likely to exist or develop in other Cessna Model 172R airplanes of the same type design, this AD requires:

—Inspecting for incorrectly routed aileron control cable in the center console area;

—Inspecting for incorrectly routed aileron control cable in the right-hand (RH) wing area;

—Inspecting for a loose or incorrectly installed center lock clamp on the forward aileron control cable drum;

—Inspecting for loose or missing elevator trim actuator mounting screws, loose rudder circuit pulleys, missing rudder cable guard pins, improper elevator trim cable routing, aileron control cable clearance, and flight control cable tension rigging outside specification; and

—If any of the above conditions are found, this AD would require correcting the condition, repairing or replacing any damaged or missing part, and reporting any condition found to the Wichita Manufacturing Inspection Office.

The inspections are to be done in accordance with the Accomplishment Instructions contained in Cessna Service Bulletins (SB) SB98–27–02, dated May 11, 1998, SB98–27–03, dated June 1, 1998, SB98–27–05, dated June 1, 1998, and SB98–27–06, dated June 15, 1998, whichever is applicable.

Determination of the Effective Date of the AD

Since a situation exists that requires the immediate adoption of this regulation, it is found that notice and opportunity for public prior comment

hereon are impracticable, and that good cause exists for making this amendment effective in less than 30 days.

Comments Invited

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

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this rule must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 98–CE–60–AD.'' The postcard will be date stamped and returned to the commenter.

Regulatory Impact

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

The FAA has determined that this regulation is an emergency regulation that must be issued immediately to correct an unsafe condition in aircraft, and is not a significant regulatory action under Executive Order 12866. It has been determined further that this action involves an emergency regulation under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979). If it is determined that this emergency regulation otherwise would be significant under DOT Regulatory Policies and Procedures, a final regulatory evaluation will be prepared and placed in the Rules Docket (otherwise, an evaluation is not required). A copy of it, if filed, may be obtained from the Rules Docket.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive (AD) to read as follows:

98–13–41 Cessna Aircraft Company: Amendment 39–10634; Docket No. 98–CE–60–AD.

Applicability: Model 172R airplanes with serial numbers 17280001 through 17280475 and 17280506, certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (g) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required within the next 25 hours time-in-service (TIS), after the effective date of this AD, unless already accomplished.

To prevent loss of aileron and elevator control, which could result in loss of directional control of the airplane, accomplish the following:

Note 2: Some airplane serial numbers may appear in all of the actions required by this AD and some airplane serial numbers may only appear in one action required by this AD. It is recommended to look at each group of serial numbers closely.

(a) For Cessna Model 172R airplanes with serial numbers 17280001 through 17280326, 17280328, 17280330 through 17280335, 17280337, 17280339 through 17280342, 17280345, 17280346, 17280350, 17280353 through 17280359, 17280361 through 17280364, 17280366, 17280367, 17280371, 17280377, 17280380 through 17280383, 17280385, 17280387,17280390, 17280391, 17280393, 17280397, 17280423, 17280432 through 17280434, 17280440, 17280441, 17280457, 17280460, 17280461, 17280465 through 17280470, and 17280474:

(1) Inspect the aileron control cables in the center console area for incorrect routing over the cable guard, fraying or damage in accordance with the Accomplishment Instructions in Cessna Service Bulletin (SB) No. SB98–27–02, dated May 11, 1998.

(2) Prior to further flight, re-route any aileron control cable found out of place, and replace any aileron control cable found frayed or damaged in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–02, dated May 11, 1998.

(b) For Cessna Model 172R airplanes with serial numbers 17280002, 17280004, 17280021, 17280024, 17280069 through 17280073, 17280075, 17280077, 17280079 through 17280081, 17280083, 17280086, 17280092, 17280095, 17280109, 17280114, 17280120 through 17280124, 17280127, 17280133, 17280136, 17280147, 17280148, 17280150, 17280159, 17280163, 17280171, 17280207, 17280214, 17280224, 17280234, 17280239, 17280242, 17280248, 17280251, 17280253, 17280257, 17280262, 17280275, 17280281, 17280282, 17280285, 17280287, 17280292, 17280301, 17280305, 17280329, 17280337, 17280338, 17280341, 17280342, 17280343, 17280345, 17280351, 17280354, 17280356, 17280357, 17280359, 17280365, 17280429, and 17280506 that were not factory equipped with an autopilot:

(1) Inspect the right-hand wing for an incorrectly routed aileron control cable in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–05, dated June 1, 1998.

(2) If the aileron control cable is mis-routed, prior to further flight, correct the routing, and if there is fraying or damage to the aileron control cable, prior to further flight, replace the control cable in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–05, dated June 1, 1998.

(c) For Cessna Model 172R airplanes with serial numbers 17280001 through 17280349:

(1) Inspect for a loose or incorrectly installed center lock clamp on the forward aileron control cable drum in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–03, dated June 1, 1998.

(2) If the center lock clamp is loose or is installed incorrectly, prior to further flight, correct and adjust appropriately in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–03, dated June 1, 1998.

(d) For Cessna Model 172R airplanes with serial numbers 17280001 through 17280475:

(1) Inspect for loose or missing elevator trim actuator mounting screws, loose rudder circuit pulleys, missing rudder cable guard pins, incorrect elevator trim cable routing, aileron control cable clearance, and flight control cable tension or rigging outside the design specifications in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–06, dated June 15, 1998.

(2) If any condition in paragraph (d)(1) of this AD is found, prior to further flight, repair, replace, or correct in accordance with the Accomplishment Instructions in Cessna SB No. SB98–27–06, dated June 15, 1998.

(e) If any of the conditions noted above in paragraphs (a), (b), (c), or (d) of this AD are found within 10 days of the inspection, report the condition found, date of inspection, and the serial number of the airplane to Doyle M. King, Jr., Manager, Wichita Manufacturing Inspection, Office, 1801 Airport Road, Rm. 101, Mid-Continent Airport, Wichita, Kansas, 67209. Reporting requirements have been approved by the Office of Management and Budget and assigned OMB control number 2120–0056.

(f) Special flight permits may be issued in accordance with sections §§ 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

(g) An alternative method of compliance or adjustment of the compliance time that provides an equivalent level of safety may be approved by the Manager, Wichita Aircraft Certification Office (ACO), 1801 Airport Road, Rm. 100, Mid-Continent Airport, Wichita, Kansas, 67209. The request shall be forwarded through an appropriate FAA Maintenance Inspector, who may add comments and then send it to the Manager, Wichita ACO.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Wichita ACO.

(h) The inspections, repairs, replacements, adjustments, and corrections required by this AD shall be done in accordance with Cessna Service Bulletins No. SB98–27–02, dated May 11, 1998, No. SB98–27–03, dated June 1, 1998, No. SB98–27–05, dated June 1, 1998, and No. SB98–27–06, dated June 15, 1998. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from The Cessna Aircraft Company, P. O. Box 7706, Wichita, Kansas 67277. Copies may be inspected at the FAA, Central Region, Office of the Regional Counsel, Room 1558, 601 E. 12th Street, Kansas City, Missouri, or at the Office of the Federal Register, 800 North Capitol Street, NW, suite 700, Washington, DC.

(i) This amendment becomes effective on August 18, 1998.

Issued in Kansas City, Missouri, on June 19, 1998.

James E. Jackson,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98–17020 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 97–SW–06–AD; Amendment 39–10631; AD 98–13–40]

RIN 2120–AA64

Airworthiness Directives; Eurocopter France Model SA 330F, G, and J Helicopters

AGENCY: Federal Aviation Administration, DOT.

ACTION: Final rule.

SUMMARY: This amendment adopts a new airworthiness directive (AD), applicable to Eurocopter France Model SA 330F, G, and J helicopters, that requires verifying the torque on the nut that secures the two transformer-rectifiers' common ground; and subsequently installing a modification to separate the grounds of the two transformer-rectifiers. This amendment is prompted by a report from the airworthiness authority of France about an unsafe condition resulting from the loss of the common ground of the two transformer-rectifiers. The actions specified by this AD are intended to prevent loss of the common ground of the two transformer-rectifiers, which could result in a complete electrical failure (essential and secondary), loss of electrically-powered instrumentation, and subsequent loss of control of the helicopter.

DATES: Effective July 31, 1998.

The incorporation by reference of certain publications listed in the regulations is approved by the Director of the **Federal Register** as of July 31, 1998.

ADDRESSES: The service information referenced in this AD may be obtained from American Eurocopter Corporation, 2701 Forum Drive, Grand Prairie, Texas 75053–4005. This information may be examined at the FAA, Office of the Regional Counsel, Southwest Region, 2601 Meacham Blvd., Room 663, Fort Worth, Texas; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Mr. Carroll Wright, Aerospace Engineer, FAA, Rotorcraft Directorate, Rotorcraft Regulations Group, 2601 Meacham Blvd., Fort Worth, Texas 76137, telephone (817) 222–5120, fax (817) 222–5961.

SUPPLEMENTARY INFORMATION: A proposal to amend part 39 of the Federal Aviation Regulations (14 CFR part 39) to include an airworthiness directive (AD) that is applicable to Eurocopter France Model SA 330F, G, and J helicopters was published in the **Federal Register** on March 5, 1998 (63 FR 10783). That action proposed to require verifying the torque on the nut that secures the two transformer-rectifiers' common ground; and subsequently installing a modification to separate the grounds of the two transformer-rectifiers.

Interested persons have been afforded an opportunity to participate in the making of this amendment. No comments were received on the proposal or the FAA's determination of the cost to the public. The FAA has determined that air safety and the public interest require the adoption of the rule as proposed.

The FAA estimates that 1 helicopter of U.S. registry would be affected by this proposed AD, that it would take approximately 0.5 work hour to verify or accomplish the retorque of the nut, 2 work hours per helicopter to accomplish the proposed modifications, and that the average labor rate is $60 per work hour. Required parts for the modification would cost approximately $70 per helicopter. Based on these figures, the total cost impact of the proposed AD on U.S. operators is estimated to be $220.

The regulations adopted herein will not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this final rule does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A final evaluation has been prepared for this action and it is contained in the Rules Docket. A copy of it may be obtained from the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Incorporation by reference, Safety.

Adoption of the Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive to read as follows:

AD 98–13–40 Eurocopter France: Amendment 39–10631. Docket No. 97–SW–06–AD.

Applicability: Model SA 330F, G, and J helicopters, certificated in any category.

Note 1: This AD applies to each helicopter identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For helicopters that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must use the authority provided in paragraph (c) to request approval from the FAA. This approval may address either no action, if the current configuration eliminates the unsafe condition, or different actions necessary to address the unsafe condition described in this AD. Such a request should include an assessment of the effect of the changed configuration on the unsafe condition addressed by this AD. In no case does the presence of any modification, alteration, or repair remove any helicopter from the applicability of this AD.

Compliance: Required as indicated, unless accomplished previously.

To prevent loss of the common ground of the two transformer-rectifiers, which could result in a complete electrical failure (essential and secondary), loss of electrically-powered instrumentation, and subsequent loss of control of the helicopter, accomplish the following:

(a) Within 10 hours time-in-service (TIS), ensure that the nut, part number (P/N) 22541N080, that secures the common ground of the transformer-rectifiers is properly torqued in accordance with the Accomplishment Instructions of Eurocopter France SA 330 Service Bulletin No. 01.53R1, dated March 13, 1997.

(b) Within 500 hours TIS, install Eurocopter France Modification No. 0725580 or 0725681, as applicable, in accordance with the Accomplishment Instructions of Eurocopter France SA 330 Service Bulletin No. 01.53R1, dated March 13, 1997. Installation of Modification No. 0725580 or 0725681, as applicable, is considered a terminating action for the requirements of this AD.

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Rotorcraft Standards Staff, Rotorcraft Directorate, FAA. Operators shall submit their requests through an FAA Principal Maintenance Inspector, who may concur or comment and then send it to the Manager, Rotorcraft Standards Staff.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Rotorcraft Standards Staff.

(d) Special flight permits may be issued in accordance with §§ 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the helicopter to a location where the requirements of this AD can be accomplished.

(e) The modification shall be done in accordance with the Accomplishment Instructions of Eurocopter France SA 330 Service Bulletin No. 01.53R1, dated March 13, 1997. This incorporation by reference was approved by the Director of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. Copies may be obtained from American Eurocopter Corporation, 2701 Forum Drive, Grand Prairie, Texas 75053–4005. Copies may be inspected at the FAA, Office of the Regional Counsel, Southwest Region, 2601 Meacham Blvd., Room 663, Fort Worth, Texas; or at the Office of the Federal Register, 800 North Capitol Street, NW., suite 700, Washington, DC.

(f) This amendment becomes effective on July 31, 1998.

Note 3: The subject of this AD is addressed in Direction Generale De L'Aviation Civile (France) AD 96–173–077(B)R1, dated April 23, 1996.

Issued in Fort Worth, Texas, on June 18, 1998.

Eric Bries,

Acting Manager, Rotorcraft Directorate, Aircraft Certification Service.

[FR Doc. 98–17042 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–AGL–22]

Modification of Class E Airspace; Griffith, IN

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action modifies Class E airspace at Griffith, IN. A Global Positioning System (GPS) Standard Instrument Approach Procedure (SIAP) to Runway (Rwy) 26, has been developed for Griffith-Merrillville Airport. Controlled airspace extending upward from 700 to 1200 feet above ground level (AGL) is needed to contain aircraft executing the approach. This action adds an extension to the east for the existing controlled airspace for Griffith-Merrillville Airport.

EFFECTIVE DATE: 0901 UTC, October 08, 1998.

FOR FURTHER INFORMATION CONTACT: Michelle M. Behm, Air Traffic Division, Airspace Branch, AGL–520, Federal Aviation Administration, 2300 East Devon Avenue, Des Plaines, Illinois 60018, telephone (847) 294–7568.

SUPPLEMENTARY INFORMATION:

History

On Wednesday, April 22, 1998, the FAA proposed to amend 14 CFR part 71 to modify Class E airspace at Griffith, IN (63 FR 19857). The proposal was to add controlled airspace extending upward from 700 to 1200 feet AGL to contain Instrument Flight Rules (IFR) operations in controlled airspace during portions of the terminal operation and while transiting between the enroute and terminal environments.

Interested parties were invited to participate in this rulemaking proceeding by submitting written comments on the proposal to the FAA. No comments objecting to the proposal were received. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surface of the earth are published in paragraph 6005 of FAA Order 7400.9E dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document will be published subsequently in the Order.

The Rule

This amendment to 14 CFR part 71 modifies Class E airspace at Griffith, IN, to accommodate aircraft executing the proposed GPS Rwy 26 SIAP at Griffith-Merrillville Airport by adding an eastern extension to the existing controlled airspace at the airport. The area will be depicted on appropriate aeronautical charts.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it

is certified that this rule will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

AGL in E5 Griffith, IN [Revised]

Griffith-Merrillville Airport, IN
(Lat. 41°31′11″ N., long. 87°24′04″ W.)

That airspace extending upward from 700 feet above the surface within a 6.4-mile radius of the Griffith-Merrillville Airport; and within 2.0 miles either side of the 080° bearing from the airport, extending from the 6.4-mile radius to 7.8 miles east of the airport, excluding that area within the Chicago, IL, Class E airspace area.

* * * * *

Issued in Des Plaines, Illinois on June 16, 1998.

David B. Johnson,

Acting Manager, Air Traffic Division.

[FR Doc. 98–17050 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–AGL–23]

Modification of Class E Airspace; Fort Atkinson, WI

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action modifies Class E airspace at Fort Atkinson, WI. A Global Positioning System (GSP) Standard Instrument Approach Procedure (SIAP) to Runway (Rwy) 03 has been developed for Fort Atkinson Municipal Airport. Controlled airspace extending upward from 700 to 1200 feet above ground level (AGL) is needed to contain aircraft executing the approach. This action increases the radius of the existing controlled airspace for Fort Atkinson Municipal Airport.

EFFECTIVE DATE: 0901 UTC, October 08, 1998.

FOR FURTHER INFORMATION CONTACT: Michelle M. Behm, Air Traffic Division, Airspace Branch, AGL–520, Federal Aviation Administration, 2300 East Devon Avenue, Des Plaines, Illinois 60018, telephone (847) 294–7568.

SUPPLEMENTARY INFORMATION:

History

On Wednesday, April 22, 1998, the FAA proposed to amend 14 CFR part 71 to modify Class E airspace at Fort Atkinson, WI (63 FR 19856).

The proposal was to add controlled airspace extending upward from 700 to 1200 feet AGL to contain Instrument Flight Rules (IFR operations in controlled airspace during portions of the terminal operation and while transiting between the enroute and terminal environments.

Interested parties were invited to participate in this rulemaking proceeding by submitting written comments on the proposal to the FAA. No comments objecting to the proposal were received. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surface of the earth are published in paragraph 6005 of FAA Order 7400.9E dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document will be published subsequently in the Order.

The Rule

This amendment to 14 CFR part 71 modifies Class E airspace at Fort Atkinson, WI, to accommodate aircraft executing the proposed GPS Rwy 03 SIAP at Fort Atkinson Municipal Airport by increasing the radius of the existing controlled airspace for the airport. The area will be depicted on appropriated aeronautical charts.

The FAA has determined that this regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this regulation—(1) is not a ''significantly regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this is a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

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

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

AGL WI E5 Fort Atkinson, WI [Revised]

Fort Atkinson Municipal Airport, WI
(Lat. 42°57′48″ N, long. 88°49′03″ W)

That airspace extending upward from 700 feet above the surface within a 8.6-mile radius of Fort Atkinson Municipal Airport, excluding that airspace within the Watertown, WI, Class E airspace area.

* * * * *

Issued in Des Plaines, Illinois on June 16, 1998.

David B. Johnson,

Acting Manager, Air Traffic Division.

[FR Doc. 98–17049 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–m

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–AGL–24]

Modification of Class E Airspace; Youngstown Elser Metro Airport, OH

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This action modifies Class E airspace at Youngstown Elser Metro Airport, OH. A Global Positioning System (GPS) Standard Instrument Approach Procedure (SIAP) to Runway (Rwy) 28 has been developed for Youngstown Elser Metro Airport. Controlled airspace extending upward from 700 to 1200 feet above ground level (AGL) is needed to contain aircraft executing the approach. This action adds an extension to the east for the existing controlled airspace for Youngstown Elser Metro Airport.

EFFECTIVE DATE: 0901 UTC, October 08, 1998.

FOR FURTHER INFORMATION CONTACT: Michelle M. Behm, Air Traffic Division, Airspace Branch, AGL–520, Federal Aviation Administration, 2300 East Devon Avenue, Des Plaines, Illinois 60018, telephone (847) 294–7568.

SUPPLEMENTARY INFORMATION:

History

On Wednesday, April 22, 1998, the FAA proposed to amend 14 CFR part 71 to modify Class E airspace at Youngstown Elser Metro Airport, OH (63 FR 19855). The proposal was to add controlled airspace extending upward from 700 to 1200 feet AGL to contain Instrument Flight Rules (IFR) operations in controlled airspace during portions of the terminal operation and while transiting between the enroute and terminal environments.

Interested parties were invited to participate in this rulemaking proceeding by submitting written comments on the proposal to the FAA. No comments objecting to the proposal were received. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surface of the earth are published in paragraph 6005 of FAA Order 7400.9E dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. the Class E airspace designation listed in this document will be published subsequently in the Order.

The Rule

This amendment to 14 CFR part 71 modifies Class E airspace at Youngstown Elser Metro Airport, OH, to accommodate aircraft executing the proposed GPS Rwy 28 SIAP at Youngstown Elser Metro Airport by adding an extension to the east for the existing controlled airspace for the airport. The area will be depicted on appropriate aeronautical charts.

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

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 208454, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward form 700 feet or more above the surface of the earth.

* * * * *

AGL OH E5 Youngstown Elser Metro Airport, OH [Revised]

Youngstown Elser Metro Airport, OH
(lat. 40°57′38″ N., long. 80°40′36″ W.)

That airspace extending upward from 700 feet above the surface within a 6.4-mile radius of the Youngstown Elser Metro Airport; and within 4.0 miles either side of the 108° bearing from the airport, extending from the 6.4-mile radius to 8.8 miles east of the airport, excluding that airspace within the Youngstown-Warren Regional Airport, OH, Class E airspace area, and excluding that airspace within the New Castle, PA, Class E airspace area.

* * * * *

Issued in Des Plaines, Illinois on June 16, 1998.

David B. Johnson,

Acting Manager, Air Traffic Division.

[FR Doc. 98–17051 Filed 6–24–98; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–ASO–5]

Amendment of Class E Airspace; Roxboro, NC

AGENCY: Fedeal Aviation Administration (FAA), DOT.

ACTION: Final rule.

SUMMARY: This amendment modifies Class E airspace at Roxboro, NC. A Global Positioning System (GPS) Runway (RWY) 6 Standard Instrument Approach Procedure (SIAP) has been developed for Person County Airport. As a result, additional controlled airspace extending upward from 700 feet Above Ground Level (AGL) is needed to accommodate the SIAP and for Instrument Flight Rules (IFR) operations at Person County Airport. The Class E airspace has been increased from a 6.4 to a 6.6-mile radius.

EFFECTIVE DATE: 0901 UTC, August 13, 1998.

FOR FURTHER INFORMATION CONTACT: Nancy B. Shelton, Manager, Airspace Branch, Air Traffic Division, Federal Aviation Administration, PO Box 20636, Atlanta, Georgia 30320; telephone (404) 305–5586.

SUPPLEMENTARY INFORMATION:

History

On April 6, 1998, the FAA proposed to amend part 71 of the Federal Aviation Regulations (14 CFR part 71) by amending Class E airspace at Roxboro, NC, (63 FR 16718). This action provides adequate Class E airspace for IFR operations at Person County Airport. Designations for Class E airspace extending upward from 700 feet or more above the surface of the earth are published in Paragraph 6005 of FAA Order 7400.9E, dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR part 71.1. The Class E airspace designation listed in this document will be published subsequently in the Order.

Interested parties were invited to participate in this rulemaking proceeding by submitting written comments on the proposal to the FAA. No comments objecting to the proposal were received.

The Rule

This amendment to part 71 of the Federal Aviation Regulations (14 CFR part 71) modifies Class E airspace at Roxboro, NC. A GPS RWY 6 SIAP has been developed for Person County Airport. Additional controlled airspace extending upward from 700 feet AGL is needed to accommodate the SIAP and for IFR operations at Person County Airport.

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

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

Adoption of the Amendment

In consideration of the foregoing, the Federal Aviation Administration amends 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for 14 CFR part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; EO 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

ASO NC E5 Roxboro, NC [Revised]

Person County Airport, NC
(lat. 36°17′08″ N, long. 78°59′00″ W)

That airspace extending upward from 700 feet or more above the surface of the earth within a 6.6-mile radius of Person County Airport.

* * * * *

Issued in College Park, Georgia, on May 29, 1998.

Jeffery N. Burner,

Acting Manager, Air Traffic Division, Southern Region.

[FR Doc. 98–16957 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–M

FEDERAL TRADE COMMISSION

16 CFR Part 14

Amended Enforcement Policy Statement Concerning Clear and Conspicuous Disclosure in Foreign Language Advertising and Sales Materials

AGENCY: Federal Trade Commission.

ACTION: Final rule; Statement of policy.

SUMMARY: The Commission has determined that it would be appropriate to amend its Enforcement Policy Statement regarding clear and conspicuous disclosures in foreign language advertising and sales materials. The amended policy statement is intended to clarify the 1973 Enforcement Policy Statement.

EFFECTIVE DATE: June 26, 1998.

FOR FURTHER INFORMATION CONTACT: Linda K. Badger or Matthew D. Gold, San Francisco Regional Office, Federal Trade Commission, 901 Market Street, Suite 570, San Francisco, CA 94103, (415) 356–5270.

SUPPLEMENTARY INFORMATION: The Federal Trade Commission (''Commission'') has noted that some advertisements appearing in foreign language publications feature advertising copy in both English and a foreign language, but include the required disclosure only in English. Because the target audience for these ads is non-English speaking, the Commission believes that the required disclosure should be provided in the language of the target audience, rather than English. This policy statement clarifies the Commission's policy under these circumstances.

The Commission, on two occasions, has addressed the issue of disclosures in foreign language advertising. On August 9, 1973, the Commission issued an Enforcement Policy Statement dealing with disclosures in foreign language advertising. That policy statement, which is codified at 16 CFR 14.9, reads in pertinent part: ''(a) Where cease-and-desist orders as well as rules, guides and other statements require 'clear and conspicuous' disclosure of certain information, that disclosure must be in the same language as that principally used in the advertisements and sales materials involved.[1] Staff has been informed that some companies have interpreted the 1973 Enforcement Policy Statement to mean that a disclosure must be in English, regardless of the target audience of the advertisement, if the number of English words in an advertisement exceeds the number of foreign language words.

On November 4, 1986, the Commission issued its Regulations Under the Comprehensive Smokeless Tobacco Health Education Act of 1986.[2] Those regulations address, *inter alia*, the language in which the Surgeon General's health warning must appear in advertisements for smokeless tobacco products. The smokless tobacco regulations require that:

In the case of an advertisement for a smokeless tobacco product in a newspaper, magazine, periodical, or other publication that is not in English, the warning statement shall appear in the predominant language of the publication in which the advertisement appears. In the case of any other advertisement, the warning statement shall appear in the same language as that principally used in the advertisement.[3]

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[1] 38 FR 21494 (Aug. 9, 1973).
[2] 16 CFR 307 (1997).
[3] 16 CFR 307.5

While the policy statement focuses on the principal language of the advertisement, the smokeless tobacco regulation looks to the predominant language of the publication in determining the language in which the Surgeon General's health warning must appear.

The Commission believes that, for advertisements in publications, the smokeless tobacco language is better calculated to ensure compliance with the original intent of the 1973 Enforcement Policy Statement—that disclosures be communicated effectively to the advertisement's target audience.

By amending the policy statement as proposed, the Commission would not be creating a new regulation. The policy statement amendment merely would clarify the original intent of the 1973 Enforcement Policy Statement—that all American consumers, regardless of the language they speak, have access to important information regarding the products they purchase.

List of Subjects in 16 CFR Part 14

Trade practices.

Accordingly, for the reasons set forth in the preamble, the Commission hereby amends Title 16, Part 14 of the Code of Federal Regulations as follows:

PART 14—ADMINISTRATIVE INTERPRETATIONS, GENERAL POLICY STATEMENTS, AND ENFORCEMENT POLICY STATEMENTS

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

Authority: 15 U.S.C. 41–58

2. Section 14.9 is amended by revising paragraphs (a) and (b) to read as follows:

§ 14.9 Requirements concerning clear and conspicuous disclosures in foreign language advertising and sales materials.

* * * * *

(a) Where cease-and-desist orders as well as rules, guides and other statements require ''clear and conspicuous'' disclosure of certain information in an advertisement or sales material in a newspaper, magazine, periodical, or other publication that is not in English, the disclosure shall appear in the predominant language of the publication in which the advertisement or sales material appears. In the case of any other advertisement or sales material, the disclosure shall appear in the language of the target audience (ordinarily the language principally used in the advertisement or sales material).

(b) Any respondent who fails to comply with this requirement may be the subject of a civil penalty or other law enforcement proceeding for violating the terms of a Commission cease-and-desist order or rule.

By direction of the Commission

Donald S. Clark,

Secretary.

[FR Doc. 98–16953 Filed 6–25–98; 8:45 am]

BILLING CODE 6750–01–M

DEPARTMENT OF THE TREASURY

Customs Service

19 CFR Parts 19, 24, 111, 113, 143, 162, 163, 178, and 181

(T.D. 98–56)

RIN 1515–AB77

Recordkeeping Requirements

AGENCY: Customs Service; Department of the Treasury.

ACTION: Final rule; correction.

SUMMARY: This document makes a correction to the document published in the **Federal Register** which set forth final amendments to the Customs Regulations to reflect changes to the Customs laws regarding recordkeeping and related requirements. The correction involves an incorrect citation within § 163.6 of the final regulatory texts.

EFFECTIVE DATE: This correction is effective July 16, 1998.

FOR FURTHER INFORMATION CONTACT: Francis W. Foote, Regulations Branch, Office of Regulations and Rulings (202–927–0163).

SUPPLEMENTARY INFORMATION:

Background

On June 16, 1998, Customs published in the **Federal Register** (63 FR 32916) as T.D. 98–56 a final rule document setting forth final amendments to the Customs Regulations to reflect changes to the Customs laws regarding recordkeeping requirements, examination of records and witnesses, regulatory audit procedures, and judicial enforcement contained in the Customs Modernization provisions of the North American Free Trade Agreement Implementation Act (Pub. L. 103–182, 107 Stat. 2057). The majority of those final regulatory texts are contained in new part 163 (19 CFR part 163) which reflects general recordkeeping requirements applicable to persons who engage in specified types of customs transactions.

Within new part 163, § 163.6 includes requirements concerning the production and examination of entry records and prescribes the monetary penalty assessment and additional actions that Customs may take for a failure to comply with those requirements. Within § 163.6, paragraph (b)(2)(i) specifies the additional actions that Customs may take and paragraph (b)(2)(ii) sets forth an exception to the paragraph (b)(2)(i) general rule. However, the text of paragraph (b)(2)(ii), as published, improperly included a reference to paragraph ''(b)(2)(ii)(B)'' which should have read ''(b)(2)(i)(B)''. This document corrects this typographical error.

Correction to the Final Regulations

§ 163.6 [Corrected]

On page 32948, in the third column, in § 163.6, in paragraph (b)(2)(ii), the reference ''(b)(2)(ii)(B)'' is corrected to read ''(b)(2)(i)(B)''.

Dated: June 22, 1998.

Harold M. Singer,

Chief, Regulations Branch.

[FR Doc. 98–17060 Filed 6–25–98; 8:45 am]

BILLING CODE 4820–02–P

UNITED STATES INFORMATION AGENCY

22 CFR Part 514

Exchange Visitor Program

AGENCY: United States Information Agency.

ACTION: Interim final rule.

SUMMARY: The Agency adopts a fee sufficient for it to recover the full cost of its administrative processing of requests for waiver of the two-year return to the home country requirement set forth in Section 212(e) of the Immigration and Naturalization Act (8 U.S.C. 1182(e)).

DATES: This interim rule is effective June 26, 1998. The specified fee will be assessed for all waiver applications post-marked after July 27, 1998. Written comments must be submitted on or before July 27, 1998.

ADDRESSES: Written comments should be submitted to: Public Comment Clerk, Office of General Counsel, United States Information Agency, 301 4th Street, SW., Washington, DC 20547.

FOR FURTHER INFORMATION CONTACT: Stanley S. Colvin, Assistant General Counsel, Office of the General Counsel, 301 4th Street, SW., Washington, DC 20547; telephone, (202) 619–6531.

SUPPLEMENTARY INFORMATION: Pursuant to the provisions of the Fulbright-Hays Act of 1961 (Pub. L. 87–256) the Agency administers the Exchange Visitor Program by facilitating the entry of over

200,000 program participants each year. The Exchange Visitor Program is a component of the public diplomacy efforts of the United States Government and fosters mutual understanding and peaceful relations between the United States and other countries through educational and cultural exchange activities. Program participants enter the United States in nonimmigrant J-visa status. A statutory requirement has been imposed to ensure that certain program participants return to their home country and share with their countrymen the education, skills, and understanding of the United States acquired as a program participant.

Commonly referred to as the Section 212(e) return to the home country requirement, this statutory provision applies to a program participant who has entered the United States and received government funding to participate in an exchange activity, or who has pursued graduate medical education or training as a participant, or who has pursued study or training in a field of interest to his or her home government as evidenced by such field's inclusion on the identified ''skills list'' for that country. If subject to the provisions of Section 212(e), a program participant may not adjust his or her nonimmigrant status to that afforded under the provisions of 8 U.S.C. 1101 (h) or (l) or to legal permanent resident unless the participants has been either physically present in his or her home country for a period of two years following completion of his or her Exchange Visitor Program or has received a waiver of this requirement.

Based upon the statutory and administrative authorities set forth below, the Agency has determined that its review of and recommendation regarding requests for the waiver of the two year return to the home country requirement confers a specific benefit to the requesting individual. Accordingly, a fee sufficient to recoup the costs of conferring this specific benefit is appropriate.

Legislative Authority

The Department of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 1998 (Pub. L. 105–119) authorizes the Agency to collect fees related to its provision of Exchange Visitor Program services. Specifically, this appropriations statute authorizes the Agency to charge a fee and recycle such monies by providing ''* * * That not to exceed $6,000,000, to remain available until expended, may be credited to this appropriation from fees or other payments received from or in connection with English teaching, library, motion pictures, and publication programs as authorized by section 810 of such Act of 1948 (22 U.S.C. 1475e) and, notwithstanding any other law, fees from educational advising and counseling, and exchange visitor program services * * *.''

In adopting a fee for exchange visitor program services provided to the public, the Agency is also guided by the provisions of the Independent Offices Appropriations Act of 1952 (Pub. L. 82–137), 31 U.S.C. 9701. This statute permits an agency to prescribe regulations establishing the charge for a service or thing of value provided by the agency. Such regulations so adopted are subject to policies prescribed by the President. The statute directs that any charge adopted shall be (i) fair; and (ii) based on the costs to the Government, the value of the service to the recipient, the public policy or interest served, and other relevant facts. The Agency has determined that an application to the Agency for a waiver recommendation is a request for a service within the meaning of these statutes that confers a specific benefit upon an identifiable beneficiary. Further, the Agency also relies upon the decisions in *Auyda, Inc.* v. *Attorney General*, 661 F. Supp. 33 (1987); and *Engine Manufacturers Association* v. *E.P.A.*, 20 F.3d 1177 (1994) in adopting a fee for the review of such applications.

Finally, the Agency's adoption and implementation of a fee for review of waiver applications will be subject to the provisions of the Chief Financial Officers Act of 1990 (Pub. L. 101–576.) Section 205(a)(8) of this Act requires the Agency's Chief Financial Officer to ''review, on a biennial basis, the fee, royalties, rents, and other charges imposed by the agency for services and things of value it provides, and make recommendations on revising those charges to reflect costs incurred by it in providing those services and things of value.'' (31 U.S.C. 902(a)(8))

Office of Management and Budget Circular No. A–25

Pursuant to Circular No. A–25, The Office of Management and Budget (OMB) has established the Federal policy governing fees assessed for Government services and for the sale or use of Government goods or resources. OMB Circular No. A–25 sets forth the general policy that a ''user charge * * * will be assessed against each identifiable recipient for special benefits derived from Federal activities beyond those received by the general public.'' To determine whether a ''special benefit'' has accrued, Circular No. A–25 offers the following guidance:

> For example, a special benefit will be considered to accrue and a user charge will be imposed when a Government service: (a)(E)nables the beneficiary to obtain more immediate or substantial gains or values (which may or may not be measurable in monetary terms) than those that accrue to the general public (e.g., receiving a patent, insurance, or guarantee provision, or a license to carry on a specific activity or business or various kinds of public land use); or (b) (P)rovides business stability or contributes to public confidence in the business activity of the beneficiary (e.g., insuring deposits in commercial banks); or (c) (I)s performed at the request of or for the convenience of the recipient, and is beyond the services regularly received by other members of the same industry or group or by the general public (e.g., receiving a passport, visa, airman's certificate, or a Customs inspection after regular duty hours.)
>
> (OMB Circular A–25, section 6.a.(1))

In calculating the amount of the fee to be charged for the Agency's review of an application for a Section 212(e) waiver and recommendation thereon, the Agency will rely upon the guidance set forth in OMB Circular A–25. Agencies are directed to recoup the ''full costs'' of providing a service or specific benefit. Full cost is defined as including all direct and indirect costs to any part of the Federal Government of providing a good, resource, or service. These costs include, but are not limited to, an appropriate share of:

> (a) Directed and indirect personnel costs, including salaries and fringe benefits such as medical insurance and retirement. Retirement costs should include all (funded or unfunded) accrued costs not covered by employee contributions as specified in Circular No. A–11.
>
> (b) Physical overhead, consulting, and other indirect costs including material and supply costs, utilities, insurance, travel, and rents or imputed rents on land, buildings, and equipment. If imputed rental costs are applied, they should include:
>
> (i) Depreciation of structures and equipment, based on official Internal Revenue Service depreciation guidelines unless better estimates are available; and
>
> (ii) An annual rate of return (equal to the average long-term Treasury bond rate) on land, structures, equipment and other capital resources used.
>
> (c) The management and supervisory costs.
>
> (d) The costs of enforcement, collection, research, establishment of standards, and regulation, including any required environmental statements.
>
> (e) Full cost shall be determined or estimated from the best available records of the agency, and new cost account systems need not be established solely for this purpose.
>
> (OMB Circular A–25 Section 6.d)

Circular A–25 further directs the federal agencies to adopt user charges by promulgating regulations, to ensure that proper internal control systems and

appropriate audit standards are in place, and to review user charges biennially to ensure adjustment of such charges to reflect unanticipated changes in costs or market values.

Fee Calculation

Having determined that imposition of a user fee for Agency review of waiver requests is a lawful exercise of Agency authority, the amount of such fee must be calculated. In calculating the amount of this fee, the Agency is guided by the provisions of OMB Circular No. A–25, User Charges and the Federal Accounting Standards Advisory Board Statement of Federal Financial Accounting Standards No. 4: Managerial Cost Accounting Concepts and Standards for the Federal Government. These standards direct that an agency identify and recoup the full cost of providing a benefit or service. Full cost is defined to mean both the direct and indirect costs of providing said service or benefit. The Agency's organizational structure facilitates the calculation of the full cost associated with review of waiver applications as performance of this function is centralized in the Agency's Office of General Counsel Waiver Review Branch (Waiver Branch).

The Waiver Branch is headed by a branch chief who supervises five waiver officers, four waiver assistants and two program assistants. These twelve employees process some 6,000 waiver applications each year. This processing is broken dawn along geographic lines with each officer responsible for specific countries with the waiver and program assistants providing necessary support services. In addition, the Waiver Branch receives general management oversight from the Agency's General Counsel and Deputy General Counsel and legal oversight and assistance from an Agency Assistant General Counsel.

In processing waiver applications, the Waiver Branch unit is required to perform the following tasks:

Receive waiver applications, which includes the tasks of receiving, opening, and screening applications;

Record fee, which includes, in cooperation with the Agency's Management Bureau, the task of receipting fees, reconciling registers, preparing and making deposits, and recording information into program and financial systems;

Input application data, which includes the tasks of entering data from applications into program systems, verifying data, and printing system data;

Manage records, which includes the tasks of creating files; connecting requested information and documents with application files; putting, storing, and moving files; and archiving inactive files;

Adjudicate application, which includes the tasks of distributing workload; reviewing, examine, and adjudicating applications; making and recording adjudicative decisions; requesting and reviewing additional information as needed; and consulting with supervisors and legal counsel on non-routine adjudications;

Prepare outgoing correspondence, which includes the tasks of preparing decision letters, copying, and mailing;

Respond to inquiries, which includes the tasks of receiving and responding to inquiries on the status of a waiver application or the request for an advisory opinion regarding whether an alien is subject to the two year return to the home country requirement. These inquiries may be from applicants, legal representatives, or members of Congress and are received by both telephone and in writing.

As stated above, these identified tasks are performed on a full-time basis by the twelve members of the Waiver Branch with three additional Agency employees providing supervision and legal services on a less than full-time basis. Through application of FASAB Federal Financial Standards No. 4: Managerial Cost Accounting Concepts and Standards for the Federal Government, the Agency has identified $632,872 in direct costs attributable to the performance of the tasks set forth above. Based upon direct and indirect costs of $816,232, and 6,000 waiver application per year, the Agency has determined that the per unit cost of processing a waiver application is $136 and adopts this amount as the fee to be collected for the future processing of waiver applications.

Public Comment

The Agency invites comments from the public on this interim final rule notwithstanding the fact that it is under no legal requirement to do so. The Designation of exchange visitor sponsors and the administration of the Exchange Visitor Program are deemed to be foreign affairs functions of the United States Government. The Administrative Procedures Act, 5 U.S.C. 553(a)(1)(1989) specifically exempts such functions from the rulemaking requirements of the Act.

The Agency will accept comments for thirty days following publication of this interim final rule. In accordance with 5 U.S.C. 605(b), the Agency certifies that this rule does not have a significant adverse economic impact on a substantial number of small entities. This rule is not considered to be a major rule within the meaning of section 1(b) of E.O. 12291, nor does it have federalism implications warranting the Preparation of a Federalism Assessment in accordance with E.O. 12612. This rule is not a major rule as defined by the Small Business Regulatory Enforcement Act of 1996 nor is it considered an economically significant regulatory action as defined by E.O. 12866. This rule does not impose any new reporting or record keeping requirements.

List of Subjects in 22 CFR Part 514

Cultural Exchange Programs.

Dated: June 18, 1998.

Les Jin,

General Counsel.

Accordingly, 22 CFR Part 514 is amended as follows:

PART 514—EXCHANGE VISITOR PROGRAM

1. The authority citation for part 514 continues to read as follows:

Authority: 8 U.S.C. 1101 (a)(15)(j), 1182, 1258; 22 U.S.C. 1431–1442, 2451–2460; Reorganization Plan No. 2 of 1977, 42 FR 62461, 3 CFR 1977 Comp. p. 200; E.O. 12048 43 FR 13361, 3 CFR, 1978 Comp. p. 168; USIA Delegation Order No. 85–5 (50 FR 27393).

2. Part 514 is amended by adding a new subpart H consisting of § 514.90 to read as follows:

Subpart H—Fees.

§ 514.90 Fees.

(a) *Remittances.* Fees prescribed within the framework of 31 U.S.C. 9701 shall be submitted as directed by the Agency and shall be in the amount prescribed by law or regulation. Remittances must be drawn on a bank or other institution located in the United States and be payable in United States currency and shall be made payable to the ''United States Information Agency.'' A charge of $25.00 will be imposed if a check in payment of a fee is not honored by the bank on which it is drawn. If an applicant is residing outside the United States at the time of application, remittance may be made by bank international money order of foreign draft drawn on an institution in the United States and payable to the United States Information Agency in United States currency.

(b) *Amounts of Fees.* The following fees are prescribed:

Request for waiver review and recommendation—$136.

[FR Doc. 98–16653 Filed 6–25–98; 8:45 am]

BILLING CODE 8230–01–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

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). The Deputy Assistant Judge Advocate General (Admiralty) of the Navy has determined that a prior certification of noncompliance for USS CONSTELLATION (CV 64) should be amended to reflect compliance with 72 COLREGS. The intended effect of this rule is to warn mariners in waters where 72 COLREGS apply.

EFFECTIVE DATE: June 15, 1998.

FOR FURTHER INFORMATION CONTACT: Captain R.R. Pixa, JAGC, U.S. Navy Admiralty Counsel, Office of the Judge Advocate General Navy Department, 200 Stovall Street, Alexandria, VA 22332–2400 Telephone number: (703) 325–9744.

SUPPLEMENTARY INFORMATION: Pursuant to the authority granted in 33 U.S.C. 1605, the Department of the Navy amends 32 CFR Part 706. This amendment provides notice that the Deputy Assistant Judge Advocate General (Admiralty) of the Navy, under authority delegated by the Secretary of the Navy, has determined that certain navigation lights on USS CONSTELLATION (CV 64), previously certified as not in compliance with 72 COLREGS, now comply with the applicable 72 COLREGS requirements. Specifically, the ship now has a single forward anchor light and a single aft anchor light, as required by Rule 30(a)(i). Furthermore, the forward anchor light and the aft anchor light have been relocated to comply with Annex I, paragraph 2(k), and Rule 30(a)(ii).

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 vessel in a manner differently from that prescribed herein will adversely affect the vessel's ability to perform its military functions.

List of Subjects in 32 CFR Part 706

Marine safety, Navigation (water), Vessels.

PART 706—[AMENDED]

Accordingly, 32 CFR Part 706 is amended as follows:

1. The authority citation for 32 CFR Part 706 continues to read:

Authority: 33 U.S.C. 1605.

2. Table Two of 706.2 is amended by revising the entry for USS CONSTELLATION as follows:

§ 706.2 Certifications of the Secretary of the Navy under Executive Order 11964 and 33 U.S.C. 1605.

* * * * *

TABLE TWO

Vessel	Number	Masthead lights, distance to stbd of keel in meters; rule 21(a)	Forward anchor light, distance below flight dk in meters; § 2(K), annex I	Forward anchor light, number of; rule 30(a) (i)	AFT anchor light, distance below flight dk in meters; rule 21(e), rule 30(a)(ii)	AFT anchor light, number of; rule 30(a) (ii)	Side lights, distance below flight dk in meters; § 2(g), annex I	Side lights, distance forward of forward masthead light in meters; § 3(b), annex I	Side lights, distance inboard of ship's sides in meters; § 3(b), annex I
USS CONSTELLATION	CV–64	28.2	.....	1	.....	1	0.4	.....	.....

* * * * *

Approved: June 15, 1998.

W.T. Storz,

Commander, JAGC, U.S. Navy, Acting Deputy Assistant Judge Advocate General (Admiralty).

[FR Doc. 98–17017 Filed 6–25–98; 8:45 am]

BILLING CODE 3810–FF–P

DEPARMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD08–98–025]

RIN 2115–AE46

Special Local Regulations; Independence Day Celebration Cumberland River Miles 190–191, Nashville, TN

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: Special local regulations are being adopted for the Independence Day Celebration. This event will be held on July 4, 1998 from 12 p.m. until 11 p.m. at the Riverfront in Nashville, Tennessee along the Cumberland River, miles 190.0 to 191.0. The event will include a boat parade beginning at 5 p.m. and a fireworks display beginning at 8:45 p.m. These regulations are needed to provide for the safety of life on navigable waters during the boat parade and fireworks display that will be part of the event.

DATES: These regulations are effective from 4 p.m. until 10 p.m. on July 4, 1998.

ADDRESSES: Unless otherwise indicated, documents referred to in this notice are available for inspection and copying at Marine Safety Office, Paducah, 225 Tully Street, Paducah, Kentucky, 42003 between 8 a.m. and 4 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: BM2 Stephen L. Jones, Marine Safety Office, Paducah, KY., Tel: (502) 442–1621.

SUPPLEMENTARY INFORMATION:

Regulatory History

In accordance with 5 U.S.C. 553, a notice of proposed rule making for these regulations has not been published, and good cause exists for making them effective in less then 30 days from the date of publication. Following normal rule making procedures would be impracticable. The details of the event were not finalized in sufficient time to publish proposed rules in advance of the event or so provide for a delayed effective date.

Background and Purpose

The marine event requiring this regulation is an Independence Day

celebration including a boat parade and fireworks display. The event is sponsored by the Nashville Metropolitan Board of Parks and Recreation. Spectators will be able to view the event from areas designated by the sponsor. Non-participating vessels will be able to transit the area after the river is reopened.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of that order. It has not been reviewed by the Office of Management and Budget under that order. It is not a significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 CFR 11040; February 26, 1979).

The Coast Guard expects the economic impact of this rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary because of the event's short duration.

Small Entities

The Coast Guard finds that the impact on small entities, if any is not substantial. Therefore, the Coast Guard certifies under section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq*) that this temporary rule will not have a significant economic impact on a substantial number of small entities because of the event's short duration.

Collection of Information

This rule contains no information collection requirements under the Paperwork Reduction Act (44 USC 3501 *et seq*.).

Federalism Assessment

The Coast Guard has analyzed this action in accordance with the principles and criteria of Executive Order 12612 and has determined that this rule does not raise sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environmental Assessment

The Coast Guard considered the environmental impact of this rule and concluded that under section 2–1, paragraph (34)(h) of Commandant Instruction M16475.1C, this rule is categorically excluded from further environmental documentation.

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements.

Temporary Regulations

In consideration of the foregoing, Part 100 of Title 33, Code of Federal Regulations, is amended as follows:

PART 100—[AMENDED]

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

Authority: 33 USC 1233; 49 CFR 1.46 and 33 CFR 100.35.

2. A temporary § 100–T08–025 is added to read as follows:

§ 100.35–T08–025 Cumberland River at Nashville, Tennessee

(a) *Regulated Area:* Cumberland River Miles 190.0–191.0.

(b) *Special Local Regulation:* All persons and/or vessels not registered with the sponsors as participants or official patrol vessels are considered spectators. The ''official patrol'' consists of any Coast Guard, public, state or local law enforcement enforcement and/or sponsor provided vessels assigned to patrol the event.

(1) No spectator shall anchor, block, loiter in, or impede the through transit of participants or official patrol vessels in the regulated area during effective dates and times, unless cleared for such entry by or through an official patrol vessel.

(2) When hailed and/or signaled by an official patrol vessel, a spectator shall come to an immediate stop. Vessel shall comply with all directions given; failure to do so may result in a citation.

(3) The Patrol Commander is empowered to control the movement of all vessels in the regulated area. The Patrol Commander may terminate the event at any time it is deemed necessary for the protection of life and/or property and can be reached on VHF–FM Channel 16 by using the call signal ''PATCOM''.

(b) *Effective Date:* This section is effective from 4 p.m. and 10 p.m to July 4, 1998.

Dated: June 19, 1998.

A.L. Gerfin, Jr.

Captain, U.S. Coast Guard, Acting Commander, 8th Coast Guard District.

[FR Doc. 98–17072 Filed 6–25–98; 8:45 am]

BILLING CODE 4019–15–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD07–98–037]

RIN 2115–AE46

Special Local Regulations; Cellular One Offshore Cup; San Juan Bay and North of Old San Juan, Puerto Rico

AGENCY: Coast Guard, DOT.

ACTION: Temporary final rule.

SUMMARY: Temporary special local regulations are being adopted for the 1998 Cellular One Offshore Cup. The event will be held from 1 p.m. to 2:30 p.m. Atlantic Standard Time (AST) on June 28, 1998, in San Juan Bay and North of Old San Juan, Puerto Rico. These regulations are needed to provide for the safety of life on navigable waters because of the expected number of spectator craft in the vicinity of the racecourse.

DATES: These regulations become effective at 12:30 p.m. and terminate at 3 p.m. AST on June 28, 1998.

ADDRESSES: Documents as indicated in the preamble may be made available for inspection or copying at La Puntilla Finale, San Juan, PR 00902 between 9 a.m. and 2 p.m., Monday through Friday, except Federal holidays.

FOR FURTHER INFORMATION CONTACT: LT D.L. Garrison at (787) 729–6800, extension 227.

SUPPLEMENTARY INFORMATION:

Background and Purpose

On June 28, 1998, there will be 20 high speed offshore power boats racing on a fixed course in San Juan Bay, the bay entrance around Punta El Morro, east 2 n.m. along the coast to Penon San Jorge, then back around into the bay. The race boats will be competing at high speeds with numerous spectator craft in the area, creating an extra or unusual hazard in the navigable waterways. These regulations are required to provide for the safety of life on navigable waters during the running of the 1998 Cellular One Offshore Cup.

In accordance with 5 U.S.C. 553, a notice of proposed rulemaking has not been published for these regulations and good cause exists for making them effective in less than 30 days after **Federal Register** publication. Publishing a NPRM and delaying its effective date would be contrary to national safety interests since immediate action is needed to minimize potential danger to the public, as the exact date of the race

was only established less than 3 weeks prior to the event.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(f) of that order. It has been exempted from review by the Office of Management and Budget under that order. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979). The Coast Guard expects the economic impact of this proposal to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulated policies and procedures of DOT is unnecessary. The regulated area encompasses San Juan Bay, the bay entrance, and the waters extending to ½ n.m. offshore of Old San Juan from Punta El Morro East to Penon San Jorge, entry into which is only prohibited for 2½ hours on the day of the event.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Coast Guard must consider whether this rule will have a significant economic impact on a substantial number of small entities. ''Small entities'' include small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their field and governmental jurisdictions with populations of less than 50,000.

Therefore, the Coast Guard certifies under section 605(b) that this rule will not have a significant effect upon a substantial number of small entities, as these regulations will only be in effect in a limited area in the vicinity of San Juan for three hours on the day of the event.

Collection of Information

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

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that this rulemaking does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environmental Assessment

The Coast Guard has considered the environmental impact of this action consistent with figure 2–1, paragraph 34(h), of Commandant Instruction M16475.1C. In accordance with that section, this action has been environmentally assessed (EA completed), and the Coast Guard has determined that it will not significantly affect the quality of the human environment. An Environmental Assessment and Finding of No Significant Impact have been prepared and are available for inspection and copying in the docket.

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements, Waterways.

Temporary Regulations

In consideration of the foregoing, the Coast Guard amends Part 100 of Title 33, Code of Federal Regulations, as follows:

PART 100—[AMENDED]

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

Authority: 33 U.S.C. 1233, 49 CFR 1.46, and 33 CFR 100.35.

2. A new temporary § 100.35T–07–037 is added as follows:

§ 100.35T–07–037 Cellular One Offshore Cup; San Juan, Puerto Rico

(a) *Regulated Area:* A regulated area is established for the waters north of Old San Juan beginning at 18–28.24N, 066–08W, then North to 18–28.54N, 066–08W, then East to 18–28.4N, 066–05.30W, then South to 18–28.12N, 066–05.30W, then directly South to the shore, and including all of San Juan Bay, except San Antonio Approach Channel, San Antonio Channel, Army Terminal Channel, Army Terminal Turning Basin, and Puerto Nuevo Channel, and Graving Dock Channel. All coordinates referenced use Datum: NAD 1983.

(b) *Special Local Regulations:*

(1) Entry into the regulated area by other than event participants is prohibited, unless otherwise authorized by the Patrol Commander. Spectator craft are required to remain in a spectator area to be established by the event sponsor southeast of La Puntilla. After termination of the race, all vessels may resume normal operations. Traffic may be permitted to resume normal operations between scheduled racing events, at the discretion of the Patrol Commander.

(2) Temporary buoys will be used delineate the course.

(c) Dates: This section becomes effective at 12:30 and terminates at 3 p.m. AST on June 28, 1998.

Dated: June 17, 1998.

R.C. Olsen, Jr.,

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

[FR Doc. 98–17070 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–15–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 100

[CGD07–98–024]

RIN 2115–AE46

Special Local Regulations; Deerfield Beach Super Boat Race, Deerfield Beach, FL

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard is establishing permanent special local regulations for the Deerfield Super Boat Grand Prix powerboat race. This event will be held annually during the third Sunday of July, between 12:30 p.m. and 4 p.m. Eastern Daylight Time (EDT). The regulations are necessary to provide for the safety of life on navigable waters during the event.

DATES: This rule becomes effective June 26, 1998.

ADDRESSES: Documents as indicated in the preamble are available for inspection or copying at Coast Guard Group Miami, 100 MacArthur Causeway, Miami Beach, FL, between the hours of 7:30 a.m. and 3:30 p.m., Monday through Friday except Federal holidays. Telephone (305) 535–4448.

FOR FURTHER INFORMATION CONTACT: AMCS T. Kjerulff, Coast Guard Group Miami, FL at (305) 535–4448.

SUPPLEMENTARY INFORMATION:

Regulatory History

On May 7, 1998, the Coast Guard published a Notice of Proposed Rulemaking in the **Federal Register** (63 FR 25187), seeking comments on the establishment of permanent special local regulations for the Deerfield Super Boat race. No comments were received during the comment period.

Background and Purpose

Super Boat International Productions Inc., is sponsoring a high speed power boat race that will take place annually on the third Sunday in July in the Atlantic Ocean off Deerfield Beach, Florida. Approximately thirty-five (35) race boats, ranging in length from 24 to 50 feet, will participate in the event. There will also be approximately two

hundred (200) spectator craft. The race boats will be competing at high speeds with numerous spectator crafts in the area, creating an extra or unusual hazard in the navigable waterways. These regulations will create a regulated area offshore Deerfield Beach that will only allow participant vessels to enter, and a spectator craft area.

In accordance with 5 U.S.C. 553, good cause exists for making this regulation effective in less than 30 days after **Federal Register** publication. Delaying its effective date would be contrary to national safety interests since immediate action is needed to minimize potential danger to the public, as the sponsors only recently determined that the event would be held on the third Sunday of July each year and there was not sufficient time remaining for a full comment period and delayed effective date.

Regulatory Evaluation

This rule is not a significant regulatory action under section 3(f) of Executive Order 12866 and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. It has been exempted from review by the Office of Management and Budget under that order. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979). The Coast Guard expects the economic impact of this proposed rule to be so minimal that a full Regulatory Evaluation under paragraph 10e of the regulatory policies and procedures of DOT is unnecessary. Entry into the regulated area is prohibited for only 4.5 hours on the day of the event year.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Coast Guard must consider whether this rule will have a significant economic impact on a substantial number of small entities. ''Small entities'' include small businesses, non-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

Therefore, the Coast Guard certifies under U.S.C. 605(b) that this rule would not have a significant economic impact on a substantial number of small entities, as the regulations would only be in effect in a limited area offshore Deerfield Beach for approximately 4.5 hours one day each year.

Collection of Information

These regulations contain no collection of information requirements under the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*)

Federalism

This action has been analyzed in accordance with the principles and criteria contained in Executive Order 12612, and it has been determined that the rulemkaing does not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

Environmental Assessment

The Coast Guard has considered the environmental impact of this action and has determined pursuant to Figure 2–1, paragraph 34(h) of Commandant Instruction M16475.1C, that this rule is categorically excluded from further environmental documentation. A Categorical Exclusion Determination has been prepared and is available in the docket for inspection or copying.

List of Subjects in 33 CFR Part 100

Marine safety, Navigation (water), Reporting and recordkeeping requirements, Waterways.

Final Regulations

In consideration of the foregoing, the Coast Guard amends Part 100 of Title 33, Code of Federal Regulations, as follows:

PART 100—[AMENDED]

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

Authority: 33 U.S.C. 1233, 49 CFR 1.46 and 33 CFR 100.35.

2. Add section 100.733 to read as follows:

§ 100.733 Annual Deerfield Beach Super Boat Race; Deerfield Beach, Florida.

(a) *Regulated Areas.* (1) A regulated area is established by a line joining the following points:

Corner point 1: 26 17.7′N–080 04.4′W
Corner point 2: 26 19.7′N–080 03.9′W
Corner point 3: 26 15.7′N–080 04.4′W
Corner point 4: 26 15.7′N–080 04.9′W. All coordinates reference Datum NAD: 83.

(2) A spectator area is established in the vicinity of the regulated area for spectator traffic and is defined by a line joining the following points:

Corner point 1: 26 15.7′N–080 03.9′W
Corner point 2: 26 15.7′N–080 04.1′W
Corner point 3: 26 19.7′N–080 03.7′W
Corner point 4: 26 19.7′N–080 03.5′W. All coordinates reference Datum NAD: 83.

(3) A buffer zone of 406 yards separates the racecourse and the spectator fleet.

(b) *Special local regulations.* (1) Entry into the regulated area by other than event participants is prohibited unless otherwise authorized by the Patrol Commander. After the completion of scheduled races and the departure of participants from the regulated area, traffic may resume normal operations. At the discretion of the Patrol Commander, traffic may be permitted to resume normal operations between scheduled racing events.

(2) A succession of not fewer than 5 short whistle or horn blasts from a patrol vessel will be the signal for any and all vessels to take immediate steps to avoid collision. The display of an orange distress smoke signal from a patrol vessel will be the signal for any and all vessels to stop immediately.

(3) Spectators are required to maintain a safe distance from the racecourse at all times.

(c) *Effective Date.* This section becomes effective annually on the third Sunday of July at 12 p.m. and terminates at 4:30 p.m. EDT.

Dated: June 17, 1998.

R.C. Olsen, Jr.,

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

[FR Doc. 98–17071 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–15–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

33 CFR Part 110

[CGD01–97–014]

RIN 2115–AA98

Special Anchorage Area: Groton, CT

AGENCY: Coast Guard, DOT.

ACTION: Final rule.

SUMMARY: The Coast Guard will extend the boundaries of the special anchorage area currently existing off Groton, Connecticut, between Pine Island and Avery Point. This action is taken at the request of the City of Groton, and is intended to make space available within the special anchorage area for approximately 20 additional moorings.

DATES: This final rule is effective July 27, 1998.

ADDRESSES: Documents as indicated in this preamble are available for inspection or copying at the office of the First Coast Guard District (oan), 408 Atlantic Avenue, Boston, Massachusetts, 02110–3350, between 9:30 a.m. and 2 p.m., Monday through Friday, except Federal holidays. The telephone number is 617–223–8337.

FOR FURTHER INFORMATION CONTACT: LT Matthew Stuck, Aids to Navigation Branch, First Coast Guard District, 408 Atlantic Avenue, Boston, Massachusetts, 02110–3350, (617) 223–8347.

SUPPLEMENTARY INFORMATION:

Regulatory History

On February 6, 1998, the Coast Guard published a notice of proposed rulemaking entitled ''Special Anchorage Area: Groton, CT'' in the **Federal Register** (63 FR 6141). The Coast Guard received no letters commenting on the propose rulemaking. No public hearing was requested, and none was held.

Background and Purpose

The rule is in response to a request made by the City of Groton to accommodate the increased number of vessels mooring in this area. The final rule will expand the existing special anchorage near Groton, Connecticut, described in 33 CFR 110.51, to allow its use by approximately 20 additional boats. Vessels not more than 65 feet in length when at anchor in any special anchorage shall not be required to carry or exhibit the white anchor lights required by the Navigation Rules. The rule will provide approximately twenty additional moorings in which vessel owners may enjoy the convenience of a special anchorage. The existing anchorage, located near Pine Island and Avery Point, is split into two areas by a 210-foot wide fairway channel. The change will reduce the width of the existing fairway to approximately 135 feet and extend the western boundary of the southern section of the anchorage by 75 feet. The note following section 33 CFR 110.51 is also updated to indicate the decrease in fairway channel width.

Regulatory Evaluation

This final rule is not a significant regulatory action under section 3(f) of Executive Order 12866, and does not require an assessment of potential costs and benefits under section 6(a)(3) of that Order. It has not been reviewed by the Office of Management and Budget under that Order. It is not significant under the regulatory policies and procedures of the Department of Transportation (DOT) (44 FR 11040; February 26, 1979).

The Coast Guard expects the economic impact of this rule to be so minimal that a full Regulatory Evaluation under paragraph 10(e) of the regulatory policies and procedures of DOT is unnecessary. No person will be required to spend any money in order to comply with this regulation. The regulation will exempt persons operating in the expanded area from complying with the more stringent vessel lighting regulations they would ordinarily be obliged to follow.

Small Entities

Under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*), the Coast Guard considered whether this rule will have a significant economic impact on a substantial number of small entities. ''Small entities'' include small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000. For the reasons discussed in the Regulatory Evaluation section above, the Coast Guard expects that this rule will not have a significant impact on a substantial number of small entities. Therefore, the Coast Guard certifies under section 605(b) of the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*) that this final rule will not have a significant economic impact on a substantial number of small entities.

Assistance for Small Entities

In accordance with section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 (Pub. L. 104–121), the Coast Guard offered to assist small entities in understanding the rule so that they could better evaluate its effects on them and participate in the rulemaking process.

Collection of Information

This rule does not provide for a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

Federalism

The Coast Guard has analyzed this rule under the principles and criteria contained in Executive Order 12612 and has determined that this rule does not have sufficient implications for federalism to warrant the preparation of a Federalism Assessment.

Environment

The Coast Guard has considered the environmental impact of this rule and concluded that under Figure 2–1, paragraph 34(f) Coast Guard Commandant Instruction M16475.1C that this rule is categorically excluded from further environmental documentation. A ''Categorical Exclusion Determination'' and Environmental Analysis Checklist are available in the docket for inspection and copying where indicated under **ADDRESSES** in this final rule.

List of Subjects in 33 CFR Part 110

Anchorage grounds.

Final Regulation

For the reasons discussed in the preamble, the Coast Guard amends 33 CFR part 110 as follows:

1. The authority citation for part 110 continues to read as follows:

Authority: 33 U.S.C. 471, 2071; 49 CFR 1.46 and 33 CFR 1.05–1(g). Section 110.1a and each section listed in it are also issued under 33 U.S.C. 1223 and 1231.

2. Revise § 110.51 to read as follows:

§ 110.51 Groton, Conn.

The waters between an unnamed cove and Pine Island.

(a) Beginning at a point on the shoreline of Avery Point at latitude 41°19′01.4″, longitude 072°03′42.8″; thence to a point in the cove at latitude 41°19′02.5″, longitude 72°03′36.2″; thence southeasterly to a point at latitude 41°18′56.2″, longitude 072°03′34.2″; thence northeasterly to latitude 41°19′02.5″, longitude 072°03′19.2″ thence terminating at the tip of Jupiter Point at latitude 41°19′04.4″, longitude 072°03′19.7″. DATUM: NAD 83

(b) Beginning at a point on the shoreline of Pine Island at latitude 41°18′47.1″, longitude 072°03′36.8″; thence northerly to latitude 41°18′54.1″, longitude 072°03′35.4″; thence northeasterly to a point at latitude 41°19′01.2″, longitude 072°03′19.3″; thence terminating at a point at latitude 41°18′54.0″, longitude 072°03°17.5″. DATUM: NAD 83

Note: The areas designated by (a) and (b) are principally for the use of recreational vessels. Vessels shall be anchored so that part of the vessel obstructs the 135 foot wide channel. Temporary floats or buoys for marking the location of the anchor of a vessel at anchor may be used. Fixed mooring pilings or stakes are prohibited.

Dated: June 11, 1998.

R.M. Larrabee,

Rear Admiral, U.S. Coast Guard, Commander, First Coast Guard District.

[FR Doc. 98–17073 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–15–M

DEPARTMENT OF EDUCATION

34 CFR Part 685

RIN 1840–AC45

William D. Ford Federal Direct Loan Program

AGENCY: Department of Education.

ACTION: Final regulations.

SUMMARY: The Secretary amends the William D. Ford Federal Direct Loan Program regulations to add the Office of Management and Budget (OMB) control number to certain sections of the regulations. These sections contain information collection requirements approved by OMB. The Secretary takes this action to inform the public that these requirements have been approved and affected parties must comply with them.

EFFECTIVE DATE: These regulations are effective on July 1, 1998.

FOR FURTHER INFORMATION CONTACT: Mr. Kenneth Smith, U.S. Department of Education, 600 Independence Avenue, SW, ROB–3, Room 3045, Washington, DC 20202, telephone 202–708–8242. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

Individuals with disabilities may obtain this document in an alternate format (e.g., Braille, large print, audiotape, or computer diskette) on request to the contact person listed in the preceding paragraph.

SUPPLEMENTARY INFORMATION: Final regulations for the William D. Ford Federal Direct Loan Program were published in the **Federal Register** on November 28, 1997 (62 FR 63428). Compliance with information collection requirements in certain sections of these regulations was delayed until those requirements were approved by OMB under the Paperwork Reduction Act of 1995. OMB approved the information collection requirements in the regulations on December 4, 1997. The information collection requirements in these regulations will therefore become effective with all of the other provisions of the regulations on July 1, 1998.

Waiver of Proposed Rulemaking

It is the practice of the Secretary to offer interested parties the opportunity to comment on proposed regulations. However, the publication of OMB control numbers is purely technical and does not establish substantive policy. Therefore, the Secretary has determined under 5 U.S.C. 553(b)(B), that public comment on the regulations is unnecessary and contrary to the public interest.

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List of Subjects in 34 CFR Part 685

Administrative practice and procedure, Colleges and universities, Loan programs—education, Reporting and recordkeeping requirements, Student aid, Vocational education.

Dated: June 19, 1998.

David A. Longanecker,

Assistant Secretary for Postsecondary Education.

The Secretary amends Part 685 of Title 34 of the Code of Federal Regulations as follows:

PART 685—WILLIAM D. FORD FEDERAL DIRECT LOAN PROGRAM

1. The authority citation for Part 685 continues to read as follows:

Authority: 20 U.S.C. 1087a *et seq.*, unless otherwise noted.

§ 685.212 [Amended]

2. Section 685.212, is amended by adding the OMB control number following the section to read as follows:

''(Approved by the Office of Management and Budget under control number 1840–0672)''

[FR Doc. 98–17131 Filed 6–25–98; 8:45 am]

BILLING CODE 4000–01–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[OR–2–0001; FRL–6115–5]

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

AGENCY: Environmental Protection Agency.

ACTION: Direct final rule.

SUMMARY: The Environmental Protection Agency (EPA) approves the Section 111(d) State Plan submitted by Oregon on May 14, 1997, for implementing and enforcing the Emissions Guidelines (EG) applicable to existing Municipal Solid Waste (MSW) Landfills.

DATES: This action is effective on August 25, 1998 unless significant, material, and adverse comments are received by July 27, 1998. If significant, material, and adverse comments are received a timely withdrawal will be published in the **Federal Register** informing the public that this rule will not take effect.

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

Copies of materials submitted to EPA may be examined during normal business hours at the following locations: EPA, Region 10, Office of Air Quality, 1200 Sixth Avenue (OAQ–107), Seattle, Washington 98101, and at Oregon Department of Environmental Quality, 811 SW Sixth Avenue, Portland, Oregon 97204.

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

SUPPLEMENTARY INFORMATION:

I. Background

On March 12, 1996, pursuant to Section 111 of the Clean Air Act (Act), the EPA promulgated new source performance standards (NSPS) applicable to new MSW Landfills and EG applicable to existing MSW Landfills. The NSPS and EG are codified at 40 CFR Part 60, Subparts WWW and Cc, respectively. *See* 61 FR 9905 (March 12, 1996). Under Section 111(d) of the Act, the EPA established procedures whereby States submit plans to control existing sources of designated pollutants. Designated pollutants are defined as pollutants which are not included on a list published under Section 108(a) of the Act (i.e., National Ambient Air Quality Standard pollutants), but to which a standard of performance for new sources applies under Section 111. Under Section 111(d), emission standards are to be adopted by the States and submitted to EPA for approval. The standards limit the emissions of designated pollutants from existing facilities which, if new, would be subject to the NSPS. Such facilities are called designated facilities.

The procedures under which States submit these plans to control existing sources are defined in 40 CFR Part 60,

Subpart B. According to Subpart B, the States are required to develop plans within Federal guidelines for the control of designated pollutants. The EPA publishes guideline documents for development of State emission standards along with the promulgation of any NSPS for a designated pollutant. These guidelines apply to designated pollutants and include information such as a discussion of the pollutant's effects, description of control techniques and their effectiveness, costs and potential impacts. Also as guidance for the States, recommended emission limits and times for compliance are set forth, and control equipment which will achieve these emission limits are identified in Subpart Cc for existing MSW Landfills. The EG specified limits for landfill gas requires affected facilities to operate a control system designed to reduce collected non-methane organic compounds (NMOC) concentrations by 98 weight-percent, or reduce the outlet NMOC concentration to 20 parts per million or less, using the test methods specified in 40 CFR 60.754(d).

II. Discussion

On May 14, 1997, the Oregon Department of Environmental Quality (ODEQ) submitted to EPA their 111(d) State Plan for implementing and enforcing the emission guidelines for existing MSW landfills in the State. The Plan contained Emission Standards and Limitations, Compliance Schedule, Emission Inventory, Source Surveillance, Compliance Assurance and Enforcement, and applicable State regulations (OAR 340–025–0740, and OAR 340–025–0745).

The approval of ODEQ's State Plan is based on finding that: (1) ODEQ provided adequate public notice of public hearings for the proposed rulemaking which allows Oregon to implement and enforce the EG for MSW Landfills, and (2) ODEQ also demonstrated that it has the legal authority to adopt emission standards and compliance schedules applicable to the designated facilities; enforce applicable laws, regulations, standards and compliance schedules; seek injunctive relief; obtain information necessary to determine compliance; require recordkeeping; conduct inspections and tests; require the use of monitors; require emission reports of owners and operators; and make emission data publicly available.

ODEQ's regulations adopt 40 CFR Part 60, Subpart WWW and require existing MSW Landfills to comply with the Subpart WWW emission standards and limitations. In its State Plan submittal, ODEQ affirms that MSW Landfills subject to OAR 340–025–0740 must comply with 40 CFR Part 60, Subpart WWW. Attachment 3a summarizes all emission standards and limitations for the major pollutant categories related to the designated sites and facilities. This approach is approved because the NSPS Subpart WWW requirements are at least as protective as the Federal requirements contained in Subpart Cc for existing MSW Landfills.

ODEQ also submitted Oregon Administrative Rule (OAR) 340-025–00745, which adopts 40 CFR Subpart WWW. Thus, the compliance schedules and increments of progress specified in Subpart WWW are part of the State Plan and apply to each existing MSW Landfill as stipulated in Subpart WWW. The State Rule's requirement that existing MSW Landfills comply with the compliance schedule and legally enforceable increments of progress as stated in Subpart WWW has been reviewed and is approved as being at least as protective as Federal requirements for existing MSW Landfills in Subpart Cc.

Oregon included in its Plan, under Attachment 3b, emission inventories for all its applicable sources. There are approximately 91 existing landfills in Oregon's inventory, including several closed facilities subject to the initial reporting requirements of the EG. In these inventories, all designated pollutants have been identified and data provided for each.

Oregon cites its legal authority (ORS468.095, 468A.050(2), and 468A.070) to determine the compliance status by requiring owners and operators of designated facilities to maintain records and report to ODEQ the nature and amount of emissions from the facilities. Oregon also cites it legal authority (468.055(1)&(2)) to conduct periodic inspection and testing, as necessary, of designated facilities. The State's ability to provide emission data correlated with the emission standards to the public is referenced in its State Plan submittal as well as in OAR 340–025–0740 and OAR 340–025–0745. Finally, Oregon will provide reports on progress of plan enforcement as required by 40 CFR 60.25.

All measures and other elements in the State Plan must be enforceable by ODEQ. (See Sections 111(d) and 40 CFR Part 60.) During EPA's review of a previous State Implementation Plan revision, a problem was detected concerning the State's ability to adequately enforce point source permits. EPA determined that, because a five-day advance notice provision required by Oregon Revised Statute (ORS) 468.126(1) (1991) can bar civil penalties from being imposed for certain permit violations, ORS 468 fails to provide the adequate enforcement authority the State must demonstrate to obtain State Plan submittal, required by the Clean Air Act for program approval.

However, following EPA notification to Oregon, the Governor of Oregon signed into law new legislation amending ORS 468.126 on September 3, 1993. This amendment added paragraph 468.126(2)(e) which provides that the five-day advance notice required by ORS 468.126(1) does not apply if the notice requirement will disqualify the State's program from Federal approval or delegation. ODEQ responded to EPA's interpretation of the application of 468.126(2)(e) and agreed that, if Federal statutory requirements preclude the use of the five-day advance notice provision, no advance notice will be required for violations of the State Plan requirements. Because the five-day notice provision in ORC 468.126(1) could preclude enforcement of the State Plan in some instances, application of the notice provision would preclude approval of the State MWC Plan. Accordingly, pursuant to ORS 468.126(2)(e), the five-day notice will not be required for permit violations of the State Plan.

Nothing in this action should be construed as making any determination or expressing any position regarding Oregon's audit privilege and penalty immunity law ORS 468.963, Oregon Audit Privilege Act, or its impact upon any approved provision in the State Plan, including any subsequent revisions. The action taken herein does not express or imply any viewpoint on the question of whether there are legal deficiencies in this or any other Clean Air Act program resulting from the effect of Oregon's audit privilege and immunity law. A state audit privilege and immunity law can affect only state enforcement and cannot have any impact on federal enforcement authorities. EPA may at any time invoke its authority under the Clean Air Act, including, for example, sections 113, 167, 205, 211 or 213, to enforce the requirements or prohibitions of the state plan, independently of any state enforcement effort. In addition, citizen enforcement under section 304 of the Clean Air Act is likewise unaffected by a state audit privilege or immunity law.

The EPA is publishing this action without prior proposal because the Agency views this as a noncontroversial amendment and anticipates no adverse comments. However, in a separate document in this **Federal Register** publication, the EPA has included a parallel proposal to approve the ODEQ

State Plan. If no significant, material, and adverse comments are received by July 27, 1998, this action will be effective August 25, 1998.

If the EPA receives significant, material, and adverse comments by the above date, this action will be withdrawn before the effective date by publishing a subsequent document in the **Federal Register** that will withdraw this final action. All public comments received will be addressed in a subsequent final rule based on the parallel proposed rule published in today's **Federal Register**. The EPA will not institute a second comment period on this action. Any parties interested in commenting on this action should do so at this time. If no such comments are received, the public is advised that this action will be effective August 25, 1998.

III. Administrative Requirements

A. Executive Order 12866

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

B. Regulatory Flexibility Act

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

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

C. Unfunded Mandates

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

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

D. Submission to Congress and the General Accounting Office

Under 5 U.S.C. 801(a)(1)(A), as amended by the Small Business Regulatory Enforcement Fairness Act of 1996, EPA submitted a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the General Accounting Office prior to publication of the rule in today's **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

E. Petitions for Judicial Review

Under Section 307(b)(1) of the Clean Air Act, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by August 25, 1998. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review, nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. (See section 307(b)(2), 42 U.S.C. 7607(b)(2).

List of Subjects in 40 CFR Part 62

Environmental protection, Administrative practice and procedure, Air pollution control, Emission guidelines, Intergovernmental relations, Municipal solid waste landfills, Reporting and recordkeeping requirements.

Dated: June 8, 1998.

Chuck Findley,

Acting Regional Administrator, Region 10.

40 CFR Part 62 is amended as follows:

PART 62—[AMENDED]

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

Authority: 42 U.S.C. 7401–7642.

Subpart MM—Oregon

2. Section 62.9350 is amended by adding paragraphs (b)(5) and (c)(5) to read as follows:

§ 62.9350 Identification of plan.

* * * * *

(b) * * *

(5) Control of landfill gas emission from existing Municipal Solid Waste Landfill plan was submitted by Oregon Department of Environmental Quality on May 14, 1997.

(c) * * *

(5) Existing municipal solid waste landfills.

3. Subpart MM is amended to add § 62.9510 and a new undesignated heading to read as follows:

Control of Landfill Gas Emissions From Existing Municipal Solid Waste Landfills

§ 62.9510 Identification of sources.

The plan applies to all existing MSW landfill facilities in Oregon meeting the requirements as stated in their State regulations.

[FR Doc. 98–17119 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 80

[FRL–6114–4]

Fuels and Fuel Additives; Amendments to the Enforcement Exemptions for California Gasoline Refiners

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: In this action, EPA is amending certain requirements of the reformulated gasoline (RFG) regulations which are applicable to California gasoline refiners, importers and oxygenate blenders. These amendments

add flexibility with regard to test methods, sampling and testing requirements, and the use of gasoline that does not meet the oxygen requirement for Federal RFG in California areas that are not Federal RFG areas. EPA is taking this action in order to reduce the burden associated with overlapping California and Federal regulations. There is no expected adverse environmental impact from this final action.

EFFECTIVE DATE: This rule becomes effective on July 27, 1998.

FOR FURTHER INFORMATION CONTACT: Anne Pastorkovich, U.S. Environmental Protection Agency, Office of Air and Radiation, (202) 564–8987.

SUPPLEMENTARY INFORMATION:

I. Regulated Entities

Regulated categories and entities potentially affected by this action include:

Category	Examples of regulated entities
Industry	Refiners, importers and oxygenate blenders in California

This table is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be regulated by this action. This table lists the types of entities that EPA is now aware could be potentially regulated by this action. Other types of entities not listed in the table could also be regulated. To determine whether an entity is regulated by this action, one should carefully examine the RFG provisions at 40 CFR part 80, particularly § 80.81 dealing specifically with California gasoline. If you have questions regarding the applicability of this action to a particular entity, consult the person listed in the preceding **FOR FURTHER INFORMATION CONTACT** section.

II. Background

A. RFG Standards and California Covered Areas

Section 211(k) of the Clean Air Act (the Act) requires EPA to establish requirements for reformulated gasoline (RFG) to be used in specified ozone nonattainment areas (Federal areas), as well as ''anti-dumping'' requirements for conventional gasoline used in the rest of the country, beginning in January 1995. The federal RFG covered areas in California are Los Angeles, San Diego, and Sacramento. The Act requires that RFG reduce ozone forming volatile organic compounds (VOCs) and toxic emissions from motor vehicles, not increase emission of oxides of nitrogen (NO_x), and meet certain content standards for oxygen, benzene and heavy metals. The relevant regulations for RFG and conventional gasoline may be found at 40 CFR part 80, subparts D, E, and F.[1]

B. Exemptions Specifically Related to California Gasoline

On September 18, 1992, the California Air Resources Board (CARB) adopted regulations requiring reformulation of California ''Phase 2'' gasoline. The CARB regulations established a comprehensive set of gasoline specifications designed to achieve reductions in emissions of VOCs, NOx, carbon monoxide (CO), sulfur dioxide, and toxic air pollutants from gasoline-fueled vehicles.[2] The CARB regulations set standards for eight gasoline parameters—sulfur, benzene, olefins, aromatic hydrocarbons, oxygen, Reid vapor pressure (RVP), and distillation temperatures for the 50 percent and 90 percent evaporation points (T–50 and T–90, respectively)—applicable starting March 1, 1996 for all gasoline in the California distribution network (except for gasoline being exported from California). The CARB regulations also provide for the production and sale of alternative gasoline formulations, with certification under the CARB program based on a predictive model or on vehicle emission testing.[3]

During the Federal RFG rulemaking, and in response to comments by California refiners, EPA concluded (1) that VOC and toxics emission reductions resulting from the California Phase 2 standards would be equal to or more stringent than the Federal Phase I RFG standards (applicable from January 1, 1995 through December 31, 1999), (2) that the content standards for oxygen and benzene under California Phase 2 would in practice be equivalent to the Federal content standards,[4] and (3) that the CARB's compliance and enforcement program is designed to be sufficiently rigorous.[5] While the Federal RFG and conventional gasoline standards continue to apply in California, refiners, importers, and oxygenate blenders of gasoline sold in California (referred to collectively as ''California refiners'') are exempt in most cases from various enforcement-related provisions.[6] California refiners are not exempt from these Federal enforcement requirements with regard to gasoline that is delivered for use outside California, because the California Phase 2 standards and the CARB enforcement program do not cover gasoline exported from California.

C. Issues Raised by WSPA & EPA's Response

In letters of June 15, August 3, and November 10, 1995, the Western States Petroleum Association (WSPA), on behalf of California refiners, petitioned EPA to revise the enforcement-related exemption provisions at 40 CFR 80.81. The three principal areas discussed in the petition are the gasoline testing methods, the standard for Reid vapor pressure (RVP), and use of California certification methods without minimum oxygen content requirements. (These certification methods, the predictive model and the vehicle emissions testing model, are discussed in greater detail below.) In February 1996, EPA notified WSPA that EPA would initiate rulemaking to address these issues.[7] Since the California Phase 2 program was scheduled to begin March 1, 1996, EPA announced that it would grant California refiners temporary relief through specific exemptions from enforcement-related test methods, oxygen content of gasoline not used in the RFG areas, and RVP. This temporary relief would remain in place until the rulemakings could be completed.

A final rule related to the RVP standard was published as a direct final rule in the **Federal Register** on May 8,

[1] See 59 FR 7812 (February 16, 1994), as amended at 59 FR 36964 (July 20, 1994); 60 FR 2699 (January 11, 1995); 60 FR 35491 (July 10, 1995); 60 FR 65574 (December 20, 1995); and 62 FR 68196 (December 31, 1997).

[2] See Title 13, California Code of Regulations sections 2250–2272 (as amended January 26, 1996).

[3] *Id.*, sections 2265 and 2266.

[4] As is discussed in section entitled ''Oxygen Standard,'' below, however, this is not now the case.

[5] See 59 FR 7758, 7759 (February 16, 1994) and 40 CFR 80.81.

[6] Specifically, the Federal RFG regulations at § 80.81 provide that, subsequent to March 1, 1996 (the start of the California Phase 2 program), the specified parties are exempt from meeting the enforcement requirements dealing with: compliance surveys (§ 80.68), independent sampling and testing (§ 80.65(f)), designation of gasoline (§ 80.65(d)), marking of conventional gasoline (§§ 80.65(g) and 80.82), downstream oxygenate blending (§ 80.69), record keeping (§§ 80.74 and 80.104), reporting (§§ 80.75 and 80.105), product transfer documents (§ 80.77), parameter value reconciliation requirements (§ 80.65(e)(2)), reformulated gasoline and Reformulated Gasoline Blendstock for Oxygenate Blending (RBOB) compliance requirements (§ 80.65(c)), annual compliance audit requirements (§ 80.65(h)), and compliance attest engagement requirements (subpart F). Various restrictions apply to the exemptions, and the exemptions do not apply after December 31, 1999.

[7] See letter from Mr. Steve Herman, Assistant Administrator for Enforcement and Compliance Assurance, EPA, to Mr. Douglas Henderson, Executive Director, Western States Petroleum Association, dated February 29, 1996. A copy of this letter has been placed in the docket at the location listed in the **ADDRESSES** section.

1996, and became effective on July 8, 1996.[8]

III. Description of Today's Action

On April 16, 1997 EPA published a proposal addressing the remaining two issues: gasoline testing methods and the use (in conventional gasoline areas) of gasoline certified by California methods not meeting the Federal RFG standard for oxygen content.[9] Some additional issues were addressed in the proposal, including sampling and testing, and these are discussed in greater detail below. EPA proposed changes very similar to the temporary enforcement exemptions granted to the California refiners in its February 1996 letter.

A. Test Methods

Both the Federal RFG and the California Phase 2 programs specify testing methods to demonstrate compliance with the standards applicable under each program. However, in the case of the tests for four parameters (benzene, sulfur, oxygen, and aromatics) the methods [10] specified under the two programs are different.

The applicable exemption in the Federal RFG regulation at 40 CFR 80.81(h) allows California refiners to use the California test methods prescribed in Title 13, California Code of Regulations, sections 2260 *et seq.*, instead of the Federal test methods prescribed at 40 CFR 80.46, when producing California Phase 2 gasoline that is used in California. However, California refiners are still required to use the Federal test methods prescribed at 40 CFR 80.46 for gasoline that is used outside California, including conventional gasoline subject to the anti-dumping standards specified at 40 CFR 80.101.[11]

WSPA, on behalf of California refiners, requested that EPA extend the test method exemption at 40 CFR 80.81(h) to cover the conventional gasoline produced by California refiners that is exported from California to other states. WSPA asked for this change because a refiner who is utilizing the flexibility of the CARB testing methods for gasoline sold within California, would have to also use the Federal test methods to certify the same gasoline for export to surrounding states.

After considering the issues raised, EPA believed that, under certain conditions, it may be appropriate to allow the use of non-Federal test methods for conventional gasoline exported from California. Absent relief, a California refiner that chooses to utilize the flexibility of the CARB testing methods would have to implement the Federal test methods in order to certify its conventional gasoline for distribution outside California.

EPA further believes that the standards under the California Phase 2 program are expected to result in emissions decreases at least as great as with Federal Phase I RFG and emissions levels of conventional gasoline and CARB is expected to enforce the California standards in a comprehensive, aggressive manner that will result in high compliance. The Agency does not believe that any environmental detriment would be likely to occur from allowing the use of the CARB test methods for conventional gasoline produced in California, but shipped out of state for use in non-RFG areas.

In its February 29, 1996 response to WSPA, EPA indicates its intention to change the Federal RFG regulations to allow additional testing flexibility for California refiners and immediately gave California refiners additional flexibility for a limited time. In that letter, EPA states that if certain conditions are met it will not enforce the requirement at 40 CFR 80.65(e)(1) and 40 CFR 80.101(i)(1)(i)(A) to test conventional gasoline using the Federal test methods specified under 40 CFR 80.46 for benzene, sulfur, oxygen or aromatics, with regard to gasoline that is produced in or imported into California but that is used outside California.

In order to qualify for this enforcement relief, the refiner or importer was required to meet certain conditions, as described in great detail in the February 29, 1996 letter and in the notice of proposed rulemaking.[12] Furthermore, equivalency between CARB and Federal test method results must be established, since the methods themselves are not necessarily equivalent and therefore different methods (if not correlated) would yield different results.

Thus, to qualify for the relief, EPA proposed that the gasoline must be produced at a refinery located in California at which gasoline meeting the California Phase 2 standards and requirements is produced, or the gasoline must be imported into California from outside the United States as California Phase 2 gasoline (i.e., gasoline that meets the standards and requirements of the California Phase 2 program). When exported from California, such gasoline may not be classified as Federal RFG. Furthermore, the refiner must correlate the results from any non-Federal test method to the method specified under 40 CFR § 80.46 for any gasoline that is used outside California, and such correlation must be demonstrated to EPA upon request.

EPA proposed to amend 40 CFR 80.81 to incorporate the flexibility regarding test methods that EPA temporarily granted in its February 29, 1996 letter to WSPA. EPA proposed this action because the Agency believes that it may result in lower compliance costs and greater flexibility for California refiners and because there is no expected adverse environmental impact from this proposed action.

B. Oxygen Standard

Section 211(k) of the Clean Air Act requires that the RFG standard of 2.0 weight percent (wt%) minimum oxygen must be met in each Federal RFG area. When EPA promulgated the California enforcement exemptions at 40 CFR 80.81, it was intended that the statewide standards for California Phase 2 gasoline would be equal to or more stringent than all Federal RFG standards. With regard to oxygen content, the California Phase 2 standards included a statewide flat limit of 1.8 to 2.2 wt% oxygen that EPA considered, in practice, to be equivalent to the Federal standard of 2.0 wt% minimum. As a result, EPA did not need to distinguish between California Phase 2 gasoline used in the Federal RFG areas within California, from the California Phase 2 gasoline used in the other areas of California, in order to have confidence that RFG standards would be met in each Federal RFG area in California.

The final California Phase 2 requirements were changed, however, and now allow gasoline that does not meet the Federal RFG standard for oxygen. Under two alternative California certification methods, the California predictive model and the vehicle emissions testing method, there is no minimum oxygen content requirement for summertime California Phase 2 gasoline.[13] Under 40 CFR

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[8] "Fuels and Fuel Additives—Reformulated Gasoline Sold in California; Reid Vapor Pressure lower limit adjustment— Direct Final Rule," 61 FR 20736 (May 8, 1996).

[9] "Fuels and Fuel Additives—Amendments to the Enforcement Exemptions for California Gasoline Refiners—Proposed Rule," 62 FR 18696 (April 16, 1997).

[10] *See* 40 CFR 80.46(a), (e), (f) and (g) for Federal RFG test method requirements.

[11] EPA estimates that the portion of gasoline exported from California and used in neighboring states is about twelve percent of the total California gasoline production and imports.

[12] A copy of the letter has been placed in the public docket at the location listed in the **ADDRESSES** section. See also, 62 FR 18696 (April 16, 1997).

[13] See Title 13, California Code of Regulations, section 2262.5 for the oxygen standards, section

80.81(e)(2), certain enforcement exemptions are withdrawn if a California refiner uses one of the alternative California certification methods, unless within 30 days of receiving the California certification it notifies EPA and demonstrates that its gasoline meets all Federal RFG per-gallon standards, including the 2.0 weight % oxygen standard.

Therefore, in order to retain the enforcement exemptions, 40 CFR 80.81(e)(2) required that all California Phase 2 gasoline produced by a refiner, regardless of whether it is sold in a Federal RFG area, meet the Federal RFG standard for oxygen content. Because neither of the two alternative California certification methods ensure that the Federal oxygen content standard will be met, except during designated winter months, a refiner that uses an alternative California certification method would have to provide notification and demonstrate to EPA that its gasoline meets the Federal RFG standard for oxygen content or lose its eligibility for certain Federal exemptions under 40 CFR 80.81. This loss of eligibility would apply even if the gasoline not meeting the Federal RFG standard for oxygen content is being distributed only to those areas of California that are not Federal RFG areas.

In its petition, WSPA asked EPA to amend the enforcement exemption provisions to allow California refiners to supply California Phase 2 gasoline containing less than 2.0 wt% oxygen to markets within California that are not Federal RFG areas without having to comply with the notification and demonstration requirements of 40 CFR 80.81(e)(2) and without losing the Federal enforcement exemptions. In its February 29, 1996 response to WSPA, EPA said it may be appropriate to amend 40 CFR 80.81, provided that annual gasoline quality surveys for oxygen content are conducted in each Federal RFG area, in order to ensure the gasoline sold there is in compliance with the Federal oxygen content standard.

Consistent with, and as described in, the February 29, 1996 letter, EPA proposed to amend 40 CFR 80.81 to allow refiners to produce California Phase 2 gasoline containing less than 2.0 wt% oxygen for use outside the Federal RFG areas in California, provided appropriate annual gasoline quality surveys for oxygen are conducted in each Federal RFG area in California. These surveys must show an average oxygen content in each covered area of at least 2.0 wt%. While EPA could require that all gasoline batches being produced for the Federal RFG areas be tested for oxygen content at the refinery, or prior to importation as applicable, such testing would not ensure that all gasoline being sold in the Federal RFG areas contains at least 2.0 wt% oxygen.

As in the Federal RFG program areas outside of California, the compliance surveys appear to be the most practical method to assure that, on average, Federal RFG standards are met for each covered area. The Federal RFG program at 40 CFR 80.67 allows refiners, importers, and oxygenate blenders to meet certain Federal RFG standards on average, rather than on a per-gallon basis for each batch of gasoline. The requirement must then be met on average, over the entire production, without any averaging for each specific covered area to which the gasoline is distributed. The following paragraphs describe how the general RFG survey requirements (i.e. those surveys required by § 80.68 and applicable outside California) and how the more limited California oxygen surveys are designed. For general RFG surveys, the discussion here will focus on oxygen surveys.

C. General Survey Requirements

Refiners, importers and oxygenate blenders producing gasoline to meet the Federal RFG standards on average are allowed to produce some batches of gasoline that are less stringent than the averaging standards (within the limits of a per-gallon minimum or maximum standard, as applicable). But they must also produce some batches of gasoline that are more stringent than the averaging standards, such that on average, the applicable averaging standard is met. The averaging standards are somewhat more stringent than the per-gallon standard (e.g., the oxygen content averaging standard is 2.1 wt%, and the per-gallon standard is 2.0 wt%). It is expected that, if all refiners meet either the per-gallon standards or the averaging standards, the covered areas receiving their gasoline should achieve an average oxygen content no lower than would occur without the allowance for such averaging, based on the extensive fungible distribution system for gasoline products. Even though each refinery might meet its refinery gate standard for oxygen on average, there is a risk that some areas might actually receive RFG with relatively low oxygen content while others might receive RFG with relatively high oxygen content. The surveys are designed to lessen this risk and ensure that all Federal RFG program areas at any given time receive RFG that meets the required oxygen standard.

More specifically, because many gasoline distribution systems are fungible, some uncertainty exists as to where each batch of gasoline from each supplier is ultimately distributed, and what batches, or portions of batches, from each supplier that each covered area actually receives. For example, under the averaging program, the possibility still exists that one or more covered areas may receive too many batches of RFG that have a relatively low oxygen content (e.g. greater than or equal to 1.5 wt%, but less than 2.0 wt%), so that the required oxygen levels will not have been achieved in that area.

Consequently, the Federal RFG program at 40 CFR 80.67 requires compliance surveys under 40 CFR 80.68 for refiners that elect to meet the standards on average under 40 CFR 80.41(b), (d) or (f), as applicable, rather than to meet the per-gallon standards for each batch of gasoline under 40 CFR 80.41(a), (c), or (e), as applicable. In general, the compliance surveys are to ensure that each covered area receives gasoline that cumulatively (from all suppliers and across time) has the same oxygen content it would have if averaging was not allowed. However, the Federal RFG regulations at 40 CFR 80.81(b)(1) exempted refiners of California gasoline (with respect to California gasoline) from the compliance survey provisions at 40 CFR 80.68, for the reasons described earlier.

D. Limited Oxygen Surveys for California

In response to the WSPA request concerning oxygen content requirements in California and the changes in California Phase 2 standards regarding oxygen content, EPA considered a limited application of the compliance survey provisions. EPA believes that a yearly series of oxygen surveys, similar to 40 CFR 80.68 surveys for averaging under the Federal RFG program, but limited in their scope, provides the most flexible alternative to refiners and the most assurance to EPA that complying gasoline is actually being sold in the Federal RFG areas.

In its February 29, 1996 response to WSPA, EPA decided to allow California refiners to produce gasoline that contains less than 2.0 wt% oxygen for use outside the Federal RFG areas, until today's amendments to the RFG requirements could be published in the **Federal Register** and become effective. In particular, EPA said it will not

2265 for the alternative predictive model method, and section 2266 for the alternative vehicle emission testing method.

enforce the requirement at 40 CFR 80.81(e)(2) that California refiners must demonstrate that Federal RFG per-gallon standards are met on each occasion California Phase 2 gasoline is certified under Title 13, California Code of Regulations, section 2265 (dealing with gasoline certification based on the California predictive model), provided that two conditions are met. The conditions are: first, a program of gasoline quality surveys must be conducted in each RFG covered area in California each year to monitor annual average oxygen content. Second, the surveys must be conducted in accordance with each requirement specified under 40 CFR 80.68(b) and (c), dealing with surveys for RFG quality, and 40 CFR 80.41(o) through (r), dealing with the effects of survey failures, except that the surveys need only evaluate for oxygen content and a minimum of four surveys (a survey series) must be conducted in each covered area each calendar year.

In its April 16, 1997 proposal, EPA announced its intention to retain the existing 30-day notification and demonstration provisions at 40 CFR 80.81(e)(2) as an option. EPA further proposed that the oxygen surveys conducted in California should not be considered for the purposes of determining the required number of surveys that must be conducted for compliance with the general survey provisions under the Federal RFG program at 40 CFR 80.68.[14] A fixed number of surveys (i.e. a minimum of four per year) was proposed for California, consistent with the temporary enforcement position announced in the February 29, 1996 letter. As with the surveys required under 40 CFR 80.68 for Federal areas outside of California, EPA will determine when these optional surveys conducted in California under 40 CFR 80.81(e)(2) shall be conducted.

The February 29, 1996 letter to WSPA did not address the consequences of passing and failing an optional survey series in a Federal RFG area in California under 40 CFR 80.81(e)(2). The April 16, 1997 document proposed that, for the limited oxygen survey option included in today's rule, failing a survey would result in a ''ratcheting'' of (i.e., increasing) the minimum oxygen content standard, for each gallon of averaged gasoline, by an additional 0.1%. Only one year of passing the survey series in a covered area will be needed to initiate relaxation of the minimum oxygen content standard for the following year. EPA proposed that the minimum oxygen content standard be relaxed by 0.1 wt% for each year following a year in which the survey series passes in a Federal RFG area in California. However, EPA will not allow the minimum oxygen content standard to be less than 1.5 wt%, the minimum oxygen content standard for Federal RFG under averaging. As with failures of survey series required under 40 CFR 80.68 in Federal RFG areas outside of California in accordance with 40 CFR 80.41(q)(4), adjusted standards under the compliance survey option of 40 CFR 80.81(e)(2) apply to all averaged gasoline produced by a refiner for use in any Federal RFG area.

The procedures and consequences of the oxygen surveys set forth in the April 16, 1997 notice or proposed rulemaking differed somewhat from the general survey consequences under 40 CFR 80.68, because surveys applicable in California are much smaller in scope. EPA proposed that the ultimate consequence of multiple failures of the optional compliance surveys be withdrawal of the survey option, rather than the effective withdrawal of the averaging option, as with the required compliance surveys conducted under 40 CFR 80.68 for Federal RFG areas outside of California. EPA proposed this consequence because the compliance survey option provides refiners of California gasoline additional flexibility under the Federal exemption provisions, conditioned on the premise that those refiners will control the oxygen content of the gasoline being distributed to the Federal RFG areas within California. If the refiners do not control the oxygen content of the gasoline going to those areas as determined by the results of the surveys, EPA believes that it may be reasonable to remove the flexibility provided under this option. Consequently, if EPA proposed that a failure of a survey series in one Federal RFG area in California for three consecutive years occurs, or an equivalent ''net'' failure of three years over any number of years (i.e., number of years the survey series failed subtracted from the number of years the survey series passed), the compliance survey option will no longer be applicable for any Federal RFG area in California. In practice, this situation will occur if a survey series fails for a covered area in a year in which the minimum oxygen content standard had been raised to 1.7 wt% due to a survey series failure in that covered area the previous year.

It is important to realize that successive oxygen survey failures might be an indication of the inability or unwillingness of California refiners to meet RFG standards. As such, EPA noted in the April 16, 1997 notice of proposed rulemaking that future rulemaking to remove some or all California enforcement exemptions might be appropriate. If a survey does not occur, then all refiners electing to use an alternative certification method must follow the notification requirements at § 80.81(e)(2)(i), including the requirement to demonstrate that all their gasoline meets each of the complex model standards listed in § 80.41(c). Furthermore, in accordance with § 80.81(e)(2)(i), the California enforcement exemptions will not apply to a refiner who chooses an alternative certification method, but fails to meet these notification and demonstration requirements.

Consistent with the existing compliance survey requirements for Federal RFG areas outside of California, EPA proposed to allow the optional compliance survey under 40 CFR 80.81(e)(2) to be conducted either by individual refiners under 40 CFR 80.68(a) or as a group of refiners under 40 CFR 80.68(b).[15] The temporary enforcement position announced by the February 29, 1996 response to WSPA omitted the individual survey option of 40 CFR 80.68(a), because that survey option is not currently being used and is not expected to be used for practical reasons. The consequences of any survey failure will apply to all suppliers[16] who comply on an averaging basis and who serve the failed area.

Consistent with the existing RFG regulations at 40 CFR part 80, the February 29, 1996 letter to WSPA, and the April 16, 1997 notice of proposed rulemaking, California Phase 2 gasoline that does not meet the Federal RFG standards, including the oxygen standard, is classified under the Federal regulations as conventional gasoline. In addition, today's amendments do not alter the prohibitions under section

[14] Under 40 CFR 80.68(b), the required number of compliance surveys required in a year for Federal RFG areas outside of California depends partly on the number of areas required to be surveyed in the year, the number of surveys conducted the previous year, and the survey results from the previous year.

[15] Refiners, importers, and blenders have formed a survey association which funds the survey program. In accordance with § 80.68(c)(13), the survey program is administered by an independent surveyor.

[16] There is an exception for ''low volume'' parties under 40 CFR 80.41(q)(iii). Specifically, if a refiner or oxygenate blender is able to show that the volume of RFG supplied to a covered area is less than one percent of the RFG produced at its refinery or oxygenate blending facility during the failed year, or 100,000 barrels, whichever is less, he may be exempt from the more stringent standards.

211(k)(5) of the Clean Air Act, and 40 CFR 80.78(a)(1) against selling or dispensing conventional gasoline to ultimate consumers in Federal RFG areas, and against selling conventional gasoline for resale in Federal RFG areas unless the gasoline is segregated and marked as ''conventional gasoline, not for sale to ultimate consumers in a covered area.'' Nothing in today's action would change the requirement that refiners and importers in California meet all other Federal RFG standards, including the oxygen standard, for gasoline produced or imported for use in Federal RFG covered areas in California. These standards must be met separately for each refinery and by each importer.

The amendments to 40 CFR 80.81 as set forth in today's notice are consistent with the February 29, 1996 letter to WSPA and the April 16, 1997 notice of proposed rulemaking. Comments related to this provision are summarized in section IV, ''Response to Comments,'' below.

E. Correction to § 80.81(e)(1)

EPA proposed to correct 40 CFR 80.81(e)(1), which erroneously omits one provision, paragraph (f), from the list of enforcement exemption provisions that would not apply under the conditions of paragraphs (e)(2) or (e)(3). Paragraph (e)(2) specifies that the exemption provisions listed in paragraph (e)(1) do not apply if a refiner certifies California gasoline under one of the alternative California certification procedures, unless the refiner notifies EPA of that alternative certification and demonstrates to EPA that its gasoline meets all Federal per-gallon standards. (Today's rule adds a compliance survey option to paragraph (e)(2)(ii).) Paragraph (e)(3) specifies that the exemption provisions listed in paragraph (e)(1) do not apply in the case of a refiner of California gasoline that has been assessed a civil, criminal or administrative penalty for certain violations of Federal or California regulations, except upon a showing of good cause.

Paragraph (f) specifies that for California phase 2 gasoline (California gasoline that is sold or made available for sale after March 1, 1996) the following Federal RFG enforcement requirements are waived: the oxygenated fuels provisions of § 80.78(a)(1)(iii), the product transfer provisions of § 80.78(a)(1)(iv), the oxygenate blending provisions contained in § 80.78(a)(7), and the segregation of simple and complex model certified gasoline provision of § 80.78(a)(9). Under the conditions of either paragraph (e)(2) or (e)(3), EPA would need those enforcement provisions to ensure that gasoline being used in Federal RFG areas in California complies with the Federal standards. Therefore, EPA proposed to amend paragraph 40 CFR 80.81(e)(1) to include paragraph (f) in the list of enforcement exemptions that would become inapplicable under the conditions of paragraphs (e)(2) or (e)(3). No comments were received on this aspect of the April 16, 1997 proposal and the proposed corrections are finalized in today's rule.

F. Sampling and Testing Requirements for California Refiners

Under 40 CFR 80.65(e)(1), a refiner must determine the properties of each batch of RFG it produces prior to the gasoline leaving the refinery.[17] Under the California RFG program, refiners may obtain approval to sample and test gasoline for compliance with California RFG standards at off-site ''production'' tankage. This approval would have to be obtained under Title 13, section 2260(a)(28) of the California Code of Regulations, which states:

(28) ''Production facility'' means a facility in California at which gasoline or CARBOB is produced. Upon request of a producer, the executive officer [of CARB] may designate, as part of the producer's production facility, a physically separate bulk storage facility which (A) is owned or leased by the producer, and (B) is operated by or at the direction of the producer, and (C)is not used to store or distribute gasoline or CARBOB that is not supplied from the production facility.''

It is EPA's understanding that the third requirement, (C), is interpreted by CARB to require that the gasoline must be transported to the off-site tankage via a dedicated pipeline.

On April 16, 1997, EPA proposed amendments to 40 CFR 80.81(h), which would allow California refiners who have obtained approval from the State of California to conduct sampling and testing at off-site tankage served by a dedicated pipeline to use this approach under the Federal RFG program as well. Specifically, EPA proposed to allow a California refiner who has obtained approval from the State of California to conduct sampling and testing at off-site tankage under California Code of Regulations Title 13, section 2260(a)(28), to conduct sampling and testing at such approved off-site tankage for purposes of the Federal RFG program. The gasoline must be sampled and tested under the terms of a current, valid protocol agreement between the refiner and CARB. The refiner must provide a copy of the current, valid protocol agreement specifying the off-site tankage as part of the production facility, to the EPA Administrator or the Administrator's designated agent, upon request. No comments were received on this issue and the sampling and testing provisions are finalized in today's rule as proposed.

[17] Under 40 CFR 80.2 (h), a ''refinery'' is ''a plant where gasoline or diesel fuel is produced.''

IV. Response to Comments

A. Consequences of Successive Survey Failures

As discussed above, EPA proposed that successive survey failures for three years, or an equivalent ''net'' failures of three years over any number of years (i.e. number of years the survey series failed subtracted from the number of years the survey series passed), would result in the elimination of the survey option. Elimination of the survey option would mean that all California gasoline of each refiner, including gasoline certified under an alternative certification method and sold in non-RFG cities, would have to meet Federal oxygen standards. Each refiner certifying under an alternative certification would have no option but compliance with the notification and demonstration requirements at 40 CFR 80.81(e)(1).

If successive oxygen survey failures were to occur, EPA would be forced to consider whether some or all of the California enforcement exemptions in 40 CFR 80.81 should be revoked via rulemaking. Successive survey failures might well indicate a widespread problem with the quality of California gasoline and may call into question the equivalency of such gasoline with respect to Federal Phase I RFG. Such a revocation would apply to all California refiners, importers, and blenders.

One commenter disagreed and stated that the result of successive survey failures should not be removal of the survey option and the possible revocation of some or all of the California enforcement exemptions. Rather, the commenter believes that the result of successive survey failures should be the requirement that all gasoline in Federal RFG areas meet the per-gallon 2.0 weight % minimum.

EPA disagrees with the commenter. Today's rule, which matches the proposal, is designed to add a flexibility—i.e., the flexibility to utilize a survey option and produce gasoline not meeting Federal oxygen standards in non-Federally covered areas—where such flexibility did not exist before. Nothing in today's action alters the

applicability of Federal standards in RFG areas in California. Specifically, each gallon of gasoline in RFG areas was, and is, required to meet a 2.0 weight % minimum for parties complying on a per gallon basis. Each gallon of gasoline for an averaging party is required to meet a minimum of 1.5 weight %. All gallons produced by an averaging refiner during a given compliance period must average to 2.1 weight%. Since Federal oxygen standards continue to apply in RFG areas, the consequence for survey failure suggested by the commenter, in fact, amounts to no consequence at all.

As discussed above and in the April 16, 1997 proposal, successive or excessive survey failures would raise serious concerns about the expected equivalency between Federal Phase I RFG and California Phase 2 gasoline sold in Federally covered areas. EPA would need to assess the impact of these failures, should they occur, on the program, and would initiate a notice-and-comment rulemaking procedure, if such action is in the public interest.

B. Use of GC/FTIR Method (ASTM 5986)

EPA proposed that California gasoline refiners, importers, and blenders be permitted to substitute California-approved analytical techniques or test methods for Federal test methods when producing gasoline used in California and for conventional gasoline used outside of California. California test methods could not be utilized for gasoline intended for ''export'' to markets in states outside California as Federal RFG.

One commenter stated that EPA should allow all refiners the option of using the GC/FTIR method (ASTM 5986) for aromatics, benzene, and oxygen content, independent of this rulemaking. Further, the commenter urges EPA to allow the use of California test methods for not just California gasoline sold within the state or exported as conventional, but for all RFG that is produced by California refiners for the purpose of exportation to other states as Federal Phase I RFG. At this time, EPA does not believe that adoption of California test methods for Federal RFG destined to be sold outside California is appropriate without further study. Therefore, gasoline produced by California refiners for the purpose of exportation to other states as Federal RFG remains subject to the Federal test methods. However, EPA intends to fully consider the larger issue of RFG test methods as part of a separate action related to performance-based test methods.

V. Statutory Authority

Sections 114, 211 and 301(a) of the Clean Air Act as amended (42 U.S.C. 7414, 7545, and 7601(a)).

VI. Environmental Impact

This rule is expected to have no negative environmental impact. These amendments are intended to eliminate duplicative enforcement requirements, and do not relax the Federal standards. The additional testing flexibility allowed certain refiners of California gasoline under today's regulation may, in fact, result in an environmental benefit because it would give California refiners flexibility to sell gasoline meeting California Phase 2 standards as Federal conventional gasoline in other areas. It is reasonable to expect that such gasoline would be ''cleaner'' than other conventional gasoline and could result in an environmental benefit to the areas receiving it.

VII. Economic Impact and Impact on Small Entities

EPA has determined that this final rule will not have a significant impact on a substantial number of small entities. Small entities include small businesses, small not-for-profit enterprises, and small governmental jurisdictions. Today's regulation would have a positive economic impact on the great majority of entities regulated by the RFG regulation, including small businesses. Specifically, it give refiners of California gasoline additional operational flexibility and is not expected to result in any additional compliance costs for regulated parties, including small entities. A regulatory flexibility analysis has therefore not been prepared.

VIII. Executive Order 12866

Under Executive Order 12866,[18] the Agency must determine whether a regulation is ''significant'' and therefore subject to OMB review and the requirements of the Executive Order. The Order defines ''significant regulatory action'' as one that is likely to result in a rule that may:

(1) Have an annual effect on the economy of $100 million or more, or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments of communities;

(2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency;

(3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof, or

(4) Raise novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in this Executive Order.[19]

It has been determined that this rule is not a ''significant regulatory action'' under the terms of Executive Order 12866 and is therefore not subject to OMB review.

IX. Unfunded Mandates

Under section 202 of the Unfunded Mandates Reform Act of 1995 (''UMRA''), Pub. L. 104–4, EPA must prepare a budgetary impact statement to accompany any general notice of proposed rulemaking or final rule that includes a Federal mandate which may result in estimated costs to State, local, or tribal governments in the aggregate, or to the private sector, of $100 million or more. Under section 205, for any rule subject to section 202 EPA generally must select the least costly, most cost-effective, or least burdensome alternative that achieves the objectives of the rule and is consistent with statutory requirements. Under section 203, before establishing any regulatory requirements that may significantly or uniquely affect small governments, EPA must take steps to inform and advise small governments of the requirements and enable them to provide input.

EPA has determined that this rule does not include a Federal mandate as defined in UMRA. The rule does not include a Federal mandate that may result in estimated annual costs to State, local or tribal governments in the aggregate, or to the private sector, of $100 million or more, and it does not establish regulatory requirements that may significantly or uniquely affect small governments.

X. Submission to Congress and the General Accounting Office

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in

[18] 58 FR 51736 (October 4, 1993).

[19] *Id.* at section 3(f)(1)-(4).

the **Federal Register**. This rule is not a ''major rule'' as defined by 5 U.S.C. 804(2).

XI. Children's Health Protection

This final rule is not subject to E.O. 13045, entitled ''Protection of Children from Environmental Health Risks and Safety Risks'' (62 FR 19885, April 23, 1997), because it does not involve decisions on environmental health risks or safety risks that may disproportionately affect children.

List of Subjects in 40 CFR Part 80

Environmental protection, California exemptions, Fuel additives, Gasoline, Reformulated gasoline, Imports, Labeling, Motor vehicle pollution, Penalties, Reporting and recordkeeping requirements.

Dated: June 17, 1998.

Carol M. Browner,

Administrator.

For the reasons set forth in the preamble, 40 CFR Part 80 is amended as follows:

PART 80—[AMENDED]

1. The authority citation for part 80 continues to read as follows:

Authority: Secs. 114, 211, and 301(a) of the Clean Air Act as amended (42 U.S.C. 7414, 7545, and 7601(a)).

2. Section 80.81 is amended by revising paragraphs (e)(1), (e)(2) and (h) to read as follows:

§ 80.81 Enforcement exemptions for California gasoline.

* * * * *

(e)(1) The exemption provisions contained in paragraphs (b)(2), (b)(3), (c), and (f) of this section shall not apply under the circumstances set forth in paragraphs (e)(2) and (e)(3) of this section.

(2) Such exemption provisions shall not apply to any refiner, importer, or oxygenate blender of California gasoline with regards to any gasoline formulation that it produces or imports is certified under Title 13, California Code of Regulations, section 2265 or section 2266 (as amended July 2, 1996), unless:

(i) *Written notification option.* (A) The refiner, importer, or oxygenate blender, within 30 days of the issuance of such certification:

(1) Notifies the Administrator of such certification;

(2) Submits to the Administrator copies of the applicable certification order issued by the State of California and the application for certification submitted by the regulated party to the State of California; and

(3) Submits to the Administrator a written demonstration that all gasoline formulations produced, imported or blended by the refiner, importer or oxygenate blender for use in California meets each of the complex model per-gallon standards specified in § 80.41(c).

(B) If the Administrator determines that the written demonstration submitted under paragraph (e)(2)(i)(A) of this section does not demonstrate that all certified gasoline formulations meet each of the complex model per-gallon standards specified in § 80.41(c), the Administrator shall provide notice to the party (by first class mail) of such determination and of the date on which the exemption provisions specified in paragraph (e)(1) of this section shall no longer be applicable, which date shall be no earlier than 90 days after the date of the Administrator's notification.

(ii) *Compliance survey option.* The compliance survey requirements of § 80.68 are met for each covered area in California for which the refiner, importer or oxygenate blender supplies gasoline for use in the covered area, except that:

(A) The survey series must determine compliance only with the oxygen content standard of 2.0 weight-percent;

(B) The survey series must consist of at least four surveys a year for each covered area;

(C) The surveys shall not be included in determining the number of surveys under § 80.68(b)(2);

(D) In the event a survey series conducted under this paragraph (e)(2)(ii) fails in accordance with § 80.68(c)(12), the provisions of §§ 80.41(o), (p) and (q) are applicable, except that if the survey series failure occurs in a year in which the applicable minimum oxygen content is 1.7 weight percent, the compliance survey option of this section shall not be applicable for any future year; and

(E) Not withstanding § 80.41(o), in the event a covered area passes the oxygen content series in a year, the minimum oxygen content standard for that covered area beginning in the year following the passed survey series shall be made less stringent by decreasing the minimum oxygen content standard by 0.1%, except that in no case shall the minimum oxygen content standard be less than that specified in § 80.41(d).

* * * * *

(h)(1) For the purposes of the batch sampling and analysis requirements contained in § 80.65(e)(1)and § 80.101(i)(1)(i)(A), any refiner, importer or oxygenate blender of California gasoline may use a sampling and/or analysis methodology prescribed in Title 13, California Code of Regulations, sections 2260 *et seq.* (as amended July 2, 1996), in lieu of any applicable methodology specified in § 80.46, with regards to

(i) Such gasoline; or

(ii) That portion of its gasoline produced or imported for use in other areas of the United States, provided that:

(A) The gasoline must be produced by a refinery that is located in the state of California that produces California gasoline, or imported into California from outside the United States as California Phase 2 gasoline;

(B) The gasoline must be classified as conventional gasoline upon exportation from the California; and

(C) The refiner or importer must correlate the results from the applicable sampling and /or analysis methodology prescribed in Title 13, California Code of Regulations, sections 2260 *et seq.* (as amended July 2, 1996), with the method specified at § 80.46, and such correlation must be adequately demonstrated to EPA upon request.

(2) Nothwithstanding the requirements of § 80.65(e)(1) regarding when the properties of a batch of reformulated gasoline must be determined, a refiner of California gasoline may determine the properties of gasoline as specified under § 80.65(e)(1) at off site tankage provided that:

(i) The samples are properly collected under the terms of a current and valid protocol agreement between the refiner and the California Air Resources Board with regard to sampling at the off site tankage and consistent with requirements prescribed in Title 13, California Code of Regulations, sections 2260 *et seq.*(as amended July 2, 1996); and

(ii) The refiner provides a copy of the protocol agreement to EPA upon request.

* * * * *

[FR Doc. 98–16669 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Parts 180, 185, and 186

[OPP–300638; FRL–5783–6]

RIN 2070–AB78

Recodification of Certain Tolerance Regulations

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: The Environmental Protection Agency is issuing this technical amendment to consolidate parts 185 and 186 pesticide tolerance regulations into part 180. This recodification is consistent with the Food Quality Protection Act which places all pesticide tolerances under section 408 of the Federal Food, Drug, and Cosmetic Act, thus eliminating the distinction between pesticide tolerances for raw and processed foods.

DATES: This regulation becomes effective June 26, 1998.

FOR FURTHER INFORMATION CONTACT: By mail, Joseph Nevola, Special Review Branch (7508W), Office of Pesticide Programs, Environmental Protection Agency, 401 M St., SW., Washington, DC 20460. Office location, telephone number and e-mail address: 3rd Floor, Crystal Station, 2800 Crystal Drive, Arlington, VA 22202, (703) 308-8037; e-mail: nevola.joseph@epamail.epa.gov.

SUPPLEMENTARY INFORMATION: Pesticide tolerance regulations promulgated under sections 408 and 409 of the Federal Food, Drug, and Costmetic Act (FFDCA), 21 U.S.C. 346a and 348, appear in parts 180, 185 and 186 of title 40 of the Code of Federal Regulations. Part 180 contains pesticide tolerance regulations for pesticide chemical residues in raw agricultural commodities. Such regulations were promulgated under FFDCA section 408. Parts 185 and 186 contain food additive regulations for pesticide chemical residues in processed food. These regulations were promulgated under FFDCA section 409.

The Food Quality Protection Act (FQPA) was signed into law in August of 1996. Under section 408(j) of the FFDCA, as amended by the FQPA, all pesticide tolerances established under FFDCA section 409 were deemed to be tolerances under FFDCA section 408. Since there is no longer a statutory reason for the separation of these tolerances into different parts of the CFR, as a part of the routine process of issuing new and revised tolerances, EPA is consolidating certain sections of the regulations in parts 185 and 186 into 40 CFR part 180. Although the tolerances are being restructured to fit into part 180, no substantive changes are being made. The tolerance regulations in parts 185 and 186 are being redesignated as follows:

Old CFR section	New CFR section
185.410	180.163(a) table
185.1450	180.142(a)(13)
185.1975(a)	180.528
185.1985	180.529
185.2150	180.530
185.2225	180.531(a)(1)
185.3450	180.276(a)(2)
185.5475	180.174(a)
186.1875	180.274(a)(2)
186.1975(a) and (b)	180.528
186.1985	180.529
186.2150(a) and (b)	180.530
186.2225	180.531(a)(2)
186.2775	180.345(a)(2)
186.4050	180.289(a) table

This action is being taken pursuant to EPA's authority under FFDCA section 408(e)(1)(C) to issue regulations implementing the requirements of section 408. Because this regulation involves a technical change to existing regulations and has no substantive impact, EPA for good cause finds that it would be in the public interest to promulgate this regulations without issuing a notice of proposed rulemaking under section 408(e)(2).

I. Regulatory Assessment Requirements

This final rule does not impose any requirements. It only implements technical amendments to the Code of Federal Regulations (CFR), by recodifying certain tolerances that have already been established under FFDCA section 408. Basically, this notice simply consolidates the tolerances, which currently appear in two separate parts of the CFR (i.e., 40 CFR parts 185 and 186), into a single part (i.e., 40 CFR part 180). As such, this action does not require review by the Office of Management and Budget (OMB) under Executive Order 12866, entitled Regulatory Planning and Review (58 FR 51735, October 4, 1993), the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, or Executive Order 13045, entitled Protection of Children from Environmental Health Risks and Safety Risks (62 FR 19885, April 23, 1997). For the same reason, it does not require any action under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) (Pub. L. 104–4), Executive Order 12875, entitled Enhancing the Intergovernmental Partnership (58 FR 58093, October 28, 1993), or Executive Order 12898, entitled Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations (59 FR 7629, February 16, 1994). In addition, since this type of action does not require any proposal, no action is needed under the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 et seq.).

II. Submission to Congress and the General Accounting Office

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

List of Subjects

40 CFR Part 180

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

40 CFR Part 185

Environmental protection, Food additives, Pesticides and pests.

40 CFR Part 186

Environmental protection, Animal feeds, Pesticides and pests.

Dated: June 3, 1998.

Lois Rossi,

Director, Special Review and Reregistration Division, Office of Pesticide Programs.

Therefore, 40 CFR chapter I is amended as follows:

1. Section 180.163 is revised to read as follows:

§ 180.163 1,1-Bis(p-chlorophenyl)-2,2,2-trichloroethanol; tolerances for residues.

(a) *General.* Tolerances for residues of the insecticide 1,1-bis(*p*-chlorophenyl)-2,2,2-trichloroethanol in or on raw agricultural commodities are established as follows:

Commodity	Parts per million
Apples	5
Apricots	10
Beans (dry form)	5
Beans, lima (succulent form)	5
Beans, snap (succulent form)	5
Blackberries	5
Boysenberries	5
Bushnuts	5
Butternuts	5
Cantaloups	5
Cherries	5
Chestnuts	5
Cottonseed	0.1
Crabapples	5
Cucumbers	5
Dewberries	5
Eggplants	5
Figs	5

Commodity	Parts per million
Filberts	5
Grapefruit	10
Grapes	5
Hay, peppermint	25
Hay, spearmint	25
Hazelnuts	5
Hickory nuts	5
Hops	30
Kumquats	10
Lemons	10
Limes	10
Loganberries	5
Melons	5
Muskmelons	5
Nectarines	10
Oranges	10
Peaches	10
Pears	5
Pecans	5
Peppers	5
Pimentos	5
Plums (fresh prunes)	5
Pumpkins	5
Quinces	5
Raspberries	5
Spearmint hay	25
Strawberries	5
Summer squash	5
Tangerines	10
Tea, dried	45
Tomatoes	5
Walnuts	5
Watermelons	5
Winter squash	5

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

2. Section 180.174 is revised to read as follows:

§ 180.174 Tetradifon; tolerances for residues.

(a) *General.* Tolerances are established for residues of the insecticide tetradifon (2,4,5,4′-tetrachlorodiphenyl sulfone) in or on raw agricultural commodities as follows:

Commodity	Parts per million
Apples	5
Apricots	5
Cherries	5
Citrus citron	2
Crabaples	5
Cucumber	1
Figs	6
Figs, dried	10
Grapefruit	2
Grapes	5
Hops, dried	120
Hops, fresh	30
Lemons	2
Limes	2
Meat	0
Melons	1
Milk	0
Nectarines	5
Oranges	2
Peaches	5
Pears	5
Peppermint	100
Plums (fresh prunes)	5
Pumpkins	1
Quinces	5
Spearmint	100
Strawberries	5
Tangerines	2
Tea, dried	8
Tomatoes	1
Winter squash	1

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

3. Section 180.274 is revised to read as follows:

§ 180.274 Propanil; tolerances for residues.

(a) *General.* (1)Tolerances are established for combined residues of the herbicide propanil (3′,4′-dichloropropionanilide; CAS Reg. No. 709–98–8) and its metabolites (calculated as propanil) in or on the following raw agricultural commodities:

Commodity	Parts per million
Barley, grain	.2
Barley, straw	.75
Cattle, fat	0.1(N)
Cattle, mbyp	0.1(N)
Cattle, meat	0.1(N)
Eggs	0.05(N)
Goats, fat	0.1(N)
Goats, mbyp	0.1(N)
Goats, meat	0.1(N)
Hogs, fat	0.1(N)
Hogs, mbyp	0.1(N)
Hogs, meat	0.1(N)
Horses, fat	0.1(N)
Horses, mbyp	0.1(N)
Horses, meat	0.1(N)
Milk	0.05(N)
Oats, grain	.2
Oats, straw	.75
Poultry, fat	0.1(N)
Poultry, mbyp	0.1(N)
Poultry, meat	0.1(N)
Rice	2
Rice bran	10
Rice hulls	10
Rice mill fractions	10
Rice polishings	10
Rice, straw	75(N)
Sheep, fat	0.1(N)
Sheep, mbyp	0.1(N)
Sheep, meat	0.1(N)
Wheat, grain	0.2
Wheat, straw	0.75

(2) Tolerances are established for the combined residues of the herbicide propanil (3′,4′-dichloropropionanilide; CAS Reg. No. 709–98–8) and its metabolites (calculated as the parent compound) in or on the following processed feeds when present therein as a result of application of the herbicide to the growing crops:

Commodity	Parts per million
Rice bran	10
Rice hulls	10
Rice mill fractions	10
Rice polishings	10

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

4. Section 180.276 is revised to read as follows:

§ 180.276 Formetanate hydrochloride; tolerances for residues.

(a) *General.* (1) Tolerances are established for residues of the insecticide formetanate hydrochloride (m-[[(dimethylamino) methylene]amino]phenyl methylcarbamate hydrochloride) in or on raw agricultural commodities as follows:

Commodity	Parts per million
Apples	3
Grapefruit	4
Lemons	4
Limes	4
Nectarines	4
Oranges	4
Peaches	5
Pears	3
Plums (fresh prunes)	2
Tangerines	4

(2) A tolerance of 8 parts per million is established for residues of the insecticide formetanate hydrochloride (*m*-[(dimethylamino) methylene amino] phenyl methyl-carbamate hydrochloride) in dried prunes when present therein as a result of the application of the insecticide to growing plums (fresh prunes).

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

5. Section 180.289 is revised to read as follows:

§ 180.289 Methanearsonic acid; tolerances for residues.

(a) *General.* Tolerances are established for residues of the herbicide methanearsonic acid (calculated as As_2O_3) from application of the disodium and monosodium salts of methanearsonic acid in or on raw agricultural commodities as follows:

Commodity	Parts per million
Citrus fruit	0.35
Cottonseed	0.7
Cottonseed hulls	0.9

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

6. Section 180.345 is revised to read as follows:

§ 180.345 Ethofumesate; tolerances for residues.

(a) *General.* Tolerances are established for combined residues of the herbicide ethofumesate (2-ethoxy-2,3-dihydro-3,3-dimethyl-5-benzofuranyl methanesulfonate) and its metabolites 2-hydroxy-2,3-dihydro-3,3-dimethyl-5-benzofuranyl methanesulfonate and 2,3-dihydro-3,3-dimethyl-2-oxo-5-benzofuranyl methanesulfonate (both calculated as the parent compound) in or on the following raw agricultural commodities:

Commodity	Parts per million
Beets, sugar, roots	0.1
Beets, sugar, tops	1.00
Cattle, fat	0.05
Cattle, mbyp	0.05
Cattle, meat	0.05
Goats, fat	0.05
Goats, mbyp	0.05
Goats, meat	0.05
Grass, straw	1
Hogs, fat	0.05
Hogs, mbyp	0.05
Hogs, meat	0.05
Horses, fat	0.05
Horses, mbyp	0.05
Horses, meat	0.05
Sheep, fat	0.05
Sheep, mbyp	0.05
Sheep, meat	0.05

(2) Tolerances are established for combined residues of the herbicide ethofumesate (2-ethoxy-2,3-dihydro-3,3-dimethyl-5-benzofuranyl methanesulfonate; CAS Reg. No. 26225–79–6) and its metabolites 2-hydroxy-2,3-dihydro-3,3-dimethyl-5-benzofuranyl methanesulfonate and 2,3-dihydro-3,3-dimethyl-2-oxo-5-benzofuranyl methanesulfonate, (both calculated as the parent compound) in or on the following processed feeds when present therein as a result of application of the herbicide to the growing crops:

Commodity	Parts per million
Sugar beet molasses	0.5

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

7. Section 180.528 is added to read follows:

§ 180.528 Dihydro-5-heptyl-2(3H)-furanone; tolerances for residues.

(a) *General.* The food additive/feed additive dihydro-5-heptyl-2(3H)-furanone may be safely used in accordance with the following conditions:

(1) It is used in combination with the active ingredients d-limonene and dihydro-5-pentyl-2(3H)-furanone in insect-repellent tablecloths and in insect-repellent strips used in food- or feed-handling establishments.

(2) To assure safe use of the insecticide, its label and labeling shall conform to that registered by the U.S. Environmental Protection Agency, and it shall be used in accordance with such label and labeling.

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

8. Section 180.529 is added to read as follows:

§ 180.529 Dihydro-5-pentyl-2(3H)-furanone.

(a) *General.* The food additive/feed additive dihydro-5-pentyl-2(3H)-furanone may be safely used in accordance with the following conditions:

(1) It is used in combination with the active ingredients d-limonene and dihydro-5-heptyl-2(3H)-furanone in insect-repellent tablecloths and in insect-repellent strips used in food- or feed-handling establishments.

(2) To assure safe use of the insecticide, its label and labeling shall conform to that registered by the U.S. Enviornmental Protection Agency, and it shall be used in accordance with such label and labeling.

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

9. Section 180.530 is added to read as follows:

§ 180.530 2,2-Dimethyl-1,3-benzodioxol-4-ol methylcarbamate; tolerances for residues.

(a) *General.* (1) The insecticide 2,2-dimethyl-1,3-benzodioxol-4-ol methylcarbamate may be safely used in spot and/or crack and crevice treatments in animal feed handling establishments, including feed manufacturing and processing establishments, such as stores, supermarkets, dairies, meat slaughtering and packing plants, and canneries.

(2) The insecticide 2,2-dimethyl-1,3-benzodioxol-4-ol methylcarbamate may be safely used in spot and/or crack and crevice treatments in food handling establishments, including food service, manufacturing and processing establishments, such as restaurants, cafeterias, supermarkets, bakeries, breweries, dairies, meat slaughtering and packing plants, and canneries.

(3) To ensure safe use of the additive, its label and labeling shall conform to that registered with the U.S. Environmental Protection Agency and it shall be used in accordance with such label and labeling.

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

10. Section 180.531 is added to read as follows:

§ 180.531 O,O-Dimethyl S-[4-oxo-1,2,3-benzotriazin-3 (4H)-ylmethyl] phosphorodithioate.

(a) *General.* (1) A tolerance of 1 part per million is established for residues of the insecticide *O,O*- dimethyl *S*-[4-oxo-1,2,3-benzotriazin-3(4*H*)-ylmethyl] phosphorodithioate in soybean oil resulting from application of the insecticide to the raw agricultural commodity soybeans.

(2) The following tolerances are established for residues of the insecticide *O,O*- dimethyl *S*-[4-oxo-1,2,3-benzotriazin-3(4H)-ylmethyl] phosphorodithioate in the indicated commodities when used for the feed of cattle, goats, and sheep. Such residues may be present therein only as a result of the application of the insecticide to the growing agricultural crop.

Commodity	Parts per million
Citrus pulp, dried	5

Commodity	Parts per million
Sugarcane bagasse	1.5

(b) *Section 18 emergency exemptions.* [Reserved]

(c) *Tolerances with regional registrations.* [Reserved]

(d) *Indirect or inadvertent residues.* [Reserved]

2. In part 185:

PART 185—[AMENDED]

a. The authority citation for part 185 continues to read as follows:

Authority: 21 U.S.C. 346a and 348.

§ 185.410 [Removed]

b. Section 185.410 is removed.

§ 185.1450 [Partially Redesignated and Removed]

c. The text of § 185.1450 is transferred to § 180.142 and redesignated as follows:

i. Paragraph (a) introductory text is redesignated as § 180.142(a)(13).

ii. Paragraphs (a)(1) and (a)(2) are redesignated as § 180.142(a)(13)(i) and (a)(13)(ii).

iii. Paragraphs (a)(3) introductory text, (a)(3)(i), (a)(3)(ii) and (a)(3)(iii) are redesignated as § 180.142(a)(13)(iii) introductory text, (a)(13)(iii)(A), (a)(13)(iii)(B) and (a)(13)(iii)(C), respectively. The remainder of § 185.1450 is removed.

§ 185.1975 [Removed]

d. Section 185.1975 is removed.

§ 185.1985 [Removed]

e. Section 185.1985 is removed.

§ 185.2150 [Removed]

f. Section 185.2150 is removed.

§ 185.2225 [Removed]

g. Section 185.2225 is removed.

§ 185.3450 [Removed]

h. Section 185.3450 is removed.

§ 185.5475 [Removed]

i. Section 185.5475 is removed.

3. In part 186:

PART 186—[AMENDED]

a. The authority citation continues to read as follows:

Authority: 21 U.S.C. 342, 348, and 371.

§ 186.1875 [Removed]

b. Section 186.1875 is removed.

§ 186.1975 [Removed]

c. Section 186.1975 is removed.

§ 186.1985 [Removed]

d. Section 186.1985 is removed.

§ 186.2150 [Removed]

e. Section 186.2150 is removed.

§ 186.2225 [Removed]

f. Section 186.2225 is removed.

§ 186.2775 [Removed]

g. Section 186.2775 is removed.

§ 186.4050 [Removed]

h. Section 186.4050 is removed.

[FR Doc. 98–16942 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–F

Proposed Rules

Federal Register
Vol. 63, No. 123
Friday, June 26, 1998

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 TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 95–CE–64–AD]

RIN 2120–AA64

Airworthiness Directives; SOCATA—Groupe AEROSPATIALE Models TB20, and TB21 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes to adopt a new airworthiness directive (AD) that would apply to certain SOCATA—Groupe AEROSPATIALE (Socata) Models TB20 and TB21 airplanes. The proposed action would require repetitively inspecting the main landing gear (MLG) attachment bearing (using a dye penetrant method) for cracks, and if cracks are found, replacing the bearing. The proposed AD is the result of mandatory continuing airworthiness information (MCAI) issued by the airworthiness authority for France. The actions specified by the proposed AD are intended to prevent cracks in the MLG attachment bearing, which could result in collapse of the main landing gear during taxi and landing operations.

DATES: Comments must be received on or before July 20, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 95–CE–64–AD, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106. Comments may be inspected at this location between 8 a.m. and 4 p.m., Monday through Friday, holidays excepted.

Service information that applies to the proposed AD may be obtained from the SOCATA—Groupe AEROSPATIALE, Socata Product Support, Aeroport Tarbes-Ossun-Lourdes, B P 930, 65009 Tarbes Cedex, France; telephone: 62.41.74.26; facsimile: 62.41.74.32; or the Product Support Manager, SOCATA—Groupe AEROSPATIALE, North Perry Airport, 7501 Pembroke Road, Pembroke Pines, Florida 33023; telephone: (954) 964–6877; facsimile: (954) 964–1668. This information also may be examined at the Rules Docket at the address above.

FOR FURTHER INFORMATION CONTACT: Mr. Karl Schletzbaum, Aerospace Engineer, FAA, Small Airplane Directorate, 1201 Walnut Street, suite 900, Kansas City, Missouri 64106; telephone: (816) 426–6934; facsimile: (816) 426–2169.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications should identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 95–CE–64–AD.'' The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 95–CE–64–AD, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106.

Discussion

The Direction Générale de l'Aviation Civile (DGAC), which is the airworthiness authority for France, notified the FAA that an unsafe condition may exist on certain Socata Models TB20 and TB21 airplanes. The DGAC reports that some MLG's have collapsed due to failed MLG attachment bearings. Further analysis of the failed MLG attachment bearings revealed cracks which are due to fatigue.

These conditions, if not detected and corrected, could result in collapse of the airplane's main landing gear during taxi or landing operations.

Relevant Service Information

Socata has issued Service Bulletin No. SB 10–080 57, Amdt. 2, dated November 1995, which specifies procedures for repetitively inspecting (using a dye penetrant method) the MLG attachment bearing for cracks. If cracks are found in the attachment bearing, the service information specifies procedures for replacing the bearing.

The DGAC classified this service bulletin as mandatory and issued French AD 94–266(A)R2, dated December 6, 1995, in order to assure the continued airworthiness of these airplanes in France.

The FAA's Determination

These airplane models are manufactured in France and are type certificated for operation in the United States under the provisions of section 21.29 of the Federal Aviation Regulations (14 CFR 21.29) and the applicable bilateral airworthiness agreement. Pursuant to this bilateral airworthiness agreement, the DGAC has kept the FAA informed of the situation described above.

The FAA has examined the findings of the DGAC; reviewed all available information, including the service information referenced above; and determined that AD action is necessary for products of this type design that are certificated for operation in the United States.

Explanation of the Provisions of the Proposed AD

Since an unsafe condition has been identified that is likely to exist or develop in other Socata Models TB20

and TB21 airplanes of the same type design registered in the United States, the FAA is proposing AD action. The proposed AD would require repetitively inspecting (using a dye penetrant method) for cracks on the MLG attachment bearing. If cracks are found, the proposed AD would require replacing the cracked attachment bearing. Accomplishment of the proposed inspections and replacement would be in accordance with Socata Service Bulletin No. SB 10–080 57, Amdt. 2, dated November 1995.

Cost Impact

The FAA estimates that 199 airplanes in the U.S. registry would be affected by the proposed AD.

Accomplishing the proposed inspection would take approximately 4 workhours per airplane, and the average labor rate is approximately $60 an hour. Based on these figures, the total cost impact of the proposed inspection on U.S. operators is estimated to be $47,760, or $240 per airplane.

The proposed replacement would take approximately 1 workhour to replace the bearing, if necessary, at an average labor rate of $60 per hour. Parts cost approximately $800 per airplane. Based on these figures, the total cost impact of the proposed modification on U.S. operators is estimated to be $171,140 or $860 per airplane.

The FAA has no way to determine the number of repetitive inspections that would be incurred over the life of the airplane.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action has been placed in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption **ADDRESSES**.

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding a new airworthiness directive (AD) to read as follows:

SOCATA—Groupe Aerospatiale: Docket No. 95–CE–64–AD.

Applicability: Models TB20 and TB21 airplanes, serial numbers 1 through 9999, certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (c) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated in the body of this AD, unless already accomplished.

To prevent cracks in the main landing gear (MLG) attachment bearing, which could result in collapse of the MLG during taxi and landing operations, accomplish the following:

Note 2: The compliance times of this AD are presented in landings instead of hours time-in-service (TIS). If the number of landings is unknown, hours TIS may be used by multiplying the number of hours TIS by 1.5.

(a) Upon the accumulation of 6,000 landings, upon the accumulation of 4,000 hours total TIS, or within the next 100 hours TIS after the effective date of this AD, whichever occurs later, inspect (with a dye penetrant method) the main landing gear (MLG) attachment bearing for cracks in accordance with the Accomplishment Instructions in SOCATA Service Bulletin (SB) No. SB 10–080 57, Amdt. 2, dated November 1995;

(1) If no cracks are found, continue to inspect the MLG attachment bearing for cracks at intervals not to exceed 1,500 landings or 1,000 hours TIS, whichever occurs later, until cracks are found, in accordance with the Accomplishment Instructions in the SOCATA SB No. SB 10–080 57, Amdt. 2, dated November 1995;

(2) If cracks are found in the MLG attachment bearing during any inspection required by this AD, prior to further flight, replace the MLG attachment bearing in accordance with the Accomplishment Instructions in the SOCATA SB No. SB 10–080 57, Amdt. 2, dated November 1995; and

(3) Upon the accumulation of 6,000 landings or 4,000 hours TIS after the date of any MLG attachment bearing replacement, whichever occurs later, and thereafter at intervals not to exceed 1,500 landings or 1,000 hours TIS, inspect the MLG attachment bearing for cracks as specified in paragraph (a) of this AD.

(b) Special flight permits may be issued in accordance with §§ 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

(c) An alternative method of compliance or adjustment of the initial or repetitive compliance times that provides an equivalent level of safety may be approved by the Manager, Small Airplane Directorate, FAA, 1201 Walnut, suite 900, Kansas City, Missouri 64106. The request shall be forwarded through an appropriate FAA Maintenance Inspector, who may add comments and then send it to the Manager, Small Airplane Directorate.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Small Airplane Directorate.

(d) Questions or technical information related to Socata Service Bulletin No. SB 10–080 57, Amdt. 2, dated November 1995, should be directed the SOCATA—Groupe AEROSPATIALE, Tarbes-Ossun-Lourdes, B P 930, 65009 Tarbes Cedex, France; telephone: 33.5.62.41.73.58; facsimile: 33.5.62.41.74.18; or the Product Support Manager, SOCATA—Groupe AEROSPATIALE, North Perry Airport, 7501 Pembroke Road, Pembroke Pines, Florida 33023; telephone: (954) 893–1160; facsimile: (954) 964–4141. This service information may be examined at the FAA, Central Region, Office of the Regional Counsel, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106.

Note 4: The subject of this AD is addressed in French AD 94–266(A)R2, dated December 6, 1995.

Issued in Kansas City, Missouri, on June 19, 1998.

James E. Jackson,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98–17019 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 98–NM–166–AD]

RIN 2120–AA64

Airworthiness Directives; McDonnell Douglas Model DC–9–80 Series Airplanes, and Model MD–88 Airplanes

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes the adoption of a new airworthiness directive (AD) that is applicable to certain McDonnell Douglas Model DC–9–80 series airplanes, and Model MD–88 airplanes. This proposal would require a one-time inspection to detect corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer; and corrective actions, if necessary. This proposal is prompted by reports of corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer, apparently due to the improper brushing of cadmium on the hinge plates during manufacture. The actions specified by the proposed AD are intended to detect and correct corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer, which could result in reduced structural integrity of the airplane.

DATES: Comments must be received by August 10, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM–114, Attention: Rules Docket No. 98–NM–166–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056. Comments may be inspected at this location between 9:00 a.m. and 3:00 p.m., Monday through Friday, except Federal holidays.

The service information referenced in the proposed rule may be obtained from The Boeing Company, Douglas Products Division, 3855 Lakewood Boulevard, Long Beach, California 90846, Attention: Technical Publications Business Administration, Dept. C1–L51 (2–60). This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington; or at the FAA, Transport Airplane Directorate, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California.

FOR FURTHER INFORMATION CONTACT: Brent Bandley, Aerospace Engineer, Airframe Branch, ANM–120L, FAA, Transport Airplane Directorate, Los Angeles Aircraft Certification Office, 3960 Paramount Boulevard, Lakewood, California 90712–4137; telephone (562) 627–5237; fax (562) 627–5210.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications shall identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket Number 98–NM–166–AD.'' The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Transport Airplane Directorate, ANM–114, Attention: Rules Docket No. 98–NM–166–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056.

Discussion

The FAA has received reports of corrosion on the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer on certain McDonnell Douglas Model DC–9–80 series airplanes, and Model MD–88 airplanes. This corrosion occurred on airplanes that had accumulated between 15,000 and 30,000 total flight hours. Investigation has revealed that the hinge plates were apparently brushed with cadmium during the assembly drill out and line ream processes. During these manufacturing processes, it appears that the cadmium material became trapped between the mating hinge plates. Consequently, chemical action caused corrosion to occur around the lug bores. The corrosion has been attributed to the cadmium-brushed plates, which were not part of the approved type design. Such corrosion, if not detected and corrected in a timely manner, could result in reduced structural integrity of the airplane.

Explanation of Relevant Service Information

The FAA has reviewed and approved McDonnell Douglas Service Bulletin MD80–55–054, dated March 3, 1998, which describes procedures for a one-time visual inspection to detect corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer; and corrective actions, if necessary. Corrective actions include removal of corrosion that is within the limits specified in the Structural Repair Manual; and replacement of the hinge plates with new parts, if the corrosion exceeds the limits specified in the Structural Repair Manual. Accomplishment of the actions specified in the service bulletin is intended to adequately address the identified unsafe condition.

Explanation of Requirements of Proposed Rule

Since an unsafe condition has been identified that is likely to exist or develop on other products of this same type design, the proposed AD would require a one-time inspection to detect corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer; and corrective actions, if necessary. The proposed AD also would require that operators report results of inspection findings (positive or negative) to the FAA.

Cost Impact

There are approximately 1,059 airplanes of the affected design in the worldwide fleet. The FAA estimates that 706 airplanes of U.S. registry would be affected by this proposed AD. It would take approximately 117 work hours per airplane (which includes removal and installation) to accomplish the proposed inspection, at an average labor rate of $60 per work hour. Based on these figures, the cost impact of the proposed AD on U.S. operators is estimated to be $4,956,120, or $7,020 per airplane.

The cost impact figure discussed above is based on assumptions that no operator has yet accomplished any of the proposed requirements of this AD action, and that no operator would accomplish those actions in the future if this AD were not adopted.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this proposed regulation (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under the DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action is contained in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by adding the following new airworthiness directive:

McDonnell Douglas: Docket 98–NM–166–AD.

Applicability: Model DC–9–81 (MD–81), DC–9–82 (MD–82), DC–9–83 (MD–83), and DC–9–87 (MD–87) series airplanes, and Model MD–88 airplanes; as listed in McDonnell Douglas Service Bulletin MD80–55–054, dated March 3, 1998; certificated in any category.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (c) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required as indicated, unless accomplished previously.

To detect and correct corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer, which could result in reduced structural integrity of the airplane, accomplish the following:

(a) Within 18 months after the effective date of this AD, perform a one-time visual inspection to detect corrosion of the lug bores and the surface of the hinge plates of the vertical-to-horizontal stabilizer, in accordance with McDonnell Douglas Service Bulletin MD80–55–054, dated March 3, 1998.

(1) *Condition 1:* If no corrosion is detected, no further action is required by this paragraph.

(2) *Condition 2:* If any corrosion is detected that is within the limits specified in the Structural Repair Manual, prior to further flight, remove the corrosion in accordance with the service bulletin.

(3) *Condition 3:* If any corrosion is detected that exceeds the limits specified in the Structural Repair Manual, prior to further flight, replace the hinge plates with new parts, in accordance with the service bulletin.

(b) Within 10 days after accomplishing the inspection required by paragraph (a) of this AD, or within 10 days after the effective date of this AD, whichever occurs later, submit a report of the inspection results (both positive and negative findings) to the Manager, Los Angeles Aircraft Certification Office (ACO), FAA, Transport Airplane Directorate, 3960 Paramount Boulevard, Lakewood, California 90712–4137; fax (562) 627–5210. Information collection requirements contained in this regulation have been approved by the Office of Management and Budget (OMB) under the provisions of the Paperwork Reduction Act of 1980 (44 U.S.C. 3501 *et seq.*) and have been assigned OMB Control Number 2120–0056.

(c) An alternative method of compliance or adjustment of the compliance time that provides an acceptable level of safety may be used if approved by the Manager, Los Angeles ACO. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, Los Angeles ACO.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Los Angeles ACO.

(d) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

Issued in Renton, Washington, on June 19, 1998.

Darrell M. Pederson,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98–17007 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 97–CE–138–AD]

RIN 2120–AA64

Airworthiness Directives; Cessna Aircraft Company 180 and 185 Series Airplanes.

AGENCY: Federal Aviation Administration, DOT.

ACTION: Notice of proposed rulemaking (NPRM).

SUMMARY: This document proposes to supersede Airworthiness Directive (AD) 80–10–01, which is applied to certain Cessna Aircraft Company 180 and 185 series airplanes that are equipped with Airglas Engineering Company, Inc., (AECI) Model LW3600–180 single position or Model LW3600–180A two position fixed penetration wheel ski installations. AD 80–10–01 currently requires: modifying the ski bungee assemblies, safety cables, and check cables; limiting the maximum airspeed to 160 knots with skis installed; and installing an airspeed limitation placard. The proposed AD would retain the actions required in AD 80–10–01, and would require marking the maximum airspeed limits on the airspeed indicator; placing a supplemental airplane flight manual (AFM) and AFM supplement in the cockpit; and adding the Cessna Model 180K airplane to the applicability. Reports that certain airspeeds cause the skis to rotate into a nose-down position during flight prompted the AD action. The actions specified by the proposed AD are intended to prevent one or both wheel skis from rotating into a nose-down position during flight, which could result in loss of control of the airplane and/or possible airplane damage during flight or landing operations.

DATES: Comments must be received on or before August 24, 1998.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 97–CE–138–AD, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106. Comments may be inspected at this location between 8 a.m. and 4 p.m., Monday through Friday, holidays excepted.

Service information that applies to the proposed AD may be obtained from Airglas Engineering Company, Inc., P.O. Box 190107, Anchorage, Alaska 99519–0107; telephone: (907) 344–1450; facsimile: (907) 349–4938. This information also may be examined at the Rules Docket at the address above.

FOR FURTHER INFORMATION CONTACT: Mr. Gordon K. Mandell, Aerospace Engineer, FAA, Anchorage Aircraft Certification Office, 222 West 7th Avenue, #14, Annex G, Room A18, Anchorage, Alaska 99513–7587; telephone: (907) 271–2670; facsimile: (907) 271–6365.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested persons are invited to participate in the making of the proposed rule by submitting such written data, views, or arguments as they may desire. Communications should identify the Rules Docket number and be submitted in triplicate to the address specified above. All communications received on or before the closing date for comments, specified above, will be considered before taking action on the proposed rule. The proposals contained in this notice may be changed in light of the comments received.

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

Commenters wishing the FAA to acknowledge receipt of their comments submitted in response to this notice must submit a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. 97–CE–138–AD.'' The postcard will be date stamped and returned to the commenter.

Availability of NPRMs

Any person may obtain a copy of this NPRM by submitting a request to the FAA, Central Region, Office of the Regional Counsel, Attention: Rules Docket No. 97–CE–138–AD, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106.

Discussion

AD 80–10–01, Amendment 39–3762, applies to Cessna 180 and 185 series airplanes that are equipped with AECI Model LW3600–180 or Model LW3600–180A wheel ski installations in accordance with supplemental type certificate (STC) SA213AL. This AD currently requires modifying the ski bungee assemblies and their attachments to the airplane and the skis, safety cables, and check cables and their attachments to the airplane and the skis; and installing a placard adjacent to the airspeed indicator that limits the knots indicated airspeed (KIAS) to never exceed 160 knots with the skis installed.

Actions Since Issuance of Previous Rule

Since the issuance of AD 80–10–01, additional field reports of incidents occurring on the affected airplanes with these wheel skis installed has prompted the FAA to review the actions required in AD 80–10–01. The manufacturer and the FAA have decided that additional measures are needed to ensure that the airspeed limitations are followed.

Relevant Service Information

Airglas Engineering Company, Inc., has issued Service Bulletin No. LW3600–3, originally issued: September 21, 1979; Amended: October 10, 1997, which specifies modifying the ski bungee assemblies, safety cables, and check cables and their attachments to the airplane and the skis in accordance with the procedures specified in AECI Drawing No. LW3600–180A–1 and –2, Revision ''B'', dated September 21, 1979; AECI Drawing No. LW3600–180A–3, Revision ''A'', dated April 30, 1979; and AECI Drawing No. LW3600–180, Revision ''F'', dated September 21, 1979 (for single position wheel ski installations) or AECI Drawing No. LW3600–180A, Revision ''E'', dated September 21, 1979 (for two position wheel ski installations).

AECI Service Bulletin No. LW3600–3, originally issued: September 21, 1979; Amended: October 10, 1997, also specifies:

- Reducing the maximum structural cruising speed to 139 knots indicated air speed (KIAS) with the skis installed;
- Reducing the never exceed speed to 160 KIAS with the skis installed;
- Installing a placard near the airspeed indicator with words prohibiting flight over 160 KIAS when the wheel skis are installed in accordance with AECI Drawing No. LW3600–180A–11, originally issued: September 21, 1979;
- Marking the airspeed indicator so that these maximum KIAS limitations are clear to the pilot; and
- Placing AECI Document AE97–13FM, ''Supplemental Airplane Flight Manual and Airplane Flight Manual Supplement'', dated October 10, 1997, in the airplane cockpit.

The FAA's Determination

After examining the circumstances and reviewing all available information related to the incidents described above, the FAA has determined that AD action should be taken to prevent one or both wheel skis from rotating into a nose-down position during flight, which could result in loss of control of the airplane and/or possible airplane damage during flight or landing operations.

Explanation of the Provisions of the Proposed AD

Since an unsafe condition has been identified that is likely to exist or develop in other Cessna 180 and 185 series airplanes of the same type design, that are equipped with AECI Model LW3600–180 or Model LW3600–180A wheel ski installations in accordance with STC SA213AL, the proposed AD would supersede AD 80–10–01 with a new AD. The proposed AD would require the following:

—Modifying the ski bungee assemblies and their attachments to the airplane and the skis, the safety cables, and the check cables and their attachments to the airplane and the skis;

—Installing a placard adjacent to the airspeed indicator limiting the never exceed speed to 160 knots and the maximum structural cruising speed to 139 knots with the skis installed;

—Marking the airspeed indicator to reflect the never exceed speed (160 KIAS) and the maximum structural cruising speed (139 KIAS) with the skis installed; and,

—Placing AECI Document No. AE97–13FM, ''Supplemental Airplane Flight Manual and Airplane Flight Manual Supplement'', dated October 10, 1997, in the airplane cockpit.

Cost Impact

The FAA estimates that 170 airplanes in the U.S. registry would be affected by the proposed AD, that it would take approximately 4 workhours per airplane to accomplish the proposed action, and that the average labor rate is approximately $60 an hour. Parts cost approximately $350 per airplane. Based on these figures, the total cost impact of

the proposed AD on U.S. operators is estimated to be $100,300, or $590 per airplane.

Airglas Engineering Company, Inc. has informed the FAA that approximately 12 of the affected airplanes have incorporated the proposed actions. Owners/operators of the affected airplanes that have already completed the proposed actions would reduce the estimated total cost impact by $7,080 from $100,300 to $93,220.

AD 80–10–01 currently requires most of the same actions on the affected airplanes as are proposed in this NPRM. The only differences between the proposed AD and AD 80–10–01 are the addition of the Cessna Model 180K airplane to the applicability and the requirements for marking the airspeed indicator and for placing a supplemental AFM and AFM supplement in the cockpit. These proposed actions can be accomplished for an airplane used under Part 91 of the Federal Aviation Regulations (14 CFR 91) by an owner/operator who holds at least a private pilot's certificate, and for an airplane used under Part 135 of the Federal Aviation Regulations (14 CFR 135) by an operator who holds an operating certificate issued under Part 135 of the Federal Aviation Regulations (14 CFR 135), as authorized by sections 43.3, 43.7, and 43.9 of the Federal Aviation Regulations (14 CFR 43.3, 43.7, and 43.9), if the airspeed indicator is re-marked by painting the outside of the glass. The only cost impact upon the public for airplanes other than affected Cessna Model 180K airplanes, is the time it will take the affected airplane owners/operators to incorporate these actions. Therefore, the proposed AD has additional cost impact over that already required by AD 80–10–01 only for affected Cessna Model 180K airplanes.

Regulatory Impact

The regulations proposed herein would not have substantial direct effects on the States, on the relationship between the national government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, in accordance with Executive Order 12612, it is determined that this proposal would not have sufficient federalism implications to warrant the preparation of a Federalism Assessment.

For the reasons discussed above, I certify that this action (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034, February 26, 1979); and (3) if promulgated, will not have a significant economic impact, positive or negative, on a substantial number of small entities under the criteria of the Regulatory Flexibility Act. A copy of the draft regulatory evaluation prepared for this action has been placed in the Rules Docket. A copy of it may be obtained by contacting the Rules Docket at the location provided under the caption **ADDRESSES.**

List of Subjects in 14 CFR Part 39

Air transportation, Aircraft, Aviation safety, Safety.

The Proposed Amendment

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

PART 39—AIRWORTHINESS DIRECTIVES

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

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

§ 39.13 [Amended]

2. Section 39.13 is amended by removing Airworthiness Directive (AD) 80–10–01, Amendment 39–3762, and by adding a new AD to read as follows:

Cessna Aircraft Company: Docket No. 97–CE–138–AD; Supersedes AD 80–10–01, Amendment 39–3762.

Applicability: The following airplane models, all serial numbers, certificated in any category, that are equipped with Airglas Engineering Company, Inc., Model LW3600–180 (single position wheel ski installation) or Model LW3600–180A (two position fixed penetration wheel ski installation) in accordance with supplemental type certificate (STC) SA213AL:

Models; 180, 180A, 180B, 180C, 180D, 180E, 180F, 180G, 180H, 180J, 180K, 185, 185A, 185B, 185C, 185D, 185E, A185E, A185F.

Note 1: This AD applies to each airplane identified in the preceding applicability provision, regardless of whether it has been modified, altered, or repaired in the area subject to the requirements of this AD. For airplanes that have been modified, altered, or repaired so that the performance of the requirements of this AD is affected, the owner/operator must request approval for an alternative method of compliance in accordance with paragraph (g) of this AD. The request should include an assessment of the effect of the modification, alteration, or repair on the unsafe condition addressed by this AD; and, if the unsafe condition has not been eliminated, the request should include specific proposed actions to address it.

Compliance: Required within the next 50 hours time-in-service (TIS) after the effective date of this AD, unless already accomplished.

To prevent one or both wheel skis from rotating into a nose-down position during flight, which could result loss of control of the airplane and/or possible airplane damage during flight or landing operations, accomplish the following:

(a) Modify the wheel ski bungee assemblies, safety cables, and check cables and their attachments to the airplane and the skis, in accordance with Airglas Engineering Company, Inc. (AECI) Drawing No. LW3600–180A–1 and –2, Revision ''B'', dated September 21, 1979; AECI Drawing No. LW3600–180A–3, Revision ''A'', dated April 30, 1979; and AECI Drawing No. LW3600–180, Revision ''F'', dated September 21, 1979 (for single position wheel ski installations) or AECI Drawing No. LW3600–180A, Revision ''E'', dated September 21, 1979 (for two position wheel ski installations).

Note 2: Airglas Engineering Company, Inc. Service Bulletin (SB) No. LW3600–3, originally issued: September 21, 1979; Amended: October 10, 1997, specifies following the procedures provided in the drawings referenced in paragraph (a) of this AD.

(b) Fabricate and install a placard adjacent to the airspeed indicator with words at least 1/8-inch in height in accordance with AECI Drawing No. LW3600–180A–11, originally issued: September 21, 1979, and referenced in AECI SB No. LW3600–3, originally issued: September 21, 1979; Amended: October 10, 1997.

(c) Mark the airspeed indicator to reflect the never exceed airspeed (160 knots indicated airspeed (KIAS)) and the maximum structural cruising speed (139 KIAS) in accordance with Airglas Engineering Company, Inc. Service Bulletin (SB) No. LW3600–3, originally issued: September 21, 1979; Amended: October 10, 1997.

(d) Place AECI Document AE97–13FM, ''Supplemental Airplane Flight Manual and Airplane Flight Manual Supplement'', dated October 10, 1997, in the airplane cockpit in accordance with the Accomplishment Instructions section in AECI SB No. LW3600–3, originally issued: September 21, 1979; Amended: October 10, 1997.

(e) The actions required in paragraphs (b), (c), and (d) of this AD can be accomplished for an airplane used under Part 91 of the Federal Aviation Regulations (14 CFR part 91) by an owner/operator who holds at least a private pilot's certificate, and for an airplane used under Part 135 of the Federal Aviation Regulations (14 CFR part 135) by an operator who holds an operating certificate issued under Part 135 of the Federal Aviation Regulations (14 CFR part 135), as authorized by sections 43.3, 43.7, and 43.9 of the Federal Aviation Regulations (14 CFR 43.3, 43.7, and 43.9), if the airspeed indicator is re-marked by painting the outside of the glass.

(f) Special flight permits may be issued in accordance with sections 21.197 and 21.199 of the Federal Aviation Regulations (14 CFR 21.197 and 21.199) to operate the airplane to a location where the requirements of this AD can be accomplished.

(g) An alternative method of compliance or adjustment of the compliance time that provides an equivalent level of safety may be approved by the Manager, Anchorage Aircraft Certification Office (ACO), 222 West 7th Avenue, #14, Annex G Room A18,

Anchorage, Alaska 99513–7587. The request shall be forwarded through an appropriate FAA Maintenance Inspector, who may add comments and then send it to the Manager, Anchorage ACO. Alternative methods of compliance approved for AD 80–10–01 are not considered approved as alternative methods of compliance for this AD.

Note 3: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the Anchorage ACO.

(h) All persons affected by this directive may obtain copies of the documents referred to herein upon request to Airglas Engineering Company, Inc., P.O. Box 190107, Anchorage, Alaska 99519–0107 or may examine these documents at the FAA, Central Region, Office of the Regional Counsel, Room 1558, 601 E. 12th Street, Kansas City, Missouri 64106.

(i) This amendment supersedes AD 80–10–01, Amendment 39–3762.

Issued in Kansas City, Missouri, on June 15, 1998.

James E. Jackson,

Acting Manager, Small Airplane Directorate, Aircraft Certification Service.

[FR Doc. 98–16591 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–AEA–098]

Proposed Amendment of Class E Airspace; Johnstown, PA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This proposed rule would amend Class E airspace at Johnstown, PA. The development of a new Standard Instrument Approach Procedure (SIAP), Helicopter Point In Space Approach based on the Global Positioning System (GPS), and serving the Conemaugh Valley Memorial Hospital Heliport has made this proposal necessary. The intended effect of this proposal is to provide adequate controlled airspace for Instrument Flight Rules (IFR) operations to the heliport. The area would be depicted on aeronautical charts for pilot reference.

DATES: Comments must be received on or before July 27, 1998.

ADDRESSES: Send comments on the proposed rule in triplicate to: Manager, Airspace Branch, AEA–520, Docket No. 98–AEA–08, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy Int'l Airport, Jamaica, NY 11430. The official docket may be examined in the Office of the Regional Counsel, AEA–7, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, New York 11430.

An informal docket may also be examined during normal business hours in the Airspace Branch, AEA–520, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, NY 11430.

FOR FURTHER INFORMATION CONTACT: Mr. Francis T. Jordan, Jr., Airspace Branch, AEA–520, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, New York 11430; telephone: (718) 553–4521.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 98–AEA–08''. 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 the FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Office of the Regional Counsel, AEA–7, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, NY 11430. 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. 11–2A, which describes the application procedure.

The Proposal

The FAA is considering an amendment to Part 71 of the Federal Aviation Regulations (14 CFR part 71) to amend Class E airspace extending upward from 700 feet above the surface (AGL) at Johnstown, PA. A GPS Point In Space Approach has been developed for the Conemaugh Valley Memorial Hospital Heliport. Additional controlled airspace extending upward from 700 feet above the surface (AGL) is needed to accommodate this approach and for IFR operations to the heliport. The area would be depicted on appropriate aeronautical charts.

Class E airspace designations for airspace extending upward from 700 feet above the surface are published in Paragraph 6005 of FAA Order 7400.9E, dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this proposed regulation—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that would only affect air traffic procedures and air navigation, it is certified that this proposed rule would not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—[AMENDED]

1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854; 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9E, dated September 10, 1997, and effective September 16, 1997, is proposed to be amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

AEA PA E5 Johnstown, PA [Revised]

Johnstown-Cambria County Airport, PA
(Lat. 40°19′00″ N., long. 78°50′04″ W.)
The Conemaugh Valley Memorial Hospital Heliport, PA
Point In Space Coordinates
(Lat. 40°18′15″ N., long. 78°54′54″ W.)

That airspace extending upward from 700 feet above the surface within a 6.6-mile radius of Johnstown-Cambria County Airport and within a 6-mile radius of the Point In Space serving Conemaugh Valley Memorial Hospital Heliport.

* * * * *

Issued in Jamaica, New York, on June 16, 1998.

Franklin D. Hatfield,

Manager, Air Traffic Division, Eastern Region.

[FR Doc. 98–17053 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–AEA–13]

Proposed Establishment of Class E Airspace; Fairfax, VA

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This proposed rule would establish Class E airspace at Fairfax, VA. A Global Positioning System (GPS), Standard Instrument Approach Procedure (SIAP), 100° helicopter point in space approach has been developed for the Mobil Business Resources Corporation (MBRC) heliport at Fairfax, VA. Controlled airspace extending upward from 700 feet above ground level (AGL) is needed to contain aircraft executing the approach and to provide adequate controlled airspace for instrument Flight Rules (IFR) operations to the heliport. The area would be depicted on aeronautical charts for pilot reference.

DATES: Comments must be received on or before July 27, 1998.

ADDRESSES: Send comments on the proposed rule in triplicate to: Manager, Airspace Branch, AEA–520, Docket No. 98–AEA–13, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy Int'l Airport, Jamaica, NY 11430. The official docket may be examined in the Office of the Regional Counsel, AEA–7, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica New York 11430.

An informal docket may also be examined during normal business hours in the Airspace Branch, AEA–520, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, NY 11430.

FOR FURTHER INFORMATION CONTACT: Mr. Francis T. Jordan, Jr., Airspace Specialist, Airspace Branch, AEA–520, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, New York 11430; telephone: (718) 553–4521.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views, or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 98–AEA–13''. 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 the FAA personnel concerned with this rulemaking will be filed in the docket.

Availability of NPRMs

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Office of the Regional Counsel, AEA–7, F.A.A. Eastern Region, Federal Building #111, John F. Kennedy International Airport, Jamaica, NY 11430. 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. 11–2A, which describes the application procedure.

The Proposal

The FAA is considering an amendment to Part 71 of the Federal Aviation Regulations (14 CFR part 71) to establish Class E airspace extending upward from 700 feet above the surface (AGL) at Fairfax, VA. A GPS Point In Space Approach has been developed for the MBRC Heliport. Additional controlled airspace extending upward from 700 feet above the surface (AGL) is needed to accommodate this approach and for IFR operations to the heliport. The area would be depicted on appropriate aeronautical charts.

Class E airspace designations for airspace extending upward from 700 feet above the surface are published in Paragraph 6005 of FAA Order 7400.9E, dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. Therefore, this proposed regulation—(1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a regulatory evaluation as the anticipated impact is so minimal. Since this is a routine matter that would only affect air traffic procedures and air navigation, it is certified that this proposed rule would not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71 [AMENDED]

1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g), 40103, 40113, 40120; E.O. 10854; 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

2. The incorporation by reference in 14 CFR 71.1 of the Federal Aviation Administration Order 7400.9E, dated September 10, 1997, and effective September 16, 1997, is proposed to be amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

AEA VA E5 Fairfax, VA [New]

Mobil Business Resources Corporation Heliport, VA
Point In Space Coordinates
(Lat. 38°51′41″ N., long. 77°14′31″ W.)

That airspace extending upward from 700 feet above the surface within a 6-mile radius of the Point In Space serving the Mobil Business Resources Corporation Heliport excluding that portion that coincides with the Washington, DC and Chantilly, VA, Class E airspace areas.

* * * * *

Issued in Jamaica, New York, on June 16, 1998.

Franklin D. Hatfield,

Manager, Air Traffic Division, Eastern Region.

[FR Doc. 98–17052 Filed 6–25–98; 8:45 am]

BILLING CODE 4819–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–ASO–7]

Proposed Amendment of Class E Airspace; Savannah, TN

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document proposes to amend Class E airspace at Savannah, TN. A Non-Directional Beacon (NDB) Runway (RWY) 19 Standard Instrument Approach Procedure (SIAP) has been developed for Savannah-Hardin County Airport. As a result, additional controlled airspace extending upward from 700 feet Above Ground Level (AGL) is needed to accommodate the SIAP and for Instrument Flight Rules (IFR) operations at Savannah-Hardin County Airport. The Class E airspace would be increased from a 6.4 to a 6.5-mile radius of Savannah-Hardin County Airport and the width of the airspace each side of the 009° bearing from the Pinhook NDB extending from the 6.5-mile radius to 7 miles north of the NDB would be increased from 2.4 to 3.2 miles.

DATES: Comments must be received on or before July 27, 1998.

ADDRESSES: Send comments on the proposal in triplicate to: Federal Aviation Administration, Docket No. 98–ASO–7, Manager, Airspace Branch, ASO–520, P.O. Box 20636, Atlanta, Georgia 30320.

The official docket may be examined in the Office of Regional Counsel for Southern Region, Room 550, 1701 Columbia Avenue, College Park, Georgia 30337, telephone (404) 305–5586.

FOR FURTHER INFORMATION CONTACT: Nancy B. Shelton, Manager, Airspace Branch, Air Traffic Division, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–5586.

SUPPLEMENTARY INFORMATION:

Comments Invited

Intersted parties are invited to participate in this proposed rulemaking by submitting such written data, views or arguments as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 98–ASO–7.'' 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 light of the comments received. All comments submitted will be available for examination in the Office of Regional Counsel for Southern Region, Room 550, 1701 Columbia Avenue, College Park, Georgia 30337, 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 NPRMs

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Federal Aviation Administration, Manager, Airspace Branch, ASO–520, Air Traffic Division, P.O. Box 20636, Atlanta, Georgia 30320. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRMs should also request a copy of Advisory Circular No. 11–2A which describes the application procedure.

The Proposal

The FAA is considering an amendment to part 71 of the Federal Aviation Regulations (14 CFR Part 71) to amend Class E airspace at Savannah, TN. A Non-Directional Beacon (NDB) RWY 19 SIAP has been developed for Savannah-Hardin County Airport. Additional controlled airspace extending upward from 700 feet AGL is needed to accommodate the SIAP and for IFR operations at Savannah-Hardin County Airport. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surfaced are published in Paragraph 6005 of FAA Order 7400.9E dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore, (1) is not a ''significant 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 than will only affect air traffic procedures and air navigation, it is certified that this rule, when promulaged; will not have a significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

The Proposed Amendment

In consideration of the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

ASO TN E5 Savannah, TN [Revised]

Savannah-Hardin County Airport
(Lat. 35°10′13″N, long 88°12′57″ W)

That airspace extending upward from 700 feet or more above the surface of the earth within 6.5-mile radius of Savannah-Hardin County Airport and within 3.2 miles each side of the 009 degree bearing from the Pinhook, NDB, extending from the 6.5-mile radius to 7 miles north of the NDB.

* * * * *

Issued in College Park, Georgia, on May 29, 1998.

Jeffery N. Burner,

Acting Manager, Air Traffic Division, Southern Region.

[FR Doc. 98–16956 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 98–ASO–10]

Proposed Establishment of Class E Airspace; Hartford, KY

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of proposed rulemaking.

SUMMARY: This document proposes to establish Class E airspace at Hartford, KY. Global Positioning System (GPS) Runways (RWY) 3–21 and a VHF Omnidirectional Range/Distance Measuring Equipment (VOR/DME)—A Standard Instrument Approach Procedures (SIAP's) have been developed for Ohio County Airport. As a result, controlled airspace extending upward from 700 feet Above Ground Level (AGL) is needed to accommodate the SIAP's and for Instrument Flight Rules (IFR) operations at Ohio County Airport. The operating status of the airport will change from Visual Flight Rules (VFR) to include IFR operations concurrent with the publication of the SIAP's.

DATES: Comments must be received on or before July 27, 1998.

ADDRESSES: Send comments on the proposal in triplicate to: Federal Aviation Administration, Docket No. 98–ASO–10, Manager, Airspace Branch, ASO–520, P.O. Box 20636, Atlanta, Georgia 30320.

The official docket may be examined in the Office of the Regional Counsel for Southern Region, Room 550, 1701 Columbia Avenue, College Park, Georgia 30337, telephone (404) 305–5586.

FOR FURTHER INFORMATION CONTACT: Nancy B. Shelton, Manager, Airspace Branch, Air Traffic Division, Federal Aviation Administration, P.O. Box 20636, Atlanta, Georgia 30320; telephone (404) 305–5586.

SUPPLEMENTARY INFORMATION:

Comments Invited

Interested parties are invited to participate in this proposed rulemaking by submitting such written data, views or arguments, as they may desire. Comments that provide the factual basis supporting the views and suggestions presented are particularly helpful in developing reasoned regulatory decisions on the proposal. Comments are specifically invited on the overall regulatory, aeronautical, economic, environmental, and energy-related aspects of the proposal. Communications should identify the airspace docket number and be submitted in triplicate to the address listed above. Commenters wishing the FAA to acknowledge receipt of their comments on this notice must submit with those comments a self-addressed, stamped postcard on which the following statement is made: ''Comments to Airspace Docket No. 98–ASO–10.'' 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 light of the comments received. All comments submitted will be available for examination in the Office of the Regional Counsel for Southern Region, Room 550, 1701 Columbia Avenue, College Park, Georgia 30337, 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 NPRMs

Any person may obtain a copy of this Notice of Proposed Rulemaking (NPRM) by submitting a request to the Federal Aviation Administration, Manager, Airspace Branch, ASO–520, Air Traffic Division, P.O. Box 20636, Atlanta, Georgia 30320. Communications must identify the notice number of this NPRM. Persons interested in being placed on a mailing list for future NPRMs should also request a copy of Advisory Circular No. 11–2A which describes the application procedure.

The Proposal

The FAA is considering an amendment to part 71 of the Federal Aviation Regulations (14 CFR Part 71) to establish Class E airspace at Hartford, KY. GPS RWY's 3–21 and a VOR/DME A SIAP's have been developed for Ohio County Airport. As a result, controlled airspace extending upward from 700 feet AGL is needed to accommodate the SIAP's and for IFR operations at Ohio County Airport. The operating status of the airport will change from VFR to include IFR operations concurrent with the publication of the SIAP. Class E airspace designations for airspace areas extending upward from 700 feet or more above the surface republished in Paragraph 6005 of FAA Order 7400.9E dated September 10, 1997, and effective September 16, 1997, which is incorporated by reference in 14 CFR 71.1. The Class E airspace designation listed in this document would be published subsequently in the Order.

The FAA has determined that this proposed regulation only involves an established body of technical regulations for which frequent and routine amendments are necessary to keep them operationally current. It, therefore, (1) is not a ''significant regulatory action'' under Executive Order 12866; (2) is not a ''significant rule'' under DOT Regulatory Policies and Procedures (44 FR 11034; February 26, 1979); and (3) does not warrant preparation of a Regulatory Evaluation as the anticipated impact is so minimal. Since this a routine matter that will only affect air traffic procedures and air navigation, it is certified that this rule, when promulgated, will not have a

significant economic impact on a substantial number of small entities under the criteria of the Regulatory Flexibility Act.

List of Subjects in 14 CFR Part 71

Airspace, Incorporation by reference, Navigation (Air).

The Proposed Amendment

In consideration on the foregoing, the Federal Aviation Administration proposes to amend 14 CFR part 71 as follows:

PART 71—DESIGNATION OF CLASS A, CLASS B, CLASS C, CLASS D, AND CLASS E AIRSPACE AREAS; AIRWAYS; ROUTES; AND REPORTING POINTS

1. The authority citation for Part 71 continues to read as follows:

Authority: 49 U.S.C. 106(g); 40103, 40113, 40120; E.O. 10854, 24 FR 9565, 3 CFR, 1959–1963 Comp., p. 389.

§ 71.1 [Amended]

2. The incorporation by reference in 14 CFR 71.1 of Federal Aviation Administration Order 7400.9E, Airspace Designations and Reporting Points, dated September 10, 1997, and effective September 16, 1997, is amended as follows:

Paragraph 6005 Class E airspace areas extending upward from 700 feet or more above the surface of the earth.

* * * * *

ASO KY E5 Hartford, KY [New]

Ohio County Airport
(lat. 37°27′30″ N, long. 86°50′59″ W)

That airspace extending upward from 700 feet or more above the surface of the earth within a 6.4-mile radius of Ohio County Airport.

* * * * *

Issued in College Park, Georgia, on June 18, 1998.

John R. Schroeter,

Acting Manager, Air Traffic Division, Southern Region.

[FR Doc. 98–16958 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–13–M

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 62

[OR–2–0001; FRL–6116–4]

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

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: The EPA proposes to approve the Section 111(d) State Plan submitted by Oregon on May 14, 1997. The State Plan was submitted by Oregon to satisfy certain Federal Clean Air Act requirements. In the Final Rules Section of this **Federal Register**, the EPA is approving the State's Plan submittal as a direct final rule without prior proposal because the Agency views this as a noncontroversial submittal and anticipates that it will not receive any significant, material, and adverse comments. A detailed rationale for the approval is set forth in the direct final rule. If no significant, material, and adverse comments are received in response to this proposed rule, no further activity is contemplated in relation to this proposed rule. If the EPA receives adverse comments, the direct final rule will be withdrawn and all public comments received will be addressed in a subsequent final rule based on this proposed rule. The EPA will not institute a second comment period on this action.

DATES: Comments on this proposed rule must be received in writing by July 27, 1998.

ADDRESSES: Written comments should be addressed to Catherine Woo, Environmental Protection Specialist, at the EPA Regional Office listed below. Copies of the documents relevant to this proposed rule are available for public inspection during normal business hours at the following locations. The interested persons wanting to examine these documents should make an appointment with the appropriate office at least 24 hours before the day of the visit.

Environmental Protection Agency, Region 10, Office of Air Quality, 1200 6th Avenue, Seattle, WA 98101.

The State of Oregon, Department of Environmental Quality, 811 SW Sixth Avenue, Portland, Oregon 97204.

FOR FURTHER INFORMATION CONTACT: Catherine Woo, Office of Air Quality (OAQ–107), EPA, 1200 6th Avenue, Seattle, WA 98101, (206) 553–1814.

SUPPLEMENTARY INFORMATION: See the information provided in the Direct Final action which is located in the Rules Section of this **Federal Register**.

Dated: June 8, 1998.

Chuck Findley,

Acting Regional Administrator, Region 10.

[FR Doc. 98–17120 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR 197

[USCG–1998–3786]

RIN 2115–AF64

Commercial Diving Operations

AGENCY: Coast Guard, DOT.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: The Coast Guard requests comments on the type and scope of needed revisions to the commercial diving operations regulations. The regulations are over 20 years old and do not include current safety and technology standards and industry practices. At this early stage of the rulemaking process we need information on current safety practices, diving technology, and industry standards to help us identify the scope of any necessary regulatory revisions.

DATES: Comments must reach the Docket Management Facility on or before September 24, 1998.

ADDRESSES: You may mail comments to the Docket Management Facility [USCG–1998–3786], U.S. Department of Transportation, room PL–401, 400 Seventh Street SW., Washington, DC 20590–0001, or deliver them to room PL–401, located on the Plaza Level of the Nassif Building at the same address, between 10 a.m. and 5 p.m., Monday through Friday, except Federal holidays. The telephone number is 202–366–9329.

The Docket Management Facility maintains the public docket for this rulemaking. Comments, and documents indicated in this preamble, will become part of this docket and will be available for inspection or copying at room PL–401, located on the Plaza Level of the Nassif Building at the same address, between 10 a.m. and 5 p.m., Monday through Friday, except Federal holidays. You may also access this docket on the Internet at http://dms.dot.gov.

A copy of the Association of Diving Contractors' (ADC) proposed changes to the Coast Guard commercial diving regulations and of its Consensus Standards are available in the public docket at the above address or on the Internet at http://dms.dot.gov, or you may obtain a copy by contacting the project manager at the number in **FOR FURTHER INFORMATION CONTACT**.

FOR FURTHER INFORMATION CONTACT: For questions on this advance notice of rulemaking, contact Lieutenant Diane Kalina, Project Manager, Vessel and

Facility Operating Standards Division, Coast Guard, telephone 202–267–1181. For questions on viewing, or submitting material to the docket, contact Carol Kelley, Coast Guard Dockets Team Leader, or Paulette Twine, Chief, Documentary Services Division, Department of Transportation, telephone 202–366–9329.

SUPPLEMENTARY INFORMATION:

Request for Comments

The Coast Guard encourages interested persons to participate in this rulemaking by submitting written data, views, or arguments. Persons submitting comments should include their names and addresses, identify this advance notice [USCG–1998–3786] and the specific section or question in this document to which each comment applies, and give the reason for each comment. Please submit all comments and attachments in an unbound format, no larger than 8½ by 11 inches, suitable for copying and electronic filing. If you want acknowledgment of receipt of your comments, you should enclose a stamped, self-addressed postcard or envelope.

The Coast Guard will consider all comments received during the comment period when developing its proposed changes to the regulations.

The Coast Guard plans no public meetings. You may request a public meeting by submitting a comment requesting one to the address under **ADDRESSES**. The request should include the reasons why a meeting would be beneficial. If the Coast Guard determines that a meeting should be held, we will announce the time and place in a later notice in the **Federal Register**.

Purpose

The Coast Guard needs your comments and information on the issues contained in this advance notice to help us define the scope of any necessary revisions to the commercial diving operations regulations in 46 CFR 197, Subpart B. The regulations are over 20 years old and do not include current safety and technology standards and industry practices. At this early stage of the rulemaking process we need information on current safety practices, diving technology, and industry standards to help us identify necessary regulatory revisions.

Background

The existing commercial diving regulations were published in 1977 and only minor changes have been made to them since then. In 1994, the Association of Diving Contractors (ADC), a diving industry trade organization, submitted proposed regulatory changes to the Coast Guard and requested that the Coast Guard revise its regulations accordingly. A copy of their proposed changes is available in the public docket. ADC's proposal was reviewed by over 140 General Members (operating companies) of ADC; their Technical and their Safety, Medical and Education Committees; and their Board of Directors. ADC also suggested that we adopt their Consensus Standards, possibly through incorporation by reference. A copy of the Consensus Standards is also available in the public docket. The Coast Guard will consider ADC's proposed changes when developing its proposed revisions to the commercial diving operations regulations, but would like to receive your comments on the ADC proposal. A copy of ADC's proposal is also available by contacting the Coast Guard point of contact under **FOR FURTHER INFORMATION CONTACT**.

Preliminary Regulatory Assessment

This rulemaking is not likely to be classified as a significant regulatory action under section 3(f) of Executive Order 12866 and is not likely to be significant under the regulatory policies and procedures of the Department of Transportation (44 FR 11040; February 26, 1979). A draft regulatory evaluation under paragraph 10(e) of the regulatory policies and procedures of the Department of Transportation would be prepared to support any future Notice of Proposed Rulemaking (NPRM).

The Coast Guard is not yet able to prepare a benefit-cost analysis assessing the impact of potential changes to the commercial diving operations regulations because specific changes have not been identified. However, the Coast Guard would like your comments on the cost estimate provided by ADC. According to a 1995 estimate by ADC, their proposed regulatory changes would likely not cost more than $300,000 to implement on an industry-wide basis. ADC also estimates that annualized costs would be minimal. We would like your comments on whether or not ADC's cost estimate is reasonable given the scope of ADC's recommendations.

Small Entities

Under the Regulatory Flexibility Act [5 U.S.C. 601 *et seq.*], the Coast Guard must consider whether a potential rulemaking would have significant economic impacts on a substantial number of small entities. ''Small entities'' include small businesses, not-for-profit organizations that are independently owned and operated and are not dominant in their fields, and governmental jurisdictions with populations of less than 50,000.

Some commercial diving companies subject to our regulations may be small entities. Because we have not yet proposed specific revisions and because the number of affected small entities has not been identified, we cannot accurately estimate the potential impact on small entities at this time. As part of the required 5 U.S.C. 610 review of regulations affecting small entities, we are requesting information at this early stage about the aspects of this rulemaking which may affect small entities, so we can evaluate and minimize the impact of proposed changes on small entities.

Assistance for Small Entities

Under section 213(a) of the Small Business Regulatory Enforcement Fairness Act of 1996 [Pub. L. 104–21], the Coast Guard wants to assist small entities to understand this advance notice so they can better evaluate the potential effects of any future rulemaking on them and participate in the rulemaking process. If you believe that your small business, organization, or agency may be affected by this rulemaking, please explain how you could be affected, and tell us what flexibility or compliance alternatives the Coast Guard should consider to minimize the burden on you while promoting commercial diving safety. If you have questions concerning this advance notice, you may call the Coast Guard point of contact designated in **FOR FURTHER INFORMATION CONTACT**. We also maintain a small business regulatory assistance Web Page at http://www.uscg.mil/hq/g-m/regs/reghome.htm that has current information on small entity issues and proposed Coast Guard regulations. To help small entities become more involved in this rulemaking, the Coast Guard will mail copies of this advance notice to Small Business Development Center (SBDC) State Directors nationwide for distribution to local SBDC offices and interested small businesses.

Collection of Information

Under the Paperwork Reduction Act [44 U.S.C. 3501 *et seq.*], the Office of Management and Budget (OMB) reviews each proposed rule that contains a collection of information requirement to determine whether the practical value of the information is worth the burden imposed by its collection. As defined in 5 CFR 1320.3(c), ''collection of

information'' includes reporting, record-keeping, monitoring, posting, labeling, and other, similar actions. The Coast Guard will review the existing information collection requirements in 46 CFR 197.480 through 46 CFR 197.488 to either validate existing burdens or to reduce or eliminate burdens that are no longer necessary.

Questions

We request your comments and any data or information that would answer the following questions, as well as comments on any other part of the current regulations that should be revised. In responding to a question, please explain your reasons for each answer so that we can carefully weigh the consequences and impacts of any future requirements we may propose. In addition, please provide relevant data (accident data would be particularly useful), if possible, that will support the need for a revision to the commercial diving operations regulations.

1. Based on your review of the ADC submission to the Coast Guard, which revisions should the Coast Guard include in its proposed rule, not include in a proposed rule, or revise and include in a proposed rule? Why?

2. Should the Coast Guard adopt the ADC Consensus Standards or any other written industry standards? If so, which ones and why?

3. Is ADC's cost estimate of $300,000.00 for implementing their proposed regulatory changes reasonable? If not, please explain why and, if possible, provide your own cost estimate.

4. What definitions in the existing regulations should be updated or deleted? Please explain. Are there other terms that the Coast Guard should define in the regulations? Please explain.

5. Should dynamically positioned vessels (vessels with an installed system that automatically maintains the position of the vessel within a specified tolerance by controlling onboard thrusters to counter the forces of the wind, waves and currents) and remotely operated vehicles be addressed in the regulations? If so, what particular issues should the Coast Guard propose to regulate?

6. Should the Coast Guard propose regulations concerning diving in contaminated waters? If yes, how should it be addressed?

7. Should the Coast Guard propose regulations concerning one atmosphere observation bells, suits or submersibles? If yes, how should it be addressed?

8. Should the Coast Guard propose regulations concerning bell bounce (a diving procedure whereby a diving bell is used to transport divers under atmospheric pressure to a work site, and subsequently to transport the divers back to the surface in a decompression status)? If yes, how should it be addressed?

9. Should the Coast Guard propose regulations concerning saturation diving in more detail? If yes, how should it be addressed?

10. Should the Coast Guard propose regulations concerning requirements for back-up equipment at the dive site? If yes, how should it be addressed?

11. Should the Coast Guard propose regulations concerning minimum training requirements for divers? If yes, how should it be addressed?

12. If you think the regulations should include minimum training requirements, please answer the following questions:

a. What courses or information should the training include?

b. What should be the minimum number of hours required for training?

c. What would be the benefits of establishing minimum training requirements?

d. Should training organizations or providers meet certification requirements? If so, what organization should certify the training organizations or providers?

13. Should diving supervisors be licensed by the Coast Guard to ensure compliance with federal regulations? Please explain the reason for your choice and, if your answer is ''yes'', provide examples, if possible, of situations in which a licensed diving supervisor would have improved a situation.

14. If you are a small entity as defined under ''Small Entities'' and believe you will be affected by potential changes to the commercial diving regulations, please explain what flexibility or compliance options the Coast Guard should consider and how these options would minimize the burden on small entities, while promoting commercial diving safety.

Dated: June 19, 1998.

Joseph J. Angelo,

Acting Assistant Commandant for Marine Safety and Environmental Protection.

[FR Doc. 98–17069 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–15–U

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 622

[Docket No. 980608151–8151–01; I.D.122497B]

RIN 0648–AK43

Fisheries of the Caribbean, Gulf of Mexico, and South Atlantic; Golden Crab Fishery of the South Atlantic Region; Gear and Vessel Management Measures

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS issues this proposed rule to implement a regulatory amendment prepared by the South Atlantic Fishery Management Council (Council) in accordance with framework procedures for adjusting management measures of the Fishery Management Plan for the Golden Crab Fishery of the South Atlantic Region (FMP). For the golden crab fishery in the South Atlantic exclusive economic zone (EEZ), the regulatory amendment would revise the vessel size limitations applicable when a vessel permit is transferred to another vessel and would extend through January 31, 1999, the authorized use of wire cable for a mainline attached to a golden crab trap. In addition, NMFS proposes to remove from the regulations the eligibility criteria and procedures for obtaining initial commercial vessel permits in the South Atlantic golden crab fishery. Such criteria and procedures are no longer applicable. The intended effects of this proposed rule are to allow for additional evaluation of cable used as mainlines for traps, to provide greater flexibility for fishermen to fish with vessels of different lengths without adversely affecting the FMP's cap on fishing effort, and to simplify the regulations.

DATES: Written comments must be received on or before July 13, 1998.

ADDRESSES: Comments on the proposed rule must be sent to Peter Eldridge, Southeast Regional Office, NMFS, 9721 Executive Center Drive N., St. Petersburg, FL 33702.

Requests for copies of the framework regulatory amendment, which includes an environmental assessment, a regulatory impact review (RIR), and a social impact assessment/fishery impact statement, should be sent to the South

Atlantic Fishery Management Council, One Southpark Circle, Suite 306, Charleston, SC 29407-4699; Phone: 843-571-4366; Fax: 843-769-4520.

FOR FURTHER INFORMATION CONTACT: Peter Eldridge, 813-570-5305.

SUPPLEMENTARY INFORMATION: The golden crab fishery in the EEZ of the South Atlantic is managed under the FMP. The FMP was prepared by the Council and is implemented under the authority of the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) by regulations at 50 CFR part 622.

The Council has proposed to adjust management measures for the South Atlantic golden crab fishery. The Council has submitted this regulatory amendment to NMFS for its review, approval, and implementation. These measures were developed and submitted to NMFS under the FMP's framework procedure for adjustments in gear regulations and permit requirements.

Use of Cable for Mainlines

The Council proposes that the use of cable for mainlines be allowed through January 31, 1999, to allow for additional evaluation of cable in the golden crab fishery. Under current regulations at 50 CFR 622.40(d)(2)(ii), rope is the only material allowed for a buoy line or mainline attached to a golden crab trap, except that wire cable is allowed for these purposes through January 31, 1998. The Council heard extensive discussion of the issue at the joint Golden Crab Advisory Panel/Committee meeting June 16, 1997, in Key West. The Council considered extending the authorized use of cable for buoy lines but declined to do so based on safety issues raised by the Coast Guard. The Council will reexamine the use of cable in the golden crab fishery when it reviews the status of the fishery in June 1998.

Vessel Size Limitations

The Council proposes to ease the limitations on vessel size that apply when NMFS transfers a permit from one vessel to another. To obtain a vessel permit by transfer of an existing permit under current regulations, the owner of the receiving vessel must acquire a permit from a vessel with documented length overall, or permits from vessels with aggregate lengths overall, of at least 90 percent of the documented length overall of the receiving vessel. However, some owners want to use temporarily a shorter vessel (i.e., downsize) and subsequently return to a longer vessel. Current regulations may prevent them from doing so, because the permit NMFS transfers to a shorter vessel cannot be transferred again to a vessel that is more than 11.1 percent longer than that smaller-sized vessel.

To provide fishermen with greater flexibility in their choice of vessel length, the Council and this rule propose that, when NMFS has transferred a golden crab limited access permit to a smaller vessel, a subsequent transfer to a longer vessel will be limited based on the length of the vessel permitted prior to downsizing. For example, if NMFS transfers a permit issued to a vessel that is 90 ft (27.4 m) long to a vessel that is 50 ft (15.2 m) long, NMFS could subsequently transfer the permit to a vessel that is 100 ft (30.5 m) long. Such a transfer would be allowed because the length of the permitted vessel prior to downsizing is 90 percent of the length of the replacement vessel. The Council concluded that limiting vessel length based on the length of the permitted vessel prior to downsizing meets the Council's intent to cap fishing effort while at the same time providing greater flexibility for fishermen to use shorter vessels temporarily.

Changes Proposed by NMFS

NMFS proposes to remove from the regulations the eligibility criteria and procedures for obtaining initial commercial vessel permits for the South Atlantic golden crab fishery. All initial permits have been issued, and no additional permits are being issued. Therefore, the criteria and procedures are no longer applicable. This change would be accomplished by moving from § 622.17 to § 622.4 the permit requirement for the fishery and by removing from § 622.17 the paragraphs on initial eligibility, documentation of eligibility, application procedure, issuance, and appeals. The paragraph on display of a permit, which is adequately covered in § 622.4, would also be removed.

Classification

This proposed rule has been determined to be not significant for purposes of E.O. 12866.

The Assistant General Counsel for Legislation and Regulation of the Department of Commerce, based on the Council's regulatory impact review (RIR) that assesses the economic impacts of the management measures proposed in this rule on fishery participants, certified to the Chief Counsel for Advocacy of the Small Business Administration that this proposed rule, if adopted, would not have a significant economic impact on a substantial number of small entities as follows:

* * * the provisions extending use of cable for mainlines and easing the restrictions on vessel size that would apply when NMFS transfers a permit from one vessel to another would not have adverse economic effects on a substantial number of the firms that own and operate fishing vessels for golden crabs in the South Atlantic Region. All such firms are considered small entities for purposes of the Regulatory Flexibility Act. These actions would not be expected to cause any reduction in revenue or force fishermen to modify their fishing operations. No increase in production cost would be expected as a result of these actions. The proposed actions would not require any existing fishing entity to acquire new equipment or to completely refit existing equipment for compliance purposes. The economic analyses do not indicate that any entity would be forced out of business. On the contrary, the actions would enable permitted fishermen to participate actively in the fishery and contribute toward developing the market for golden crab.

As a result, a regulatory flexibility analysis was not prepared.

This rule repeats a collection-of-information requirement subject to the Paperwork Reduction Act which has been approved by the Office of Management and Budget under control number 0648–0205. Permit applications involving transfers are estimated to take 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate, or any other aspect of this data collection, including suggestions for reducing the burden, to NMFS (see **ADDRESSES**) and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC. 20503 (Attention: NOAA Desk Officer).

List of Subjects in 50 CFR Part 622

Fisheries, Fishing, Puerto Rico, Reporting and recordkeeping requirements, Virgin Islands.

Dated: June 19, 1998.

Rolland A. Schmitten,

Assistant Administrator for Fisheries, National Marine Fisheries Service.

For the reasons set out in the preamble, 50 CFR part 622 is proposed to be amended as follows:

PART 622—FISHERIES OF THE CARIBBEAN, GULF, AND SOUTH ATLANTIC

1. The authority citation for part 622 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In § 622.4, paragraph (a)(2)(x) is added to read as follows:

§ 622.4 Permits and fees.

(a) * * *

(2) * * *

(x) For a person aboard a vessel to fish for golden crab in the South Atlantic EEZ, possess golden crab in or from the South Atlantic EEZ, off-load golden crab from the South Atlantic EEZ, or sell golden crab in or from the South Atlantic EEZ, a commercial vessel permit for golden crab must be issued to the vessel and must be on board. It is a rebuttable presumption that a golden crab on board a vessel in the South Atlantic or off-loaded from a vessel in a port adjoining the South Atlantic was harvested from the South Atlantic EEZ. See § 622.17 for limitations on the use, transfer, and renewal of a commercial vessel permit for golden crab.

* * * * *

§ 622.5 [Amended]

3. In § 622.5, in paragraph (a)(1)(v), the reference to ''§ 622.17(a)'' is removed and ''§ 622.4(a)(2)(x)'' is added in its place.

§ 622.6 [Amended]

4. In § 622.6, in paragraph (a)(1)(i) introductory text, the phrase ''or § 622.17'' is removed.

§ 622.7 [Amended]

5. In § 622.7, in paragraphs (a) and (b), the phrase ''or § 622.17'' is removed, in paragraph (c), the phrase ''or § 622.17(g)'' is removed, and in paragraph (z), the reference to ''§ 622.17(h)'' is removed and ''§ 622.17(b)'' is added in its place.

§ 622.8 [Amended]

6. In § 622.8, in paragraph (a), the reference to ''§ 622.17(a)'' is removed and ''§ 622.4(a)(2)(x)'' is added in its place.

7. Section 622.17 is revised to read as follows:

§ 622.17 South Atlantic golden crab controlled access.

(a) *General.* In accordance with the procedures specified in the Fishery Management Plan for the Golden Crab Fishery of the South Atlantic Region, initial vessel permits have been issued for the fishery. No additional permits may be issued.

(b) *Fishing zones.* (1) The South Atlantic EEZ is divided into three fishing zones for golden crab. A permitted vessel may fish for golden crab only in the zone shown on its permit. A vessel may possess golden crab only in that zone, except that other zones may be transited if the vessel notifies NMFS, Office of Enforcement, Southeast Region, St. Petersburg, FL, by telephone (813–570–5344) in advance and does not fish in an unpermitted zone. The designated fishing zones are as follows:

(i) Northern zone—the South Atlantic EEZ north of 28° N. lat.

(ii) Middle zone—the South Atlantic EEZ from 25° N. lat. to 28° N. lat.

(iii) Southern zone—the South Atlantic EEZ south of 25° N. lat.

(2) An owner of a permitted vessel may request that NMFS change the zone specified on a permit from the middle or southern zone to the northern zone. A request for such change and the existing permit must be submitted from an owner of a permitted vessel to the RD.

(c) *Transfer.* (1) An owner of a vessel with a valid golden crab permit may request that NMFS transfer the permit to another vessel by returning the existing permit(s) to the RD with an application for a permit for the replacement vessel.

(2) To obtain a commercial vessel permit via transfer, the owner of the replacement vessel must submit to the RD a valid permit for a vessel with a documented length overall, or permits for vessels with documented aggregate lengths overall, of at least 90 percent of the documented length overall of the replacement vessel.

(3) In addition to the provisions of paragraph (c)(2) of this section, the owner of a permitted vessel who has requested that NMFS transfer that permit to a smaller vessel (i.e., downsized), may subsequently request NMFS transfer that permit to a vessel of a length calculated from the length of the permitted vessel immediately prior to downsizing.

(d) *Renewal.* In addition to the procedures and requirements of § 622.4(h) for commercial vessel permit renewals, for a golden crab permit to be renewed, the SRD must have received reports for the permitted vessel, as required by § 622.5(a)(1)(v), documenting that at least 5,000 lb (2,268 kg) of golden crab were landed from the South Atlantic EEZ by the permitted vessel during at least one of the two 12-month periods immediately prior to the expiration date of the vessel permit.

§ 622.31 [Amended]

8. In § 622.31, in paragraph (a) the phrase ''or § 622.17'' is removed.

§ 622.35 [Amended]

9. In § 622.35, in paragraph (f), the reference to ''§ 622.17(h)'' is removed and ''§ 622.17(b)'' is added in its place.

10. In § 622.40, in paragraph (c)(3)(ii), the reference to ''§ 622.17(h)'' is removed and ''§ 622.17(b)'' is added in its place and paragraph (d)(2)(ii) is revised to read as follows:

§ 622.40 Limitations on traps and pots.

* * * * *

(d) * * *

(2) * * *

(ii) Rope is the only material allowed to be used for a buoy line or mainline attached to a golden crab trap, except that wire cable is allowed for a buoy line through January 31, 1998, and for a mainline through January 31, 1999.

§ 622.45 [Amended]

11. In § 622.45, in paragraph (f)(2), the reference to ''§ 622.17(a)'' is removed and ''§ 622.4(a)(2)(x)'' is added in its place.

[FR Doc. 98–17129 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–22–F

Notices

Federal Register
Vol. 63, No. 123
Friday, June 26, 1998

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

Forest Service

Development of the Land and Resource Management Plan for the Midewin National Tallgrass Prairie; Will County, IL

AGENCY: Forest Service, USDA.

ACTION: Notice; intent to prepare an Environmental Impact Statement.

SUMMARY: The purpose of this notice is to inform the public that the Forest Service intends to prepare an environmental impact statement for the development of the Midewin National Tallgrass Prairie Land and Resource Management Plan (Prairie Plan) (pursuant to 16 U.S.C. 1604 and 36 CFR 219.12).

We are now soliciting comments and suggestions from individuals, organizations, Federal agencies, State and local governments, and the Native American community on the scope of the analysis to be included in the Draft Environmental Impact Statement for the Prairie Plan (40 CFR 1501.7). To be most useful, comments should (1) consider the purposes for which Midewin was established as outlined in the Illinois Land Conservation Act of 1995 (PL 104–106, section 2914); (2) identify specific concerns about the Prairie Plan Proposal, and; (3) offer possible alternatives for addressing issues associated with the proposal.

Forest Service Land and Resource Management Plans set forth goals, objectives, advisable courses of action, and limitations to actions for National Forest System lands. The advisable courses of action and limitations to actions are called standards and guidelines. Some standards and guidelines will apply prairie-wide, while others will apply only to specific subdivisions, or management areas, of the prairie. The Prairie Plan will include a framework for monitoring and evaluation to determine whether progress is being made toward reaching the goals, objectives, standards, and guidelines established in the plan. Monitoring and evaluation allows for adaptive management so adjustments can be made to the Prairie Plan as needed. There are six primary decisions that are made in Forest Service Land and Resource Management Plans as follows:

1. Unit-wide multiple-use goals and objectives (36 CFR 219.11 (b))
2. Unit-wide management requirements (36 CFR 219.27)
3. Management Area direction (36 CFR 219.11 (c))
4. Monitoring and evaluation requirements (36 CFR 219.11 (d))
5. Lands suited/not suited for timber production (36 CFR 219.14)
6. Recommendations to Congress (if any) (36 CFR 219.17)

For purposes of writing the Prairie Plan versus those plans written for National Forests, items 1–4 above will serve as the primary decisions to be made. With reference to item 5, the Midewin National Tallgrass Prairie does not contain lands suited for timber production because ''the land is not forest land * * * (36 CFR 219.14 (a) (1)).'' The reference for item 6 specifically mentions recommendations of ''potential wilderness areas'' which, given the cultural history, existing roads and railroad beds, is not relevant to Midewin lands.

In addition, project and activity level decisions may be made so long as they are specifically identified in the Record of Decision and site specific environmental effects are disclosed in the Environmental Impact Statement as required by the National Environmental Policy Act (NEPA).

In June, 1992, the U.S. Army confirmed its intentions to decommission the Joliet Army Ammunition Plant (JAAP) located just north of Wilmington, Illinois, and 40 miles southwest of Chicago, Illinois. As a result of the issues and attention the closure of the JAAP generated, the Joliet Arsenal Citizen Planning Commission (JACPC), comprised of 24 members representing various conservation organizations and State and local governments, was formed and assigned the task of developing a concept plan that would outline a strategy for the future ownership and management of the decommissioned arsenal. The plan was a concept map that provided for the conversion of 3,000 acres into two industrial parks, the development of a 910-acre National Veterans Cemetery, the creation of a 455-acre County landfill, and the establishment of a 19,000-acre prairie. The concept map was unanimously approved by the JACPC on May 30, 1995.

Legislation was drafted based on the JACPC concept map and signed as the Illinois Land Conservation Act of 1995 on February 10, 1996, adopting the JACPC concept map and establishing the Midewin National Tallgrass Prairie (MNTP). MNTP is a unit of the National Forest System and will be managed in cooperation with the State of Illinois in accordance with the Illinois Land Conservation Act of 1995 and the ''laws, rules, and regulations pertaining to the National Forest System * * * (Section 2914 (b) (1)).''

That portion of the Illinois Land Conservation Act of 1995 that is most significant to the planning process is Section 2914(c) which states that ''(t)he Midewin National Tallgrass Prairie (MNTP) is established to be managed for National Forest System purposes, including the following:

I. To manage the land and water resources of the MNTP is a manner that will conserve and enhance the native populations and habitats of fish, wildlife, and plants.

II. To provide opportunities for scientific, environmental, and land use education and research.

III. To allow the continuation of agricultural uses of lands within the MNTP consistent with section 2915(b).[1]

IV. To provide a variety of recreation opportunities that are not inconsistent with the preceding purposes.

This is the public's opportunity to get involved with the planning process for a new unit for the Forest Service that has been closed to public access for more than 50 years. The site has had little or no established uses other than agricultural leases and some hunting

[1] No agricultural special uses authorization shall be issued for agricultural purposes which has a term extending beyond the date 20 years from the date of the enactment of this title, except that nothing in this title shall preclude the Secretary of Agriculture from issuing agricultural special use authorizations or grazing permits * * * after twenty years * * * for purposes primarily related to * * * resource management activities consistent with the purpose of the Midewin National Tallgrass Prairie (*Section 2915 [b][3]*).

opportunities. The MNTP is in its infancy of development and, within the parameters of the Illinois Land Conservation Act of 1995 and the laws and regulations that guide Forest Service programs, the Forest Service needs to know how the public would like to see the MNTP developed and managed.

Numerous site tours, presentations, displays, Focus Group Sessions, meetings, and a Trails Working group have already taken place to provide information regarding Midewin, its history, the legislation, and the Forest Service planning process to individuals and organizations that have expressed an interest in the development and management of the MNTP. The meetings included two pre-Notice of Intent public workshops hosted by Midewin, in May, 1998, to review a draft Notice of Intent. Information gathered from these opportunities has been used to identify an initial set of significant issues that will need to be addressed in the Environmental Impact Statement. Those issues include: automobiles, bison and/or elk reintroduction, camping, cultural resources, dog trialing, emergency response, environmental education and interpretation, fishing, herbicide treatment, hunting, internal transportation system, prescribed fire, recreation facilities, trail systems, wetland restoration, and woody vegetation management.

Based on the issues identified to date, the purposes for the management of the MNTP as outlined in the Illinois Land Conservation Act of 1995 and listed in this Notice of Intent, and the JACPC concept map, Medewin has developed a Prairie Plan proposal. This proposal will serve as the basis upon which individuals and organizations may comment regarding issues, concerns, or opportunities provided or not provided by the proposal. Issues, concerns, and opportunities already identified (listed above) and others raised through the comment period for this Notice of Intent will be evaluated and used to develop alternatives to the proposal for the Environmental Impact Statement.

The primary activities that would occur under the proposal include: development of seed-producing nursery beds; reintroduction of bison and elk; integrated pest management; gradual conversion of cultivated row crops to prairie habitats; prescribed fire; wetland restoration; woody vegetation management; environmental education and interpretation programs; research opportunities; use of domestic livestock; designated access points; fishing for educational programs; hunting; internal transportation system (e.g., bus or tram); rail line access; recreation facilities (e.g., shelters picnic areas); an automobile loop; and a system of trails.

The environmental analysis and decision-making process leading to the Prairie Plan will include opportunities for public participation and comment, so that individuals interested in this proposal may contribute to the decision-making process:

Tentative date	Step	Public involvement
June 1998	Notice of Intent, Plan proposal	60-day formal comment period, written comments, open house meeting.
Fall, 1998	Alternative Development	Public workshops.
February, 1999	Draft Environmental Impact Statement, Proposed Plan	90-day formal comment period, written comments, open house meetings.
August, 1999	Final Environmental Impact Statement, Final Plan	Informational meetings to explain Plan decisions.

We will provide the public with general notices of opportunities to participate through mailings, news releases, an public meetings, various organizational newsletters, and the internet. Midewin's internet address is http://www.fs.fed.us/mntp/. In addition to formal opportunities for public comment, we will consider comments received at any time throughout the planning process. Midewin will host open house meetings to: 1) explain the planning process; 2) provide clarification of the proposal for the Prairie Plan; 3) describe ways that individuals can respond to this Notice of Intent; and 4) accept comments from the public on the propsoal for the Prairie Plan.

The following open house meetings will be held from 5 PM to 8PM:

July 21, 1998—Beverly Bank, Wilmington, IL
July 23, 1998—Morton Arboretum, Lisle, IL
July 28, 1998—Governor State University, University Park, IL
July 29, 1998—Evanston Public Library, Evanston, IL
July 30, 1998—Morris Public Library, Morris, IL

DATES: Comments on this Notice of Intent should be received in writing by August 31, 1998.

ADDRESSES: Send written comments to: Prairie Planning, Midewin National Tallgrass Prairie, 30071 South State Route 53, Wilmington, Illinois 60481.

FOR FURTHER INFORMATION CONTACT: Karen Nash, Planning Team Leader, at (815) 476–3135 or, to leave a message, (815) 423–6370. E-mail address: knash/r9__midewin@fs.fed.us.

SUPPLEMENTARY INFORMATION: Additional detail on this propsoal is provided in the ''Notice of Intent to Prepare an Environmental Impact Statement, Description of the Proposal for the Prairie Plan, and Supplementary Information'' and is available upon request. Those interested in Midewin and the planning process are encouraged to review this additional document prior to commenting on the Notice of Intent.

The DEIS and the proposed Prairie Plan are expected to be be published early in 1999. The public comment period for the DEIS and proposed Prairie Plan will be 90 days from the date the U.S. Environmental Protection Agency publishes the Notice of Availability in the **Federal Register.**

Comments received in response to this solicitation, including names and addresses of those who comment, will be considered part of the public record on this proposed action and will be available for public inspection. Comments submitted anonymously will be accepted and considered; however, those who submit anonymous comments will not have standing to appeal the subsequent decision under 36 CFR parts 215 or 217.

Additional, pursuant to 7 CFR 1.27(d), any person may request the agency to withhold a submission from the public record by showing how the Freedom of Information Act (FOIA) permits such confidentiality. Persons requesting such confidentiality should be aware that, under the FOIA, confidentiality may be granted in only very limited circumstances, such as to protect trade secrets.

The Forest Service will inform the requester of the agency's decision regarding the request for confidentiality, and, where the requester is denied, the agency will return the submission and notify the requester that the comments

may be resubmitted with or without name and address within 10 days.

The Forest Service believes that, at this early stage, it is important to give notice to those intending to review the DEIS of court rulings related to public participation in the environmental review process. First, reviewers of a DEIS must structure their participation in the environmental review of the proposal so that it is meaningful and alerts an agency to the reviewer's position and contentions (*Vermont Yankee Nuclear Power Corp.* v. *NRDC* U.S. 519, 533 [1978]). Also, environmental objections that could be raised at the DEIS stage but are not raised until after completion of the Final Environmental Impact Statement may be waived or dismissed by the courts (*City of Angoon* v. *Hodel*, 803 F.2d 1016, 1022 [9th Cir. 1986] and *Wisconsin Heritages, Inc.* v. *Harris*, 409 F. Supp. 1334, 1338 [E.D. Wis. 1980).

Because of these court rulings, it is very important that those interested in this proposed action participate by the close of the 90-day comment period on the DEIS, so that substantive comments and objections are made available to the Forest Service at a time when it can meaningfully consider them and respond to them in the Final Environmental Impact Statement.

To assist the Forest Service in identifying and considering issues and concerns on the proposed action, comments on the DEIS should be as specific as possible. It is also helpful if comments refer to specific pages or chapters of the DEIS or the merits of the alternatives formulated and discussed in the statement.

Reviewers may wish to refer to the Control on Environmental Quality regulations for implementing the procedural provisions of the National Environmental Policy Act (at 40 CFR 1503.3) in addressing these points.

The responsible official is Robert T. Jacobs, Regional Forester, Eastern Region, 310 W. Wisconsin Avenue, Milwaukee, Wisconsin 53203.

Dated: June 22, 1998.

Robert T. Jacobs,

Regional Forester.

[FR Doc. 98–17093 Filed 6–25–98; 8:45 am]

BILIING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Forest Service

Oregon Coast Provincial Advisory Committee Meeting

AGENCY: Forest Service, USDA.

ACTION: Notice of Meeting.

SUMMARY: The Oregon Coast Provincial Advisory Committee (PAC) will meet on July 9, 1998, in Tillamook, Oregon, at the Shilo Inn, 2515 N. Main Street (Highway 101), Tillamook, OR. The meeting will begin at 9 a.m. and continue until 3:30 p.m. Agenda items to be covered include: (1) Reports from PAC Subcommittees (Adapative Management Area and Water Quality/ Fish); (2) flood analyses by State of Oregon and other agencies, (3) road management, and (4) landscape level research. All Oregon Coast Provincial Advisory Committee meetings are open to the public. Two 15-minute open public forums are scheduled for 10 a.m. and 2:15 p.m. Interested citizens are encouraged to attend. The committee welcomes the public's written comments on committee business at any time.

FOR FURTHER INFORMATION CONTACT: Direct questions regarding this meeting to Trish Hogervorst, Public Affairs Officer, Bureau of Land Management, at (503) 375–5657, or write to Forest Supervisor, Siuslaw National Forest, P.O. Box 1148, Corvallis, Oregon 97339.

Dated: June 18, 1998.

James R. Furnish,

Forest Supervisor.

[FR Doc. 98–16987 Filed 6–25–98; 8:45 am]

BILLING CODE 3410–11–M

DEPARTMENT OF AGRICULTURE

Natural Resources Conservation Service

Cochgalechee Creek Watershed, Russell County, AL; Availability of No Significant Impact

AGENCY: Natural Resources Conservation Service, USDA.

ACTION: Notice of a Finding Of No Significant Impact.

SUMMARY: Pursuant to Section 102(2)(c) of the National Environmental Policy Act of 1969; the Council on Environmental Quality Regulations (40 CFR part 1500); and the Natural Resources Conservation Service Regulations (7 CFR part 650); the Natural Resources Conservation Service, U.S. Department of Agriculture, gives notice that an environmental impact statement is not being prepared for the Cochgalechee Creek Watershed, (Russell County, Alabama).

FOR FURTHER INFORMATION CONTACT: Ronnie D. Murphy, State Conservationist, Natural Resources Conservation Service, 3381 Skyway Drive, Auburn, Alabama, 36830, (334) 887–4535.

SUPPLEMENTARY INFORMATION: The environmental assessment of this federally assisted action indicates that the project will not cause significant local, regional, or national impacts on the environment. As a result of these findings, Ronnie D. Murphy, State Conservationist, has determined that the preparation and review of an environmental impact statement are not needed for this project.

The project purpose is flood prevention. The planned works of improvement include: selective clearing and snagging, and sediment removal in Cochgalechee Creek from 1000 feet downstream of Brickyard Road to Seale Road (2 miles), and selective placement of riprap around bridges.

The notice of a Finding Of No Significant Impact (FONSI) has been forwarded to the Environmental Protection Agency and to various Federal, State, and local agencies and interested parties. A limited number of copies of the FONSI are available to fill single copy requests at the above address. Basic data developed during the environmental assessment are on file and may be reviewed by contacting Ronnie D. Murphy, State Conservationist.

No administrative action on implementation of the proposal will be taken until 30 days after the date of this publication in the **Federal Register**.

Ronnie D. Murphy,

State Conservationist.

[FR Doc. 98–16988 Filed 6–25–98; 8:45 am]

BILLING CODE 3410–16–M

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List Additions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Additions to the Procurement List.

SUMMARY: This action adds to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities.

EFFECTIVE DATE: July 27, 1998.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Gateway 3, Suite 310, 1215 Jefferson Davis Highway, Arlington, Virginia 22202–4302.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603–7740.

SUPPLEMENTARY INFORMATION: On May 8, 1998, the Committee for Purchase From People Who Are Blind or Severely Disabled published notice (63 F.R. 25445) of proposed additions to the Procurement List. After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the services and impact of the additions on the current or most recent contractors, the Committee has determined that the services listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4. I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.

2. The action will not have a severe economic impact on current contractors for the services.

3. The action will result in authorizing small entities to furnish the services to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41U.S.C. 46–48c) in connection with the services proposed for addition to the Procurement List.

Accordingly, the following services are hereby added to the Procurement List:

Base Supply Center, Dyess Air Force Base, Texas
Base Supply Center, Bangor Submarine Base, Bangor, Washington
Base Supply Center, Naval Air Station, Whidbey Island, Washington
Operation of Individual Equipment Element, Dyess Air Force Base, Texas

This action does not affect current contracts awarded prior to the effective date of this addition or options that may be exercised under those contracts.

Beverly L. Milkman,

Executive Director.

[FR Doc. 98–17105 Filed 6–25–98; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List Proposed Additions and Deletions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Proposed Additions to and Deletions from Procurement List.

SUMMARY: The Committee has received proposal(s) to add to the Procurement List services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and to delete commodities previously furnished by such agencies.

COMMENTS MUST BE RECEIVED ON OR BEFORE: July 27, 1998.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Crystal Gateway 3, Suite 310, 1215 Jefferson Davis Highway, Arlington, Virginia 22202–4302.

FOR FURTHER INFORMATION CONTACT: Beverly Milkman (703) 603–7740.

SUPPLEMENTARY INFORMATION: This notice is published pursuant to 41 U.S.C. 47(a) (2) and 41 CFR 51–2.3. Its purpose is to provide interested persons an opportunity to submit comments on the possible impact of the proposed actions.

Additions

If the Committee approves the proposed addition, all entities of the Federal Government (except as otherwise indicated) will be required to procure the services listed below from nonprofit agencies employing persons who are blind or have other severe disabilities.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the services to the Government.

2. The action does not appear to have a severe economic impact on current contractors for the services.

3. The action will result in authorizing small entities to furnish the services to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the services proposed for addition to the Procurement List. Comments on this certification are invited. Commenters should identify the statement(s) underlying the certification on which they are providing additional information.

The following services have been proposed for addition to Procurement List for production by the nonprofit agencies listed:

Administrative Services

General Services Administration, Federal Protective Services, 255 East Temple, Los Angeles, California
NPA: Goodwill Industries of Southern California, Los Angeles, California

Administrative Services

Department of Veterans Affairs Medical Center, 4100 West Third Street, Buildings 315 and 330, Dayton, Ohio
NPA: The Clovernook Center, Opportunities for the Blind, Cincinnati, Ohio
Base Supply Center, Malmstrom Air Force Base, Montana,
NPA: Industries for the Blind, Inc., Milwaukee, Wisconsin
Base Supply Center, U.S. Naval Station, Roosevelt Roads, Building 1207, Ceiba, Puerto Rico
NPA: Winston-Salem Industries for the Blind, Winston-Salem, North Carolina
Food Service Attendant, Holloman Air Force Base, New Mexico
NPA: Tresco, Inc., Las Cruces, New Mexico
Grounds Maintenance, Franklin D. Roosevelt Library, Hyde Park, New York
NPA: Dutchess County Chapter, NYSARC, Inc., Poughkeepsie, New York
Janitorial/Custodial, United States Geological Survey Building, Colorado School of Mines, 1711 Illinois Street, Golden, Colorado
NPA: Bayaud Industries, Inc., Denver, Colorado
Janitorial/Custodial, Pentagon Building, 3rd and 4th Floor, Arlington, Virginia
NPA: Ability Unlimited, Inc., Washington, DC
Switchboard Operation, Davis-Monthan Air Force Base, Arizona
NPA: Tucson Association for the Blind and Visually Impaired, Tucson, Arizona

Deletions

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities.

2. The action does not appear to have a severe economic impact on future contractors for the commodities.

3. The action will result in authorizing small entities to furnish the commodities to the Government.

4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the commodities proposed for deletion from the Procurement List.

The following commodities have been proposed for deletion from the Procurement List:

Tray, Fiberboard, Three-Sided
P.S. #D–3915

P.S. #136
Tag, Cattle, Ear
9905–00–NSH–0027
9905–00–NSH–0028
9905–00–NSH–0029

(60% of the Government's requirement for the Department of Agriculture, Minneapolis, Minnesota)

Beverly L. Milkman,

Executive Director.

[FR Doc. 98–17106 Filed 6–25–98; 8:45 am]

BILLING CODE 6353–01–P

DEPARTMENT OF COMMERCE

International Trade Administration

North American Free Trade Agreement, Article 1904 Binational Panel Reviews

AGENCY: NAFTA Secretariat, United States Section, International Trade Administration, Department of Commerce.

ACTION: Notice of decision of binational panel and notice of completion of panel review.

SUMMARY: Pursuant to the third panel decision issued on April 13, 1998 that affirmed SECOFI's second Determination on Remand, the binational panel review in Secretariat File No. MEX–94–1904–01 was completed on May 25, 1998.

FOR FURTHER INFORMATION CONTACT: James R. Holbein, United States Secretary, NAFTA Secretariat, Suite 2061, 14th and Constitution Avenue, Washington, D.C. 20230, (202) 482–5438.

SUPPLEMENTARY INFORMATION: Chapter 19 of the North American Free Trade Agreement (''Agreement'') establishes a mechanism to replace domestic judicial review of final determinations in antidumping and countervailing duty cases involving imports from a NAFTA country with review by independent binational panels. When a Request for Panel Review is filed, a panel is established to act in place of national courts to review expeditiously the final determination to determine whether it conforms with the antidumping or countervailing duty law of the country that made the determination.

Under Article 1904 of the Agreement, which came into force on January 1, 1994, the Government of the United States, the Government of Canada and the Government of Mexico established *Rules of Procedure for Article 1904 Binational Panel Reviews* (''Rules''). These Rules were published in the **Federal Register** on February 23, 1994 (59 FR 8686). The binational panel review in this matter was conducted in accordance with these Rules.

Background and Final Decision

The panel in Secretariat File No. 94–1904–01 was convened to review the final antidumping duty determination made by the Secretaria de Comercio y Fomento Industrial (SECOFI) with respect to Imports of Cut-to-Length Plate, Covered by Customs Tariff Classifications 7208.32.01, 7208.33.01 7208.42.01 and 7208.43.01 of the Tariff Schedule of the General Tax Import Law, Originating in and Exported from the United States of America.

On September 15, 1997 the Panel issued a decision affirming in part and remanding in part the first Remand Determination of SECOFI for further action. On January 13, 1998 SECOFI submitted its second Remand Determination, which was challenged on February 2, 1998 under the Rules by New Process Steel Corporation. On April 13, 1998 after review of all documents filed in this action on remand, the Panel denied New Process's challenge to SECOFI's second Remand Determination dated January 13, 1998 and affirmed the second Remand Determination in all its parts.

The Secretariat was instructed to issue a Notice of Completion of Panel Review on the 31st day following the issuance of the Notice of Final Panel Action, if no Request for an Extraordinary Challenge was filed. No such request was filed. Therefore, on the basis of the Panel Order and Rule 80 of the *Article 1904 Panel Rules,* the Panel Review was completed and the panelists discharged from their duties effective on May 25, 1998.

Dated: June 4, 1998.

James R. Holbein,

United States Secretary, NAFTA Secretariat.

[FR Doc. 98–17110 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–GT–M

DEPARTMENT OF COMMERCE

Minority Business Development Agency

Phoenix (Formerly Automated Business Enterprise Locator System (ABELS)) and Opportunity Databases

ACTION: Proposed collection; comment request.

SUMMARY: The Department of Commerce, as part of its continuing effort to reduce paperwork and respondent burden, invites other Federal agencies and the general public to take this opportunity to comment on proposed or continuing information collections, as required by the Paperwork Reduction Act of 1995, Pub.L. 104–13 (44 U.S.C. 3506(c)(2)(A)).

DATES: Written comments must be submitted on or before August 25, 1998.

ADDRESSES: Direct all written comments to Linda Engelmeier, Departmental Forms Clearance Officer, Department of Commerce, Room 5327, 14th and Constitution Avenue, N.W., Washington, DC 20230.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection instrument and instructions should be directed to Juanita Berry, Minority Business Development Agency (MBDA), Room 5084, Washington, D.C. 20230, or call (202) 482–0404.

SUPPLEMENTARY INFORMATION:

I. Abstract

The Phoenix database constitutes the Minority Business Development Agency's (MBDA) listing of ethnic minority-owned businesses doing business in the United States. Phoenix information is gathered on-line via the Internet's World Wide Web (WWW). The information entered in the Phoenix database will be used to assist minority enterprises with marketing of goods and services. The Opportunity database is a listing of contract and other business opportunities posted on the MBDA Website (*www.mbda.gov*) by public and private entities. Using a database engine and special software, the system will match contract opportunities with eligible minority companies listed in the Phoenix database. The purpose for collecting this information will be to enable entities with an interest in contracting with a minority firm to identify and qualify potential minority contractors according to various criteria. MBDA will use the Phoenix database in conjunction with the Opportunity database to refer listed minority companies contract and other business opportunities via email and fax. Specific information on the Opportunity form, such as ''key words'' and NAICS (North American Industrial Code Standards) codes, will be compared with like information contained in the Phoenix database of minority companies. When a match is made, the eligible minority companies will be notified of any contract opportunity and the offeror of the opportunity will be notified of any eligible minority companies.

II. Method of Collection

The system resides on Y2K (year 2000) compliant platform connected to the service-provider network via the Internet and virtual private network.

III. Data

OMB Number: 0640–0002.
Type of Review: Regular.
Burden: 5,000.
Affected Public: Individuals, State or local government, Federal agencies, and profit and non-profit institutions.
Estimated Number of Respondents: 20,000.
Estimated Time Per Response: 15 minutes.
Estimated Total Annual Burden Hours: 5,000.
Estimated Total Annual Cost Per Respondent: $0—no capital expenditures are necessary to respond.

IV. Request for Comments

Comments are invited on (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden (including hours and cost) of the proposed collection of information; (c) ways to enhance the quality, utility and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents.

Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval of this information collection; they also will become a matter of public record.

Dated: June 22, 1998.

Wilson D. Haigler,

Chief, Management Control Division, Office of Management and Organization.

[FR Doc. 98–17044 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–21–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

Solicitation for Sea Grant Review Panelists

AGENCY: National Oceanic and Atmospheric Administration, Office of Oceanic and Atmospheric Research (OAR), National Sea Grant Review Panel.

ACTION: Notice of Solicitation for Sea Grant Review Panelists.

SUMMARY: This notice responds to Section 209(c) of the National Sea Grant College Program Act, 33 U.S.C. 1128, which requires the Secretary of Commerce to solicit nominations for membership on the Sea Grant Review Panel at least once a year. This advisory committee provides advice on the implementation of the National Sea Grant College Program.

DATES: Resumes should be sent to the address specified and must be received on or before July 27, 1998.

ADDRESS: Dr. Ronald C. Baird, Director; National Sea Grant College Program; 1315 East-West Highway, Room 11716; Silver Spring, Maryland 20910.

FOR FURTHER INFORMATION CONTACT: Dr. Ronald Baird of the National Sea Grant College Program at the address given above; telephone (301) 713–2448 or fax number (301) 713–1031.

SUPPLEMENTARY INFORMATION: Section 209 of the Act establishes a Sea Grant Review Panel to advise the Secretary of Commerce, the Under Secretary for Oceans and Atmosphere, and the Director of the National Sea Grant College Program on the implementation of the Sea Grant Program. The panel provides advice of such matters as:

(a) The Sea Grant Fellowship Program;

(b) Applications or proposals for, and performance under, grants and contracts award under section 205 and section 205 of the Sea Grant Program Improvement Act of 1976 as amended (33 U.S.C. 1124);

(c) The designation and operation of sea grant colleges and sea grant institutes; and the operation of the sea grant program;

(d) The formulation and application of the planning guidelines and priorities under section 204(a) and (c)(1) (33 U.S.C. 1123 (a) and (c)(1)); and

(e) Such other matters as the Secretary refers to the panel for review and advice.

The Panel is to consist of 15 voting members composed as follows: Not less than eight of the voting members of the panel should be individuals who, by reason of knowledge, experience, or training, are especially qualified in one or more of the disciplines and fields included in marine science. The other voting members shall be individuals who by reason of knowledge, experience, or training, are especially qualified in, or representative of, education, extension service, state government, industry, economics, planning, or any other activity which is appropriate to, and important for, any effort to enhance the understanding, assessment, development, utilization, or conservation of ocean and coastal resources. No individual is eligible to be a voting member of the panel if the individual is (a) the director of a sea grant college, sea grant regional consortium, or sea grant program, (b) an applicant for or beneficiary (as determined by the Secretary) of any grant or contract under Section 205 (33 U.S.C. 1124) or (c) a full-time officer or employee of the United States. The Director of the National sea grant College Program and one Director of a sea grant Program also serve as non-voting members. Positions on the panel will become vacant during 1998. Candidates who are selected to fill these vacancies will be appointed for a 3-year term.

Dated: June 22, 1998.

Elbert W. Friday, Jr.,

Assistant Administrator for Oceanic and Atmospheric Research.

[FR Doc. 98–16986 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–12–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 042398D]

Vessel Registration and Fisheries Information System

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of availability.

SUMMARY: The Sustainable Fisheries Act, passed in October 1996, added various amendments to the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act). Section 401 of the Magnuson-Stevens Act requires the Secretary of Commerce (Secretary) to deliver an implementation plan for a national fishing vessel registration and fisheries information system (System) in a Report to Congress. NMFS has developed, in consultation with interested parties, a draft of the implementation plan.

DATES: Written comments on the implementation plan must be received on or before August 25, 1998.

ADDRESSES: Address all comments concerning this notice to: Fisheries Statistics and Economic Division (F/ST1), National Marine Fisheries Service, 1315 East-West Highway, Silver Spring, MD 20910; (301) 713–2328; fax (301) 713–4137. The implementation plan is available for public comment by mail from the address here, or in electronic form (pdf format) via the world wide web at http://www.nmfs.gov/sfa.

FOR FURTHER INFORMATION CONTACT: Mark Holliday, (301) 713–2328.

SUPPLEMENTARY INFORMATION: Section 401 of the Magnuson-Stevens Act, amended in 1996, directs the Secretary

to deliver a report to Congress on the implementation of a national fishing vessel registration and information management system.

NMFS, the U.S. Coast Guard, coastal states, the three regional commissions (Pacific States Marine Fisheries Commission, Gulf States Marine Fisheries Commission, and Atlantic States Marine Fisheries Commission), and the eight regional Fishery Management Councils (New England, Mid-Atlantic, South Atlantic, Gulf of Mexico, Caribbean, Pacific, North Pacific, and Western Pacific) play various roles in commercial fishing vessel registration and marine fisheries data collection. Consistent with previous directions from the Assistant Administrator of NMFS, NMFS has been engaged in collaborative processes to develop joint regional data collection and planning activities with these organizations. Section 401 of the Magnuson-Stevens Act directs the Secretary to create a plan that will coordinate the techniques used to collect and disseminate data and to integrate these vessel registration and fisheries information systems on a national basis. This is to be accomplished while taking into account the unique characteristics of regional fisheries.

Section 401 of the Magnuson-Stevens Act sets a number of benchmarks for a national vessel registration and fisheries information system. It also defines several principles that should guide the system's development. These include the reduction of duplicative information reporting burdens on the fishing industry and the integration of existing data collection and information management systems to the furthest extent possible.

NMFS organized the implementation plan into two components: the Vessel Registration System and the Fisheries Information System (FIS). Within these components, the proposed System addresses information management architecture, integration and harmonization of data collection programs, and the institutional arrangements and accountability issues.

Vessel Registration System

Vessel registration, licensing, and permitting systems among the coastal states, territories, tribal entities and the U.S. Coast Guard have been reviewed. The Magnuson-Stevens Act requests a plan for a national system that contains the following information for each fishing vessel: (1) The name and official number or other identification, together with the address of the owner or operator or both; (2) gross tonnage, vessel capacity, type and quantity of fishing gear, mode of operation, and other such pertinent information with respect to vessel characteristics as the Secretary may require; and (3) identification of the fisheries in which the fishing vessel participates. Currently, no vessel registration system at any level fully satisfies these criteria.

Fisheries Information System

State and Federal data collection programs and information management systems have developed over time to meet specific regional needs and reflect varying degrees of integration and management efficiency. These efforts, often state-Federal partnerships, have definite time frames and outcomes. NMFS has relied on these processes to support development of the section 401 FIS.

Process

The creation of the proposed system has targeted the highest level of detail possible in the draft report to produce specific and justifiable estimates of implementation steps and resource requirements. NMFS has consulted many major stakeholders, and has gathered input through a series of presentations and meetings with stakeholders, using a ''discussion draft'' paper to highlight critical issues and options. These stakeholders included internal NMFS organizational units as well as external entities. NMFS has, to the extent possible, reconciled the comments of the various stakeholders in the draft implementation plan.

Authority: Pub. L. 104–297.

Dated: June 22, 1998.

William W. Fox, Jr.,

Director, Office of Science and Technology, National Marine Fisheries Service.

[FR Doc. 98–17128 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–22–F

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

National Sea Grant Review Panel; Public Meeting

AGENCY: Office of Oceanic and Atmospheric Research (OAR), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public meeting.

SUMMARY: This notice sets forth the schedule and proposed agenda of a forthcoming meeting of the Sea Grant Review Panel. The meeting will have several purposes. Panel members will discuss and provide advice on the National Sea Grant College Program in the areas of program management and evaluation, national strategic investments, education and extension, technology problems, legislative changes and other matters as described below.

DATES: The announced meeting is scheduled during two days: Wednesday, July 8, 8:30 a.m. to 5 p.m.; Thursday, July 9, 8:30 a.m. to 3 p.m.

ADDRESSES: National Oceanic and Atmospheric Administration Silver Spring Metro Center III; 1315 East-West Highway, Room 11836; Silver Spring, Maryland 20910.

FOR FURTHER INFORMATION CONTACT: Dr. Ronald C. Baird, Director; National Sea Grant College Program; National Oceanic and Atmospheric Administration 1315 East-West Highway, Room 11716; Silver Spring, Maryland 20910;301) 713–2448 extension 163.

SUPPLEMENTARY INFORMATION: The Panel, which consists of a balanced representation from academia, industry, state government and citizens groups, was established in 1976 by Section 209 of the Sea Grant Improvement Act (Pub. L. 94–461, 33 U.S.C. 1128) and advises the Secretary of Commerce, the Under Secretary for Oceans and Atmosphere, also the Administrator of NOAA, and the Director of the National Sea Grant College Program with respect to operations under the act, and such other matters as the Secretary refers to the Panel for review and advice. The agenda for the meeting is as follows:

Wednesday, July 8, 1998

8:30 a.m.—Welcoming and Opening Formalities
9:00 a.m.—NOAA and National Sea Grant Office Update
10:30 a.m.—Sea Grant Association Update
12:00 p.m.—Working Lunch
1:30 p.m.—Program Evaluation
3:45 p.m.—Historically Black Colleges and Universities Evaluation Report
4:15 p.m.—Recognition Ceremony for Outgoing Review Panel Members
5:00 p.m.—Adjourn

Thursday, July 9, 1998

8:30 a.m.—National Strategic Initiatives Discussion
10:30 a.m.—Technology Update
11:30 a.m.—30th Anniversary Committee Update
11:45 a.m.—Working Lunch
1:30 p.m.—Sea Grant Review Panel Liaison Reports
2:00 p.m.—Sea Grant Review Panel Comments

2:30 p.m.—Summarization and Action Items
3:00 p.m.—Adjourn

This meeting will be open to the public.

Dated: June 22, 1998.

Elbert W. Friday, Jr.,

Assistant Administrator for Oceanic and Atmospheric Research.

[FR Doc. 98–16985 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–12–M

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 062298A]

Endangered Species; Permits

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Receipt of an application for a scientific research permit (1160).

SUMMARY: Notice is hereby given that the Washington Department of Fish and Wildlife at Vancouver, WA (WDFW) has applied in due form for a permit that would authorize takes of an ESA-listed anadromous fish species for the purpose of scientific research.

DATES: Written comments or requests for a public hearing on this application must be received on or before July 27, 1998.

ADDRESSES: The application and related documents are available for review in the following offices, by appointment:

Protected Resources Division (PRD), F/NWO3, 525 NE Oregon Street, Suite 500, Portland, OR 97232–4169 (503–230–5400); and

Office of Protected Resources, F/PR3, NMFS, 1315 East-West Highway, Silver Spring, MD 20910–3226 (301–713–1401).

Written comments or requests for a public hearing should be submitted to the Chief, PRD, in Portland, OR.

FOR FURTHER INFORMATION CONTACT: Robert Koch, PRD (503–230–5424).

SUPPLEMENTARY INFORMATION: WDFW requests a permit under the authority of section 10 of the Endangered Species Act (ESA) (16 U.S.C. 1531–1543) and the NMFS regulations governing ESA-listed fish and wildlife permits (50 CFR parts 217-227).

WDFW requests a 5-year permit (1160) that would authorize annual takes of adult and juvenile, threatened, lower Columbia River steelhead (*Oncorhynchus mykiss*) associated with scientific research designed to monitor steelhead genetic and biological parameters in the Wind River Basin in WA. The monitoring effort is an integral part of the Wind River Watershed Project, a federally funded watershed recovery program intended to rebuild depressed populations of Wind River summer steelhead. The scientific research is essential to contain risks associated with conservation actions proposed in the Wind River and to detect both desired and unintended consequences. ESA-listed adult fish are proposed to be observed/harassed during redd counts and snorkel surveys. ESA-listed adult fish are also proposed to be captured, handled (examined, sampled for tissues and/or scales, and/or marked/tagged), and released. ESA-listed juvenile fish are proposed to be observed during snorkel surveys or captured, handled (examined, sampled for tissues and/or scales, and/or marked/tagged), and released. ESA-listed juvenile fish indirect mortalities associated with the scientific research activities are also requested.

To date, protective regulations for threatened lower Columbia River steelhead under section 4(d) of the ESA have not been promulgated by NMFS. This notice of receipt of an application requesting takes of this species is issued as a precaution in the event that NMFS issues protective regulations that prohibit takes of lower Columbia River steelhead. The initiation of a 30-day public comment period on the application, including its proposed takes of lower Columbia River steelhead, does not presuppose the contents of the eventual protective regulations. Those individuals requesting a hearing on this application should set out the specific reasons why a hearing would be appropriate (see **ADDRESSES**). The holding of such a hearing is at the discretion of the Assistant Administrator for Fisheries, NOAA. All statements and opinions contained in the above application summary are those of the applicant and do not necessarily reflect the views of NMFS.

Dated: June 22, 1998.

Patricia A. Montanio,

Deputy Director, Office of Protected Resources, National Marine Fisheries Service.

[FR Doc. 98–17130 Filed 6–25–98; 8:45 am]

BILLING CODE 3510–22–F

DEPARTMENT OF DEFENSE

Department of the Navy

Notice of Availability of Invention for Licensing; Government Owned Invention

AGENCY: Department of the Navy, DOD.

ACTION: Notice.

SUMMARY: The inventions listed below are assigned to the United States Government as represented by the Secretary of the Navy and are available for licensing by the Department of the Navy.

Patent Application entitled ''Force Discrimination Assay,'' filed January 20, 1998, Navy Case No. 78183.

Patent Application entitled ''Apparatus and Method for Measuring Intermolecular Interactions By Atomic Force Microscopy,'' filed May 8, 1998, Navy Case No. 78838.

ADDRESSES: Requests for copies of the patent applications cited should be directed to the Office of Naval Research, ONR 00CC, Ballston Tower One, 800 North Quincy Street, Arlington, Virginia 22217–5660, and must include the Navy Case numbers.

FOR FURTHER INFORMATION CONTACT: Mr. R. J. Erickson, Staff Patent Attorney, Office of Naval Research, ONR 00CC, Ballston Tower One, 800 North Quincy Street, Arlington, Virginia 22217–5660, telephone (703) 696–4001.

(Authority: 35 U.S C. 207, 37 CFR Part 404)

Matthew G. Shirley,

LCDR, JAGC, USN, Federal Register Liaison Officer.

[FR Doc. 98–17018 Filed 6–25–98; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF DEFENSE

Department of the Navy

Closed Meeting of the Naval Research Advisory Committee

AGENCY: Department of the Navy, DOD.

ACTION: Meeting.

SUMMARY: The Naval Research Advisory Committee Panel on Information Technology Interoperaility will meet to assess technologies and interoperability implications associated with information transfer and interaction among systems as well as between systems, especially among and between NATO and coalition forces. All sessions of this meeting will be closed to the public.

DATES: The meeting will be held on Tuesday, July 7, 1998 from 8:00 a.m. to

5:30 p.m., and on Wednesday, July 8, 1998 from 8:00 a.m. to 5:30 p.m.

ADDRESSES: The meeting will be held at Lockheed Martin Federal Systems, 9500 Godwin Drive, Building 250, Room 1GG18, Manassas, Virginia.

FOR FURTHER INFORMATION CONTACT: Diane Mason-Muir, Program Director, Naval Research Advisory Committee, 800 North Quincy Street, Arlington, VA 22217–5660, telephone number (703) 696–6769.

SUPPLEMENTARY INFORMATION: This notice of meeting is provided in accordance with the provisions of the Federal Advisory Committee Act (5 U.S.C. App. 2). All sessions of the meeting will be devoted to briefings and discussions involving technical examination of information related to interoperability among and between command, control, communications, computers and information systems/ combat systems. These briefings and discussions will contain classified information that is specifically authorized under criteria established by Executive Order to be kept secret in the interest of national defense and are in fact properly classified pursuant to such Executive Order. The classified and non-classified matters to be discussed are so inextricably intertwined as to preclude opening any portion of the meeting. In accordance with 5 U.S.C. App. 2, section 10(d), 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 5 U.S.C. section 552b(c)(1).

Matthews G. Shirley,

LCDR, JAGC, USN, Federal Register Liaison Officer.

[FR Doc. 98–17016 Filed 6–25–98; 8:45 am]

BILLING CODE 3810–FF–P

DEPARTMENT OF EDUCATION

Submission for OMB Review; Comment Request

AGENCY: Department of Education.

ACTION: Submission for OMB review; comment request.

SUMMARY: The Acting Deputy Chief Information Officer, Office of the Chief Information Officer, invites comments on the submission for OMB review as required by the Paperwork Reduction Act of 1995.

DATES: Interested persons are invited to submit comments on or before July 27, 1998.

ADDRESSES: Written comments should be addressed to the Office of Information and Regulatory Affairs, Attention: Danny Werfel, Desk Officer, Department of Education, Office of Management and Budget, 725 17th Street, NW., Room 10235, New Executive Office Building, Washington, DC 20503. Requests for copies of the proposed information collection requests should be addressed to Patrick J. Sherrill, Department of Education, 600 Independence Avenue, S.W., Room 5624, Regional Office Building 3, Washington, D.C. 20202–4651.

FOR FURTHER INFORMATION CONTACT: Patrick J. Sherrill (202) 708–8196. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday.

SUPPLEMENTARY INFORMATION: Section 3506 of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35) requires that the Office of Management and Budget (OMB) provide interested Federal agencies and the public an early opportunity to comment on information collection requests. OMB may amend or waive the requirement for public consultation to the extent that public participation in the approval process would defeat the purpose of the information collection, violate State or Federal law, or substantially interfere with any agency's ability to perform its statutory obligations. The Acting Deputy Chief Information Officer, Office of the Chief Information Officer, publishes this notice containing proposed information collection requests prior to submission of these requests to OMB. Each proposed information collection, grouped by office, contains the following: (1) Type of review requested, e.g., new, revision, extension, existing or reinstatement; (2) Title; (3) Summary of the collection; (4) Description of the need for, and proposed use of, the information; (5) Respondents and frequency of collection; and (6) Reporting and/or Recordkeeping burden. OMB invites public comment at the address specified above. Copies of the requests are available from Patrick J. Sherrill at the address specified above.

Dated: June 22, 1998.

Hazel Fiers,

Acting Deputy Chief Information Officer, Office of the Chief Information Officer.

Office of Vocational and Adult Education

Type of Review: Extension.
Title: Progress Measures.
Frequency: Annually.
Affected Public: Not-for-profit institutions.
Reporting and Recordkeeping Hour Burden:
Responses: 1,157
Burden Hours: 11,000
Abstract: The National School-to-Work Office collects information from funded local partnerships (n=1,157) to gather evidence on state and local progress in implementing school-to-work. Data elements include student, school, and employer involvement in school-to-work; graduation and postsecondary transition rates for students; and funds leveraged by partnerships to sustain their school-to-work systems. Information is used to provide an annual school-to-work report to Congress, as well as to building state's capacity to collect and analyze information for their own system improvement purposes.

Office of Special Education and Rehabilitative Services

Type of Review: Reinstatement.
Title: Report of Children with Disabilities Exiting Special Education During the 1998–99 School Year.
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs.
Reporting and Recordkeeping Hour Burden:
Responses: 58
Burden Hours: 53,244
Abstract: This package provides instructions and a form necessary for States to report the number of students aged 14 and older served under the Individuals with Disabilities Education Act (IDEA–B) exiting special education. The form satisfies reporting requirements and is used by the Office of Special Education Programs to monitor state educational agencies and for Congressional reporting.

Office of Special Education and Rehabilitative Services

Type of Review: Reinstatement
Title: Report of Children with Disabilities Receiving Special Education under Part B of Individuals with Disabilities Education Act (IDEA), As Amended.
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs.
Reporting and Recordkeeping Hour Burden:
Responses: 58.
Burden Hours: 30,624.
Abstract: This package provides instructions and a form necessary for States to report the number of children with disabilities served under IDEA-B receiving special education and related

services. It serves as the basis for distributing federal assistance, monitoring, implementing, and Congressional reporting.

Office of Special Education and Rehabilitative Services

Type of Review: Reinstatement.
Title: Report of Early Intervention Services of Individualized Family Service Plans (IFSPs) Provided to Infants, Toddlers and Their Families in Accordance with Part C and Report of Number and Type of Personnel Employed and Contracted to Provide Early Intervention Services.
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs.
Reporting and Recordkeeping Hour Burden:
Responses: 57.
Burden Hours: 5,187.
Abstract: This package provides instructions and forms necessary for States to report, by race and ethnicity, the number of infants and toddlers with disabilities and their families receiving different types of Part C services, and the number of personnel employed and contracted to provide services for infants and toddlers with disabilities and their families. Data are obtained from state and local service agencies and are used to assess and monitor the implementation of the Individuals with Disabilities Education Act (IDEA) and for Congressional reporting.

Office of Special Education and Rehabilitative Services

Type of Review: Reinstatement.
Title: Report of Infants and Toddlers Receiving Early Intervention Services and of Program Settings Where Services are Provided in Accordance with Part C, and Report on Infants and Toddlers Exiting Part C.
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs
Reporting and Recordkeeping Hour Burden:
Responses: 57.
Burden Hours: 5,472.
Abstract: This package provides instructions and forms necessary for States to report, by race and ethnicity, the number of infants and toddlers with disabilities who: a) are served under the Individuals with Disabilities Education Act (IDEA), Part C; b) are served in different program settings; and c) exit Part C because of program completion and for other reasons. Data are obtained from state and local service agencies and are used to assess and monitor the implementation of IDEA and for Congressional reporting.

Office of Special Education and Rehabilitative Services.

Type of Review: Reinstatement.
Title: Personnel (In Full-Time Equivalency of Assignment) Employed to Provide Special Education and Related Services for Children with Disabilities.
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs.
Reporting and Recordkeeping Hour Burden:
Responses: 58.
Burden Hours: 7,685.
Abstract: This package provides instructions and a form necessary for States to report the number of personnel employed and contracted in the provision of special education and related services. Data are obtained from state and local educational agencies, and are used to assess the implementation of the Individuals with Disabilities Education Act (IDEA) and for monitoring, planning and reporting to Congress.

Office of Special Education and Rehabilitative Services

Type of Review: New.
Title: Report of Children with Disabilities Subject to Unilateral Changes in Placement, Change in Placement Based on a Hearing Officer Determination, or Long-term Suspension-Explusion.
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs.
Reporting and Recordkeeping Hour Burden:
Responses: 58.
Burden Hours: 149,350.
Abstract: This package provides instructions and a form for States to report the number of children and youth and the number of acts involving students served under the Individuals with Disabilities Education Act (IDEA) involving a unilateral change in placement, change in placement based on a hearing officer determination, or long-term suspension/explusion. The form satisfies reporting requirements and is used by the Office of Special Education Programs to monitor state educational agencies and for Congressional reporting.

Office of Special Education and Rehabilitative Services

Type of Review: Reinstatement
Title: Part B, Individuals with Disabilities Education Act (IDEA) Implementation of Free Appropriate Public Education (FAPE) Requirements 1998–99 School Year
Frequency: Annually.
Affected Public: State, local or Tribal Gov't; SEAs or LEAs.
Reporting and Recordkeeping Hour Burden:
Responses: 58.
Burden Hours: 257,752.
Abstract: This package provides instructions and a form for States to report the settings in which children with disabilities served under IDEA-B receive special education and related services. The form satisfies reporting requirements and is used by the Office of Special Education Programs to monitor state educational agencies and for Congressional reporting.

[FR Doc. 98–17045 Filed 6–25–98; 8:45 am]
BILLING CODE 4000–01–P

DEPARTMENT OF EDUCATION

Office of Postsecondary Education

[CFDA No.: 84.063]

Federal Pell Grant Program

AGENCY: Department of Education.

ACTION: Notice of deadline dates for receipt of applications, reports, and other documents for the 1998–99 award year.

SUMMARY: The Secretary announces the deadline dates for receiving documents from persons applying for grants under, and from institutions participating in, the Federal Pell Grant Program in the 1998–99 award year.

SUPPLEMENTARY INFORMATION: The Federal Pell Grant Program, administered by the U.S. Department of Education (Department), provides grants to students attending eligible institutions of higher education to help them pay for their educational costs. The program supports priority three of the Department's Seven Priorities, which states that all students should be prepared for and able to afford at least two years of college by age 18, and be able to pursue lifelong learning as adults. Authority for the Federal Pell Grant Program is contained in section 401 of the Higher Education Act of 1965, as amended, 20 U.S.C. 1070a.

DEADLINE DATES: The following tables provide the deadline dates for the Federal Pell Grant Program for the 1998–99 award year. Please note that the Department may impose an adverse action, such as a fine or other penalty, for an institution's failure to report Federal Pell Grant payment data within the required 30-day timeframe as outlined in Table B. Also, failing to report within the required 30-day

timeframe may result in a program review or audit finding for an institution.

Who submits?	What is submitted?	Where is it submitted?	What is the deadline date for receipt?
A. Deadline Dates for Application Processing and Receipt of Student Aid Reports (SARs) or Institutional Student Information Records (ISIRs)			
Student	A paper original Free Application for Federal Student Aid (FAFSA) or renewal application (Renewal FAFSA).	The address indicated on the FAFSA, Renewal FAFSA, or envelope provided with the form.	June 30, 1999.
Student	Free Application for Federal Student Aid (FAFSA) in pdf obtained from http://www.fafsa.ed.gov.	The address indicated on the FAFSA.pdf.	June 30, 1999.
Student	FAFSA Express electronic application	Electronically to the Central Processing System using the FAFSA Express software and a modem.	June 30, 1999.[1]
	Signature Page	The address printed on the signature page.	August 16, 1999.
Student	Free Application for Federal Student Aid (FAFSA) on the Web or Renewal FAFSA on the Web.	Electronically to the Central Processing System using the Internet http://www.fafsa.ed.gov.	June 30, 1999.[1]
	Signature Page (if required)	The address printed on the signature page.	August 16, 1999.
Student through institution.	An electronic original or renewal application through EDExpress.	Electronically to the Central Processing System through Title IV Wide Area Network.	June 30, 1999.[1]
Student	SAR corrections and duplicate requests.	The address indicated on the SAR	August 16, 1999.
Student through institution.	Electronic corrections and duplicate requests.	Electronically to the Central Processing System through Title IV Wide Area Network.	August 25, 1999.[1]
Student	Change of address or change of institutions.	The address indicated on the SAR; or	August 16, 1999.
		The Federal Student Aid Information Center by calling (319) 337–5665.	August 25, 1999.
Student	Valid SAR	Institution	The earlier of: —the student's last date of enrollment; or —August 31, 1999.
Student through Central Processing System.	Valid ISIR	Institution	The earlier of: —the student's last date of enrollment; or —August 31, 1999.
Student	Verification documents	Institution	The earlier of:[2] —90 days after the student's last date of enrollment; or —August 31, 1999.
Student	Verified SAR	Institution	The earlier of:[3] —90 days after the student's last date of enrollment; or —August 31, 1999.
Student through Central Processing System.	Verified ISIR	Institution	The earlier of:[3] —90 days after the student's last date of enrollment; or —August 31, 1999.

Who submits?	What is submitted?	Where is it submitted?	What is the deadline date for receipt?
B. Deadline Dates for Reporting Federal Pell Grant Payment Data			
Institution	At least one acceptable student Payment Data record must be submitted for each Federal Pell Grant recipient at the institution by: Recipient Data Exchange; or Floppy Disk Data Exchange;[4] or Electronic Data Exchange (EDE)[5].	1. Institutions transmitting student Payment Data using Recipient Data Exchange or Floppy Disk Data Exchange submit through: Regular Mail: U.S. Department of Education, Student Aid Origination Team, PSS, P.O. Box 6565, Rockville, Maryland 20850–6565 or Commercial Couriers or Hand Deliveries to: U.S. Department of Education, Student Aid Origination Team, PSS, c/o Computer Data Systems, Inc., RFMS, Federal Pell Grant Program, Mail Stop 3200, One Curie Court, Rockville, Maryland 20850–4389.	An institution is required to submit student Payment Data not later than the earlier of: (a) 30 calendar days after the institution —makes a payment; or —becomes aware of the need to make an adjustment to previously reported student Payment Data or expected student Payment Data; or (b) September 30, 1999. An institution may submit student Payment Data after September 30, 1999 only if there is: —a downward adjustment of a previously reported award; or —an initial audit or program review finding per 34 CFR Part 690.83.
		2. Institutions transmitting student Payment Data using Electronic Data Exchange submit through: Title IV Wide Area Network.	
	Requests for year-to-date Processed Payment Data.	Pell Grant User Support Hotline and the Institutional Access System#: (800) 474–7268 (Requests also may be made using the information provided in items #1 and #2 above).	August 16, 1999.[6]
	Requests for Student Payment Summary (SPS) Data		
	Request for administrative relief based on an administrative error by the Department or departmental contractors.	U.S. Department of Education, Institutional Financial Management, Division, AFMS, P.O. Box 23791, Washington, DC 20026–0791.	February 1, 2000.

[1] The deadline for submitting electronic transactions is prior to 7:00 pm (Central Time) on the deadline date. Transmissions must be completed and accepted by 7:00 pm to meet the deadline. If transmissions are started before 7:00 pm but are not completed until after 7:00 pm, those transmissions will not meet the deadline. In addition, any transmission picked up on the deadline date that gets rejected may not be able to be reprocessed because the deadline will have passed by the time the user gets the information notifying him or her of the rejected transmission.

[2] Although the Department has set this deadline date for the submission of verification documents, if corrections to the SAR or ISIR are required, the above deadline dates for submission of paper or electronic corrections still must be met.

[3] For those students completing verification while no longer enrolled, the institution must have already received a SAR or ISIR with an eligible Expected Family Contribution (EFC) while the student was enrolled and eligible for payment. These students will be paid based on the higher of the two EFCs.

[4] The 1998–99 award year is the last year the Department will accept Disk Operating System (DOS) floppy diskette or DOS electronic submissions.

[5] An institution that transmits its student Payment Data information must ensure that its transmission is completed before midnight (local time at the institution's EDE destination point) on September 30, 1999.

[6] Year-to-date or SPS data files may be requested after this date. However, there may not be sufficient time for institutions to receive the file, create a payment data batch, and submit it to the Department by the September 30, 1999 deadline date for receipt of all 1998–99 requests for payment.

Proof of Delivery for Federal Pell Grant Payment Documents

If the documents were submitted by mail or by non-U.S. Postal Service courier, the Department accepts as proof of delivery one of the following:

(1) A legible mail receipt with the date of mailing stamped by the U.S. Postal Service.

(2) A legibly dated U.S. Postal Service postmark.

Note: The U.S. Postal Service does not uniformly provide a dated postmark. Before relying on this method of proof of mailing, an institution should check with the post office at which it mails its submission. An institution is strongly encouraged to use First Class Mail.

(3) A dated shipping label, invoice, or receipt from a commercial courier.

(4) Other proof of mailing or delivery acceptable to the Secretary.

The Department accepts commercial couriers or hand deliveries between 8 a.m. and 4:30 p.m., Eastern time, Monday through Friday except Federal holidays.

Other Sources for Detailed Information on the Application and Automated Processes

A more detailed discussion of the student application process for the Federal Pell Grant Program is contained in the *1998–99 Student Guide, Funding Your Education,* the *1998–99 Counselor's Handbook for High Schools,* the *1998–99 Counselor's Handbook for Postsecondary Schools, A Guide to 1998–99 SARs and ISIRs,* and the *1998–99 Federal Student Financial Aid Handbook.* A more detailed discussion of the institutional reporting requirement for student Payment Data for the Federal Pell Grant Program is also contained in the *Federal Student Financial Aid Handbook.*

Applicable Regulations

The following regulations apply:

(1) Federal Pell Grant Program, 34 CFR Part 690.

(2) Student Assistance General Provisions, 34 CFR Part 668.

(3) Institutional Eligibility Under the Higher Education Act of 1965, as amended, 34 CFR Part 600.

FOR FURTHER INFORMATION CONTACT: Jacquelyn C. Butler, Program Specialist, Student Financial Assistance Programs, U.S. Department of Education, 600 Independence Avenue, S.W. (Room 3045, ROB–3), Washington, DC 20202–5447. Telephone: (202) 708–8242. Individuals who use a telecommunications device for the deaf (TDD) may call the Federal Information Relay Service (FIRS) at 1–800–877–8339 between 8 a.m. and 8 p.m., Eastern Time, Monday through Friday.

Individuals with disabilities may obtain this document in an alternate format (e.g., Braille, large print, audiotape, or computer diskette) on request to Vicki Wilson, U.S. Department of Education, 600 Independence Avenue, S.W. (Room 3030, ROB–3), Washington, D.C. 20202–5352. Telephone: (202) 708–8619.

Electronic Access to This Document

Anyone may view this document, as well as all other Department of Education documents published in the **Federal Register**, in text or portable document format (pdf) on the World Wide Web at either of the following sites:

http://ocfo.ed.gov/fedreg.htm

http://www.ed.gov/news.html

To use the pdf you must have the Adobe Acrobat Reader Program with Search, which is available free at either of the previous sites. If you have questions about using the pdf, call the U.S. Government Printing Office toll free at 1–888–293–6498.

Anyone may also view these documents in text copy only on an electronic bulletin board of the Department. Telephone: (202) 219–1511 or, toll free, 1–800–222–4922. The documents are located under Option G—Files/Announcements, Bulletins and Press Releases.

Note: The official version of this document is the document published in the **Federal Register**.

(Authority: 20 U.S.C. 1070a)

Dated: June 19, 1998.

David A. Longanecker,

Assistant Secretary for Postsecondary Education.

[FR Doc. 98–17125 Filed 6–25–98; 8:45 am]

BILLING CODE 4000–01–P

DEPARTMENT OF ENERGY

Environmental Management Site-Specific Advisory Board, Monticello Site

AGENCY: Department of Energy.

ACTION: Notice of open meeting.

SUMMARY: Pursuant to the provisions of the Federal Advisory Committee Act (Public Law 92–463, 86 Stat. 770) notice is hereby given of the following Advisory Board Committee Meeting: Environmental Management Site-Specific Advisory Board, Monticello Site.

DATE AND TIME: Wednesday, August 19, 1998; 7:00 p.m.–9:00 p.m.

ADDRESSES: San Juan County Courthouse, 2nd Floor Conference Room, 117 South Main, Monticello, Utah 84535.

FOR FURTHER INFORMATION CONTACT: Audrey Berry, Public Affairs Specialist, Department of Energy Grand Junction Projects Office, P.O. Box 2567, Grand Junction, CO, 81502 (970) 248–7727.

SUPPLEMENTARY INFORMATION:

Purpose of the Board: The purpose of the Board is to advise DOE and its regulators in the areas of environmental restoration, waste management, and related activities.

Tentative Agenda: Updates on Supplemental Standards and project status; and reports from subcommittees on local hiring and training, health and safety, and future land use.

Public Participation: The meeting is open to the public. Written statements may be filed with the Committee either before or after the meeting. Individuals who wish to make oral statements pertaining to agenda items should contact Audrey Berry's office at the address or telephone number listed above. Requests must be received 5 days prior to the meeting and reasonable provision will be made to include the presentation in the agenda. The Designated Federal Officer is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Each individual wishing to make public comment will be provided a maximum of 5 minutes to present their comments at the end of the meeting.

Minutes: The minutes of this meeting will be available for public review and copying at the Freedom of Information Public Reading Room, 1E–190, Forrestal Building, 1000 Independence Avenue, SW, Washington, DC 20585 between 9:00 a.m. and 4 p.m., Monday–Friday, except Federal holidays. Minutes will also be available by writing to Audrey Berry, Department of Energy Grand Junction Projects Office, P.O. Box 2567, Grand Junction, CO 81502, or by calling her at (303) 248–7727.

Issued at Washington, DC, on June 23, 1998.

Rachel M. Samuel,

Deputy Advisory Committee Management Officer.

[FR Doc. 98–17055 Filed 6–25–98; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Environmental Management Site-Specific Advisory Board, Kirtland Area Office (Sandia)

AGENCY: Department of Energy.

ACTION: Notice of open meeting.

SUMMARY: Pursuant to the provisions of the Federal Advisory Committee Act (Public Law 92–463, 86 Stat. 770) notice is hereby given of the following Advisory Board Committee meeting: Environmental Management Site-Specific Advisory Board, Kirtland Area Office (Sandia).

DATES: Wednesday, July 15, 1998; 6:00 p.m.–9:00 p.m. Mountain Daylight Time).

ADDRESSES: Citizens' Advisory Board Office, 924 Park Avenue SW–PH #9, Albuquerque, New Mexico.

FOR FURTHER INFORMATION CONTACT: Mike Zamorski, Acting Manager, Department of Energy Kirtland Area Office, P.O. Box 5400, Albuquerque, NM 87185 (505) 845–4094.

SUPPLEMENTARY INFORMATION:

Purpose of the Board: The purpose of the Board is to advise DOE and its regulators in the areas of environmental restoration, waste management, and related activities.

Tentative Agenda: The Board will conduct a business meeting. A final agenda will be available at the meeting Wednesday, July 15, 1998.

Public Participation: The meeting is open to the public. Written statements may be filed with the Committee either before or after the meeting. Individuals who wish to make oral statements pertaining to agenda items should contact Mike Zamorski's office at the address or telephone number listed above. Requests must be received 5 days prior to the meeting and reasonable provision will be made to include the presentation in the agenda. The Designated Federal Officer is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Each individual wishing to make public comment will

be provided a maximum of 5 minutes to present their comments.

Minutes: The minutes of this meeting will be available for public review and copying at the Freedom of Information Public Reading Room, 1E–190, Forrestal Building, 1000 Independence Avenue, SW, Washington, DC 20585 between 9:00 a.m. and 4 p.m., Monday–Friday, except Federal holidays. Minutes will also be available by writing to Mike Zamorksi, Department of Energy Kirtland Area Office, P.O. Box 5400, Albuquerque, MN 87185, or by calling (505) 845–4094.

Issued at Washington, DC on June 23, 1998.

Rachel M. Samuel,

Deputy Advisory Committee Management Officer.

[FR Doc. 98–17056 Filed 6–25–98; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Environmental Management Site-Specific Advisory Board, Paducah

AGENCY: Department of Energy.

ACTION: Notice of open meeting.

SUMMARY: Pursuant to the provisions of the Federal Advisory Committee Act (Public Law 92–463, 86 Stat. 770) notice is hereby given of the following Advisory Committee meeting: Environmental Management Site-Specific Advisory Board (EM SSAB), Paducah Gaseous Diffusion Plant.

DATES: Thursday, July 16, 1998: 5:30 p.m.–10:00 p.m.

ADDRESS: Paducah Information Age Park Resource Center, 2000 McCracken Boulevard, Paducah, Kentucky.

FOR FURTHER INFORMATION CONTACT: Myrna E. Redfield, Site-Specific Advisory Board Coordinator, Department of Energy Paducah Site Office, Post Office Box 1410, MS–103, Paducah, Kentucky 42001, (502) 441–6815.

SUPPLEMENTARY INFORMATION:

Purpose of the Board: The purpose of the Board is to make recommendations to DOE and its regulators in the areas of environmental restoration, waste management, and related activities.

Tentative Agenda:

5:30 p.m.—Call to Order
5:45 p.m.—Approve Meeting Minutes
6:00 p.m.—Public Comment/Questions
6:30 p.m.—Presentations
7:30 p.m.—Break
7:45 p.m.—Presentations
9:00 p.m.—Public Comment
9:30 p.m.—Administrative Issues
10:00 p.m.—Adjourn

Copies of the final agenda will be available at the meeting.

Public Participation: The meeting is open to the public. Written statements may be filed with the Committee either before or after the meeting. Individuals who wish to make oral statements pertaining to agenda items should contact Myrna E. Redfield at the address or telephone number listed above. Requests must be received 5 days prior to the meeting and reasonable provision will be made to include the presentation in the agenda. The Designated Federal Officer is empowered to conduct the meeting in a fashion that will facilitate the orderly conduct of business. Each individual wishing to make public comment will be provided a maximum of 5 minutes to present their comments as the first item on the meeting agenda.

Minutes: The minutes of this meeting will be available for public review and copying at the Freedom of Information Public Reading Room, 1E–190, Forrestal Building, 1000 Independence Avenue, SW, Washington, DC 20585 between 9:00 a.m. and 4 p.m., Monday-Friday, except Federal holidays. Minutes will also be available at the Department of Energy's Environmental Information and Reading Room at 175 Freedom Boulevard, Highway 60, Kevil, Kentucky between 8:00 a.m. and 5:00 p.m. on Monday through Friday, or by writing to Carlos Alvarado, Department of Energy Paducah Site Office, Post Office Box 1410, MS–103, Paducah, Kentucky 42001, or by calling him at (502) 441–6804.

Issued at Washington, DC, on June 23, 1998.

Rachel M. Samuel,

Deputy Advisory Committee Management Officer.

[FR Doc. 98–17058 Filed 6–25–98; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Energy Information Administration

Agency Information Collection Under Review by the Office of Management and Budget

AGENCY: Energy Information Administration, Department of Energy.

ACTION: Submission for OMB review; comment request.

SUMMARY: The Energy Information Administration (EIA) has submitted the energy information collection(s) listed at the end of this notice to the Office of Management and Budget (OMB) for review under provisions of the Paperwork Reduction Act of 1995 (Pub. L. 104–13). The listing does not include collections of information contained in new or revised regulations which are to be submitted under section 3507(d)(1)(A) of the Paperwork Reduction Act, nor management and procurement assistance requirements collected by the Department of Energy (DOE).

Each entry contains the following information: (1) collection number and title; (2) summary of the collection of information (includes sponsor (the DOE component)), current OMB document number (if applicable), type of request (new, revision, extension, or reinstatement); response obligation (mandatory, voluntary, or required to obtain or retain benefits); (3) a description of the need and proposed use of the information; (4) description of the likely respondents; and (5) estimate of total annual reporting burden (average hours per response times proposed frequency of response per year times estimated number of likely respondents.)

DATES: Comments must be filed on or before July 27, 1998. If you anticipate that you will be submitting comments but find it difficult to do so within the time allowed by this notice, you should advise the OMB DOE Desk Officer listed below of your intention to do so as soon as possible. The Desk Officer may be telephoned at (202) 395–3084. (Also, please notify the EIA contact listed below.)

ADDRESSES: Address comments to the Department of Energy Desk Officer, Office of Information and Regulatory Affairs, Office of Management and Budget, 726 Jackson Place NW, Washington, D.C. 20503. (Comments should also be addressed to the Statistics and Methods Group at the address below.)

FOR FURTHER INFORMATION CONTACT: Requests for additional information should be directed to Herbert Miller, Statistics and Methods Group, (EI–70), Forrestal Building, U.S. Department of Energy, Washington, D.C. 20585. Mr. Miller may be telephoned at (202) 426–1103, FAX (202) 426–1081, or e-mail at hmiller@eia.doe.gov.

SUPPLEMENTARY INFORMATION: The energy information collection submitted to OMB for review was:

1. FE–329R, ''Powerplant and Industrial Fuel Use Act of 1978; Final Rule''.

2. Fossil Energy; OMB No. 1901–0297, Extension of Currently Approved Collection; Mandatory.

3. FE–329R Final Rule (1) incorporates Public Law No. 100–42 Fuel Use Act amendments into regulations, (2) revises and updates cost test fuel price and inflation indices, (3)

clarifies how to calculate fuel price when using natural gas, and (4) revises and updates oil/gas savings estimates for cogenerators.

4. Business or other for-profit.

5. 240 hours (8 hours per response times 1 response per year times 30 respondents).

Statutory Authority: Section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 (Pub. L. No. 104–13).

Issued in Washington, DC, June 18, 1998.

Jay H. Casselberry,

Agency Clearance Officer, Statistics and Methods Group, Energy Information Administration.

[FR Doc. 98–17057 Filed 6–25–98; 8:45 am]

BILLING CODE 6450–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP98–242–000]

CNG Transmission Corporation; Notice of Section 4 Filing

June 22, 1998.

Take notice that on June 3, 1998, CNG Transmission Corporation (CNGT), tendered for filing, pursuant to section 4 of the Natural Gas Act, a notice of termination of service on certain specified uncertificated gathering pipeline facilities in Calhoun County, West Virginia. CNGT states that it will sell these facilities to Dominion Appalachian Development, Inc. (Dominion Appalachian).

CNGT states that no contract for transportation of service with CNGT will be terminated because Dominion Appalachian will continue to delivery gas to CNGT at a delivery point further downstream of the line. CNGT further states that Hope Gas, Inc., has made arrangement with Dominion Appalachian for continued service to its three residential consumers.

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, 888 First Street, N.E., Washington, D.C., 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure. Under section 154.210 of the Commission's regulation, all such motions or protests should be filed on or before June 30, 1998. 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.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17037 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP98–251–000]

Colorado Interstate Gas Company; Notice of Proposed Changes in FERC Gas Tariff

June 22, 1998.

Take notice that on June 17, 1998, Colorado Interstate Gas Company (CIG), tendered for filing to become part of its FERC Gas Tariff, First Revised Volume No. 1, the tariff sheets listed in Appendix A to the filing, to be effective August 1, 1998.

CIG states that the purpose of this compliance filing is to conform CIG's tariff to requirements of Order No. 587–G that interstate pipelines transporting pursuant to Section 284.223 of the commissions regulations conform their tariffs to include Version 1.2 of the GISB standards and to make minor housekeeping changes by capitalizing defend terms.

CIG further states that copies of this filing have been served on CIG's jurisdictional customers and public bodies.

Any person desiring to be heard or to protest this filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Sections 385.214 and 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed as provided in Section 154.210 of the Commission's Regulations. 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 proceedings. 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 in the Public Reference Room.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17038 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket Nos. RP91–229–027, RP92–166–020]

Panhandle Eastern Pipeline Company; Notice of Refund Report

June 22, 1998.

Take notice that on June 18, 1998, Panhandle Eastern Pipe Line Company (Panhandle) tendered for filing its Refund Report pursuant to the Commission's Order on Rehearing dated June 3, 1998 (June 3, 1998 Order).

Panhandle states that concurrently with the filing of this report it made a refund to Omega Gas PipeLine Company, OPC Gas Company, Vesta Energy Company, d.b.a. Edisto Resources Inc., d.b.a. Forcenergy, Inc., pursuant to Ordering Paragraph (B) of the June 3, 1998 Order, related to the pre-restructuring rate periods in this proceeding.

Panhandle states that it also submitted schedules setting forth the calculation of the refund due Forecenergy, Inc. including additional carrying charges and the amount of refunds used to offset amounts due Panhandle.

Panhandle further states that a copy of this filing is being served on all parties to this proceeding.

Any person desiring to protest this filing should file a protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Section 385.211 of the Commission's Rules and Regulations. All such protests must be filed on or before June 29, 1998. 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 proceedings. Copies of this filing are on file with the Commission and are available for public inspection in the Public Reference Room.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17035 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP98–609–000]

Sabine Pipe Line Company; Notice of Request Under Blanket Authorization

June 22, 1998.

Take notice that on June 12, 1998, Sabine Pipe Line Company (Sabine), P.O. Box 4781, Houston, Texas 77210–4781, filed in Docket No. CP98–609–000 a request pursuant to Sections 157.205 and 157.211 of the Commission's Regulations under the Natural Gas Act (18 CFR 157.205, 157.211) for authorization to install and operate a sales tap to deliver gas to Warren Petroleum Company L. P. (Warren), under Sabine's blanket certificate issued in Docket No. CP83–199–000, pursuant to Section 7 of the Natural Gas Act, all as more fully set forth in the request that is on file with the Commission and open to public inspection.

The proposed sales tap will interconnect Sabine's 16-inch low-pressure mainline to Warren's Lake Charles Fractionation Plant near Lake Charles, Calcasieu Parish, Louisiana.

Sabine states that it will construct and pay for the interconnection, including a meter station and approximately 1,500 feet of 12-inch pipeline, that will connect Warren's facilities and Sabine's existing mainline piping. Sabine states that it will own and operate instrumentation and telemetry for flow control, the control valve assemblies and the connections to Sabine's mainline piping. Sabine also states that the maximum quantity of gas that will be delivered through the proposed interconnect is 10,000 D.H. per day. Sabine adds that the proposed delivery point will be available to all existing and potential shippers receiving service under Sabine's FT–1 and IT–1 rate schedules set forth in its FERC Gas Tariff. Sabine states the cost to construct the proposed facilities is $195,000.

Any person or the Commission's staff may, within 45 days after 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 Section 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 pursuant to Section 7 of the Natural Gas Act.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17031 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP97–343–004]

Sea Robin Pipeline Company; Notice of Petition for Waiver

June 22, 1998.

Take notice that on June 17, 1998, Sea Robin Pipeline Company (Sea Robin) filed a petition for an interim waiver of the Section 5.10 of the General Terms and Conditions of its Tariff to extend the date on which it implements pooling service on its system to the date the SoNet Premier System is implemented. Such implementation date is expected to be on or before September 1, 1998.

Sea Robin states that copies of the filing have been mailed to all of the shippers and interested state commissions.

Any person desiring to be heard or to protest this filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Sections 385.214 and 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed on or before June 29, 1998. 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 proceedings. 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 in the Public Reference Room.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17036 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. RP98–252–000]

Southern Natural Gas Company; Notice of Filing

June 22, 1998.

Take notice that on June 18, 1998, Southern Natural Gas Company (Southern) tendered for filing, pursuant to Section 4 of the Natural Gas Act, a notice of termination of gathering service that will apply to gathering service provided by Sonat Exploration Company (SEC) upon the transfer by Southern to SEC of certain gathering facilities located in Bear Creek Field, Bienville Parish, Louisiana.

Southern proposes the effective date of such termination of gathering services to be August 31, 1998.

Any person desiring to be heard or to protest this filing should file a motion to intervene or a protest with the Federal Energy Regulatory Commission, 888 First Street NE., Washington, DC 20426, in accordance with Sections 385.214 and 385.211 of the Commission's Rules and Regulations. All such motions or protests must be filed as provided in Section 154.210 of the Commission's Regulations. 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 proceedings. 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 in the Public Reference Room.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17039 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. CP98–618–000]

Texas Eastern Transmission Corporation; Notice of Application

June 22, 1998.

Take notice that on June 16, 1998, Texas Eastern Transmission Corporation (Texas Eastern), P.O. Box 1642, Houston, Texas 77251–1642, filed in Docket No. CP98–618–000 an application pursuant to Sections 7(c) and 7(b) of the Natural Gas Act to own, operate and maintain on a permanent

basis replacement facilities in Monroe County, Ohio constructed pursuant to Part 284, Subpart I of the Commission's Regulations, and abandon in place the facilities which were replaced, all as more fully set forth in the application which is on file with the Commission and open to public inspection.

Texas Eastern states that on May 6, 1998, its Main Line No. 10 ruptured in a rural area approximately one mile south of Beallsville, Ohio. It is stated that the rupture occurred near the bottom of a steep hillside. Texas Eastern indicates that after the rupture, Texas Eastern closed valves on both sides of the rupture and dispatched crews to assess damage and evaluate further actions. It is further stated that its 30-inch Line 15, which is parallel to Line 15 in the same right of way was taken out of service as a safety measure.

Texas Eastern states that it installed replacement facilities under the terms of the emergency regulations set forth in Subpart I of the Commission's Regulations. Specifically, Texas Eastern has installed approximately 933 feet of 30-inch pipeline as part of its Main Line No. 10 and 928 feet of 30-inch pipeline as part of its Main Line No. 15. Texas Eastern indicates that the replacement facilities were offset approximately 280 feet south of Texas Eastern's existing Main Line Nos. 10 and 15 following a route around a steep hillside and proceeding up a less severe slope to reconnect with Lines Nos. 10 and 15 on the top of the hill.

Texas Eastern states that it cut, capped and filled the replaced segments of Lines 10 and 15 with water and proposes to permanently abandon these segments in place.

Texas Eastern estimates a total cost of the replacement project at $4,400,000, which is being financed from funds on hand.

Any person desiring to be heard or to make any protest with reference to said application should on or before July 13, 1998, file with the Federal Energy Regulatory Commission, 888 First Street, N.E., Washington, D.C. 20426, a motion to intervene or a protest in accordance with the requirements of the Commission's Rules of Practice and Procedure (18 CFR 385.214 or 385.211) and the Regulations under the Natural Gas Act (18 CFR 157.10). All protests filed with the Commission will be considered by it in determining the appropriate action to be taken but will not serve to make the protestants parties to the proceeding. Any person wishing to become a party to a proceeding or to participate as a party in any hearing therein must file a motion to intervene in accordance with the Commission's Rules.

Take further notice that, pursuant to the authority contained in and subject to the jurisdiction conferred upon the Federal Energy Regulatory Commission by Sections 7 and 15 of the Natural Gas Act and the Commission's Rules of Practice and Procedure, a hearing will be held without further notice before the Commission or its designee on this application if no motion to intervene is filed within the time required herein, if the Commission on its own review of the matter finds that a grant of the certificate and permission for abandonment are required by the public convenience and necessity. If a motion for leave to intervene is timely filed, or if the Commission on its own motion believes that a formal hearing is required, further notice of such hearing will be duly given.

Under the procedure herein provided for, unless otherwise advised, it will be unnecessary for Texas Eastern to appear or be represented at the hearing.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17032 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER98–997–000, et al.]

California Independent System Operator Corporation, et al.; Electric Rate and Corporate Regulation Filings

June 18, 1998.

Take notice that the following filings have been made with the Commission:

1. California Independent System Operator Corporation

[Docket No. ER98–997–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing Amendment No. 1, to the Participating Generator Agreement between the ISO and Midway Sunset Cogeneration Company for acceptance by the Commission. The ISO states that Amendment No. 1, modifies the Participating Generator Agreement, as directed by the Commission, to comply with the Commission's order issued December 17, 1997 in Pacific Gas and Electric Co., 81 FERC ¶ 61,320 (1997).

The ISO states that this filing has been served on all parties listed on the official service list in the above-referenced docket.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

2. Cataula Generating Company, L.P.

[Docket Nos. EC98–44–000 and ER98–3316–000]

Take notice that on June 11, 1998, Cataula Generating Company, L.P. (Cataula), on behalf of itself and Black Hawk I Power Corporation and Peach II Power Corporation tendered for filing an application for approval pursuant to Section 203 of the Federal Power Act for approval of a change in ownership. Cataula also filed a notification of change in status pursuant to Section 205 of the Federal Power Act.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

3. Midwest Energy, Inc.

[Docket Nos. ER95–590–001 and ER96–1497–000]

Take notice that on June 12, 1998, Midwest Energy, Inc. (Midwest), tendered for filing with the Federal Energy Regulatory Commission a report of refunds pursuant to the terms of the Stipulation and Agreement approved by order of the Commission issued on April 30, 1998 in Docket Nos. ER95–590–000 and ER96–1497–000.

A copy of the refund report was served on the Kansas Corporation on each party listed on the Commission official service list for Docket Nos. ER95–590–000 and ER96–1497–000.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

4. California Independent System Operator Corporation

[Docket No. ER98–1500–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing Amendment No. 1, to the Meter Service Agreement for ISO Metered Entities between Midway Sunset Cogeneration Company and the ISO for acceptance by the Commission. The ISO states that Amendment No. 1, modifies the Meter Service Agreement for ISO Metered Entities, as directed by the Commission, to comply with the Commission's order issued December 17, 1997 in Pacific Gas and Electric Co., 81 FERC ¶ 61,320 (1997).

The ISO states that this filing has been served on all parties listed on the official service list in the above-referenced docket.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

5. PP&L, Inc.

[Docket No. ER98–1569–001]

Take notice that on June 15, 1998, PP&L, Inc. (PP&L), filed a compliance filing pursuant to Ordering Paragraph (A) of the Commission's May 14, 1998, Order in Potomac Electric Power Company, *et al.*, 83 FERC ¶ 61,162 (1998).

PP&L states that copies of this filing have been served upon each person designated on the official service list compiled by the Secretary in this proceeding.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

6. California Independent System Operator Corporation

[Docket No. ER98–1911–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing Amendment No. 1, to the Meter Service Agreement for ISO Metered Entities between Long Beach Generation and the ISO for acceptance by the Commission. The ISO states that Amendment No. 1, modifies the Meter Service Agreement for ISO Metered Entities, as directed by the Commission, to comply with the Commission's order issued December 17, 1997 in Pacific Gas and Electric Co., 81 FERC ¶ 61,320 (1997).

The ISO states that this filing has been served on all parties listed on the official service list in the above-referenced docket.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

7. California Independent System Operator Corporation

[Docket No. ER98–1913–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing Amendment No. 1, to the Meter Service Agreement for ISO Metered Entities between El Segundo Power, LLC and the ISO for acceptance by the Commission. The ISO states that Amendment No. 1, modifies the Meter Service Agreement for ISO Metered Entities, as directed by the Commission, to comply with the Commission's order issued December 17, 1997 in Pacific Gas and Electric Co., 81 FERC ¶ 61,320 (1997).

The ISO states that this filing has been served on all parties listed on the official service list in the above-referenced docket.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

8. AES Huntington Beach, L.L.C., AES Alamitos, L.L.C. and AES Redondo Beach, L.L.C.

[Docket Nos. ER98–2184–002, ER98–2185–002, ER98–2186–002 (Not consolidated)]

Take notice that on June 15, 1998, AES Alamitos, L.L.C., AES Huntington Beach, L.L.C., and AES Redondo Beach, L.L.C. (AES Companies), pursuant to the Commission's order of June 12, 1998, in these dockets, submitted for filing a long-term service agreement between the AES Companies and Williams Energy Services Company. The AES Companies request confidential treatment of the agreement pursuant to 18 CFR 388.112.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

9. Northeast Electricity Inc.

[Docket No. ER98–3048–000]

Take notice that on June 15, 1998, Northeast Electricity Inc. (NEI), petitioned the Commission for acceptance of NEI Rate Schedule FERC No. 1; the granting of certain blanket approvals, including the authority to sell electricity at market based rates; and the waiver of certain Commission Regulations.

NEI intends to engage in wholesale electric power and energy purchases and sales as a marketer. NEI is not in the business of generating or transmitting electric power. NEI is a wholly owned and privately held company, with no affiliates.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

10. PowerSource, Corp.

[Docket No. ER98–3052–000]

Take notice that on June 15, 1998, PowerSource, Corp. (PSC), tendered for filing an amended application for acceptance of PSC Rate Schedule FERC No. 1; the granting of certain blanket approvals, including the authority to sell electricity at market-based rates; and the waiver of certain Commission Regulations.

PSC intends to engage in wholesale electric power and energy purchases and sales as a marketer.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

11. Duquesne Light Company

[Docket No. ER98–3333–000]

Take notice that June 15, 1998, Duquesne Light Company (DLC), filed a Service Agreement dated June 9, 1998 with Entergy Power Marketing Corp., under DLC's Open Access Transmission Tariff (Tariff). The Service Agreement adds Entergy Power Marketing Corp., as a customer under the Tariff. DLC requests an effective date of June 9, 1998, for the Service Agreement.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

12. Duquesne Light Company

[Docket No. ER98–3334–000]

Take notice that on June 15, 1998, Duquesne Light Company (DLC), filed a Service Agreement dated June 9, 1998, with First Energy Trading and Power Marketing, Inc., under DLC's Open Access Transmission Tariff (Tariff). The Service Agreement adds First Energy Trading and Power Marketing, Inc., as a customer under the Tariff. DLC requests an effective date of June 9, 1998, for the Service Agreement.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

13. Southwestern Public Service Company

[Docket No. ER98–3335–000]

Take notice that on June 12, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credit resulting from its merger with Public Service company of Colorado required in its agreement with Central Valley Electric Cooperative, Inc. (Central Valley), filed in Docket No ER97–3904–000.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

14. Southwestern Public Service Company

[Docket No. ER98–3336–000]

Take notice that on June 15, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credit resulting from its merger with Public Service Company of Colorado required in its agreement with Lea County Electric Cooperative, Inc. (Lea County), filed in Docket No ER97–3905–000.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

15. Rochester Gas and Electric Corporation

[Docket No. ER98–3337–000]

Take notice that on June 15, 1998, Rochester Gas and Electric Corporation (RG&E), tendered for filing a Service

Agreement between RG&E and the Rochester Gas and Electric Corporation (Customer). This Service Agreement specifies that the Customer has agreed to the rates, terms and conditions of the RG&E open access transmission tariff filed on July 9, 1996 in Docket No. OA96–141–000.

RG&E requests waiver of the Commission's sixty (60) day notice requirements and an effective date of June 10, 1998, for the Rochester Gas and Electric Corporation Service Agreement. RG&E has served copies of the filing on the New York State Public Service Commission and on the Customer.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

16. Illinois Power Company

[Docket No. ER98–3338–000]

Take notice that on June 15, 1998, Illinois Power Company (Illinois Power), 500 South 27th Street, Decatur, Illinois 62526, tendered for filing a Power Sales Tariff, Service Agreement under which City of Sikeston will take service under Illinois Power Company's Power Sales Tariff. The agreements are based on the Form of Service Agreement in Illinois Power's tariff.

Illinois Power has requested an effective date of June 8, 1998.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

17. New York State Electric & Gas Corporation

[Docket No. ER98–3339–000]

Take notice that on June 15, 1998, New York State Electric & Gas Corporation (NYSEG), filed Service Agreements between NYSEG and Cinergy Operating Companies, PG&E Energy Trading, VTEC Energy and Plum Street Energy Marketing (Customers). These Service Agreements specify that the Customer has agreed to the rates, terms and conditions of the NYSEG open access transmission tariff filed and effective on June 11, 1997, in Docket No. OA97–571–000.

NYSEG requests waiver of the Commission's sixty-day notice requirements and an effective date of June 15, 1998, for the Service Agreements. NYSEG has served copies of the filing on The New York State Public Service Commission and on the Customer.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

18. Duquesne Light Company

[Docket No. ER98–3340–000]

Take notice that on June 15, 1998, Duquesne Light Company (DLC), tendered for filing a Service Agreement dated June 9, 1998, with ConAgra Energy Services, Inc., under DLC's Open Access Transmission Tariff (Tariff). The Service Agreement adds ConAgra Energy Services, Inc., as a customer under the Tariff. DLC requests an effective date of June 9, 1998, for the Service Agreement.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

19. California Independent System Operator Corporation

[Docket No. ER98–3341–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing a Scheduling Coordinator Agreement between the ISO and Gardner Energy Group, Inc. (Gardner), for acceptance by the Commission.

The ISO states that this filing has been served on Gardner and the California Public Utilities Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

20. California Independent System Operator Corporation

[Docket No. ER98–3342–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing a Meter Service Agreement for Scheduling Coordinators between the ISO and Hafslund Energy Trading L.L.C. (Hafslund), for acceptance by the Commission.

The ISO states that this filing has been served on Hafslund and the California Public Utilities Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

21. California Independent System Operator Corporation

[Docket No. ER98–3343–000]

Take notice that on June 15, 1998, the California Independent System Operator Corporation (ISO), tendered for filing a Meter Service Agreement for Scheduling Coordinators between the ISO and Gardner Energy Group, Inc. (Gardner), for acceptance by the Commission.

The ISO states that this filing has been served on Gardner and the California Public Utilities Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

22. Omni Energy

[Docket No. ER98–3344–000]

Take notice that on June 15, 1998, Omni Energy, tendered for filing a petition to the Commission for acceptance of Omni Energy's Rate Schedule FERC No. 1; the granting of certain blanket approvals, including the authority to purchase and resell electricity at negotiated, market-based rates; and the waiver of certain Commission Regulations.

Omni Energy will engage in wholesale electric power and energy transactions as a marketer. Omni Energy is engaged presently as a broker of electricity, natural gas and petroleum products. Omni Energy is a wholly owned and privately held company.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

23. Wisconsin Electric Power Company

[Docket No. ER98–3345–000]

Take notice that on June 15, 1998, Wisconsin Electric Power Company (Wisconsin Electric), tendered for filing a Transmission Service Agreement between itself and Upper Peninsula Power Company (UPPCO). The Transmission Service Agreement allows UPPCO to receive multi-year firm point-to-point transmission service under Wisconsin Electric's FERC Electric Tariff, Volume No. 7, which is pending Commission consideration in Docket No. OA97–578.

Wisconsin Electric requests an effective date coincident with its filing and waiver of the Commission's notice requirements in order to allow for economic transactions as they appear.

Copies of the filing have been served on UPPCO, the Public Service Commission of Wisconsin and the Michigan Public Service Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

24. New York State Electric & Gas Corporation

[Docket No. ER98–3346–000]

Take notice that on June 15, 1998, New York State Electric & Gas Corporation (NYSEG), tendered for filing pursuant to Section 35.13 of the Federal Energy Regulatory Commission's Regulations, 18 CFR 35.13, a Supplement to its September 28, 1993, Marcy-South 345 kV Transmission Facilities-Transmission Reinforcement Agreement (Agreement) with the New York Power Authority (NYPA), designated NYSEG Rate Schedule FERC No. 112. The proposed changes would decrease revenues for

the ten month period ending April 30, 1999.

This rate filing is made pursuant to Article No. 2, of the Agreement. The annual charges associated with other taxes, operating expenses, maintenance expenses, working capital, and associated revenue taxes are revised based on data taken from NYSEG's Annual Report to the Federal Energy Regulatory Commission (FERC Form 1) for the twelve months ended December 31, 1997.

NYSEG requests an effective date of July 1, 1998, and therefore, requests waiver of the Commission's notice requirements for good cause shown.

Copies of the filing were served upon the New York Power Authority and on the Public Service Commission of the State of New York.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

25. Central Hudson Gas & Electric Corporation

[Docket No. ER98–3348–000]

Take notice that on June 15, 1998, Central Hudson Gas and Electric Corporation (Central Hudson), tendered for filing its development of actual costs for 1997 related to substation service provided to Consolidated Edison Company of New York, Inc. (Con Edison), in accordance with the provisions of its Rate Schedule FERC No. 43.

Central Hudson indicates that the actual cost amounted to $286,523 for 1997 and will be the basis on which estimated charges for 1998 will be billed.

Central Hudson requests waiver on the notice requirements set forth in 18 CFR 35.11 of the Regulations to permit charges to become effective January 1, 1998, as agreed by the parties.

Central Hudson states that a copy of its filing was served on Con Edison and the State of New York Public Service Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

26. Central Hudson Gas & Electric Corporation

[Docket No. ER98–3349–000]

Take notice that on June 15, 1998, Central Hudson Gas and Electric Corporation (Central Hudson), tendered for filing its development of actual costs for 1997 related to transmission service provided from the Roseton Generating Plant to Consolidated Edison Company of New York, Inc. (Con Edison) and Niagara Mohawk Power Corporation (Niagara Mohawk) in accordance with the provisions of its Rate Schedule FERC No. 42.

The actual costs for 1997 amounted to $0.9898 per Mw.-day to Con Edison and $3.2838 per Mw.-day to Niagara Mohawk and are the basis on which charges for 1998 have been estimated.

Central Hudson requests waiver on the notice requirements set forth in 18 CFR 35.11 of the Regulations to permit charges to become effective January 1, 1998, as agreed by the parties.

Central Hudson states that a copy of its filing was served on Con Edison, Niagara Mohawk and the State of New York Public Service Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

27. Montaup Electric Company

[Docket No. ER98–3350–000]

Take notice that on June 15, 1998, Montaup Electric Company (Montaup) filed (1) executed unit sales service agreements under Montaup's FERC Electric Tariff, Original Volume No. 3; and (2) executed service agreements for the sale of system capacity and associated energy under Montaup's FERC Electric Tariff, Original Volume No. 4. The service agreements under both tariffs are between Montaup and the following companies (Buyers):

1. Cinergy Capital & Trading, Inc. (CCT)
2. SCANA Energy Marketing, Inc. (SCANA)

Montaup requests a waiver of the sixty-day notice requirement so that the service agreements may become effective as of June 15, 1998. No transactions have occurred under any of the agreements.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

28. Black Hills Corporation

[Docket No. ER98–3351–000]

Take notice that on June 15, 1998, Black Hills Corporation, doing business as and operating its electric utility under the name Black Hills Power and Light Company, tendered for filing revised tariff sheets to its open access transmission tariff.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

29. UtiliCorp United Inc.

[Docket No. ER98–3352–000]

Take notice that on June 15, 1998, UtiliCorp United Inc., tendered for filing on behalf of its operating division, Missouri Public Service, a Service Agreement under its Power Sales Tariff, FERC Electric Tariff Original Volume No. 10, with Northern/AES Energy, LLC. The Service Agreement provides for the sale of capacity and energy by Missouri Public Service to Northern/AES Energy, LLC, pursuant to the tariff and for the sale of capacity and energy by Northern/AES Energy, LLC to Missouri Public Service pursuant to Northern/AES Energy, LLC's Rate Schedule No. 1.

UtiliCorp also has tendered for filing a Certificate of Concurrence by Northern/AES Energy, LLC.

UtiliCorp requests waiver of the Commission's Regulations to permit the Service Agreement to become effective in accordance with its terms.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

30. UtiliCorp United Inc.

[Docket No. ER98–3353–000]

Take notice that on June 15, 1998, UtiliCorp United Inc., tendered for filing on behalf of its operating division, WestPlains Energy-Kansas, a Service Agreement under its Power Sales Tariff, FERC Electric Tariff Original Volume No. 12, with Northern/AES Energy, LLC. The Service Agreement provides for the sale of capacity and energy by WestPlains Energy-Kansas to Northern/AES Energy, LLC pursuant to the tariff, and for the sale of capacity and energy by Northern/AES Energy, LLC to WestPlains Energy-Kansas pursuant to Northern/AES Energy, LLC's Rate Schedule No. 1.

UtiliCorp also has tendered for filing a Certificate of Concurrence by Northern/AES Energy, LLC.

UtiliCorp requests waiver of the Commission's Regulations to permit the Service Agreement to become effective in accordance with its terms.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

31. UtiliCorp United Inc.

[Docket No. ER98–3354–000]

Take notice that on June 15, 1998, UtiliCorp United Inc., tendered for filing on behalf of its operating division, WestPlains Energy-Colorado, a Service Agreement under its Power Sales Tariff, FERC Electric Tariff Original Volume No. 11, with Northern/AES Energy, LLC. The Service Agreement provides for the sale of capacity and energy by WestPlains Energy-Colorado to Northern/AES Energy, LLC pursuant to the tariff, and for the sale of capacity and energy by Northern/AES Energy, LLC to WestPlains Energy-Colorado pursuant to Northern/AES Energy, LLC's Rate Schedule No. 1.

UtiliCorp also has tendered for filing a Certificate of Concurrence by Northern/AES Energy, LLC.

UtiliCorp requests waiver of the Commission's Regulations to permit the Service Agreement to become effective in accordance with its terms.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

32. Wisconsin Electric Power Company

[Docket No. ER98–3355–000]

Take notice that on June 15, 1998, Wisconsin Electric Power Company (Wisconsin Electric), tendered for filing an electric service agreement under its Market Rate Sales Tariff (FERC Electric Tariff, Original Volume No. 8) with Coral Power, L.L.C., (Coral). Wisconsin Electric respectfully requests an effective date of May 28, 1998, to allow for economic transactions.

Copies of the filing have been served on Coral, the Michigan Public Service Commission, and the Public Service Commission of Wisconsin.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

33. Wisconsin Electric Power Company

[Docket No. ER98–3357–000]

Take notice that on June 15, 1998, Wisconsin Electric Power Company (Wisconsin Electric), tendered for filing an electric service agreement under its Market Rate Sales Tariff (FERC Electric Tariff, Original Volume No. 8) with Rainbow Energy marketing Corporation (Rainbow). Wisconsin Electric respectfully requests an effective date of May 20, 1998, to allow for economic transactions.

Copies of the filing have been served on Rainbow, the Michigan Public Service Commission, and the Public Service Commission of Wisconsin.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

34. UtiliCorp United Inc.

[Docket No. ER98–3358–000]

Take notice that on June 15, 1998, UtiliCorp United Inc. (UtiliCorp), on behalf of its WestPlains Energy-Colorado division (WestPlains-Colorado), filed revisions to WestPlains-Colorado's open-access transmission tariff pending in this docket. UtiliCorp states that the primary purpose of the proposed revisions is to modify the priority of non-firm use on the WestPlains-Colorado system to accommodate WestPlains-Colorado's membership in the Rocky Mountain Reserve Group.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

35. Florida Power & Light Company

[Docket No. ER98–3359–000]

Take notice that on June 15, 1998, Florida Power & Light Company (FPL), filed a Service Agreement with Cinergy Capital & Trading, Inc., for service pursuant to Tariff No. 1, for Sales of Power and Energy by Florida Power & Light. In addition, FPL filed a Service Agreement with Cinergy Capital & Trading, Inc., for service pursuant to FPL's Market Based Rates Tariff. FPL requests that the Service Agreements be made effective on June 3, 1998.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

36. Southwestern Public Service Company

[Docket No. ER98–3360–000]

Take notice that on June 15, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credit resulting from its merger with Public Service company of Colorado required in its agreement with New Corp Resources, Inc. (New Corp), filed in Docket No. ER97–3903–000.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

37. Southwestern Public Service Company

[Docket No. ER98–3361–000]

Take notice that on June 15, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credit resulting from its merger with Public Service Company of Colorado required in its agreement with Lyntegar Electric Cooperative, Inc. (Lyntegar), filed in Docket No. ER97–3906–000.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

38. Duke Energy Corporation

[Docket No. ER98–3362–000]

Take notice that on June 15, 1998, Duke Power, a division of Duke Energy Corporation (Duke), tendered for filing a Market Rate Service Agreement (the MRSA) between Duke and Constellation Power Source, Inc., dated as of June 2, 1998. The parties have not engaged in any transactions under the MRSA as of the date of filing. Duke requests that the MRSA be made effective as of June 2, 1998.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

39. Sithe Mystic LLC; Sithe New Boston LLC, Sithe Edgar LLC, Sithe Framingham LLC, and Sithe West Medway LLC

[Docket Nos. ER98–3364–000]

Take notice that on June 15, 1998, Sithe Mystic LLC, Sithe New Boston LLC, Sithe Edgar LLC, Sithe Framingham LLC, and Sithe West Medway LLC (Project LLCs), tendered for filing with the Federal Energy Regulatory Commission Service Agreements between Sithe Power Marketing, Inc., and each of the Project LLCs, for service provided under the Project LLCs' respective FERC Electric Tariffs No. 1. The Project LLCs request that the Service Agreements become effective as of May 16, 1998.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

40. Public Service Electric and Gas Company

[Docket No. ER98–3365–000]

Take notice that on June 15, 1998, Public Service Electric and Gas Company (PSE&G), of Newark, New Jersey tendered for filing an agreement for the sale of capacity and energy to El Paso Energy Marketing Company (El Paso), pursuant to the PSE&G Wholesale Power Market Based Sales Tariff, presently on file with the Commission.

PSE&G further requests waiver of the Commission's Regulations such that the agreement can be made effective as of May 18, 1998.

Copies of the filing have been served upon El Paso and the New Jersey Board of Public Utilities.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

41. Public Service Electric and Gas Company

[Docket No. ER98–3366–000]

Take notice that on June 15, 1998, Public Service Electric and Gas Company (PSE&G), of Newark, New Jersey, tendered for filing an agreement for the sale of capacity and energy to Florida Power & Light Company (FP&L), pursuant to the PSE&G Wholesale Power Market Based Sales Tariff, presently on file with the Commission.

PSE&G further requests waiver of the Commission's Regulations such that the agreement can be made effective as of May 18, 1998.

Copies of the filing have been served upon FP&L and the New Jersey Board of Public Utilities.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

42. Public Service Electric and Gas Company

[Docket No. ER98–3367–000]

Take notice that on June 15, 1998, Public Service Electric and Gas Company (PSE&G), of Newark, New Jersey, tendered for filing an agreement for the sale of capacity and energy to Potomac Electric Power Company (PEPCO), pursuant to the PSE&G Wholesale Power Market Based Sales Tariff, presently on file with the Commission.

PSE&G further requests waiver of the Commission's Regulations such that the agreement can be made effective as of May 18, 1998.

Copies of the filing have been served upon PEPCO and the New Jersey Board of Public Utilities.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

43. Public Service Electric and Gas Company

[Docket No. ER98–3368–000]

Take notice that on June 15, 1998, Public Service Electric and Gas Company (PSE&G), of Newark, New Jersey tendered for filing an agreement for the sale of capacity and energy to The Dayton Power and Light Company (Dayton), pursuant to the PSE&G Wholesale Power Market Based Sales Tariff, presently on file with the Commission.

PSE&G further requests waiver of the Commission's Regulations such that the agreement can be made effective as of May 18, 1998.

Copies of the filing have been served upon Dayton and the New Jersey Board of Public Utilities.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

44. Public Service Electric and Gas Company

[Docket No. ER98–3369–000]

Take notice that on June 15, 1998, Public Service Electric and Gas Company (PSE&G), of Newark, New Jersey, tendered for filing an agreement for the sale of capacity and energy to Avista Energy, Inc. (Avista), pursuant to the PSE&G Wholesale Power Market Based Sales Tariff, presently on file with the Commission.

PSE&G further requests waiver of the Commission's Regulations such that the agreement can be made effective as of May 18, 1998.

Copies of the filing have been served upon Avista and the New Jersey Board of Public Utilities.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

45. Pacific Gas and Electric Company

[Docket No. ER98–3370–000]

Take notice that on June 15, 1998, Pacific Gas and Electric Company (PG&E), Southern California Edison Company (Edison), and San Diego Gas & Electric Company (SDG&E) (collectively the California Companies), tendered for filing a Rate Schedule change in the form of an amendment to the August 1, 1967, contract between the California Companies and Sacramento Municipal Utility District for Extra High Voltage Transmission and Exchange Service (the EHV Contract).

The Amendment submitted seeks to: (1) provide for a change from the existing loss factors to utilize transmission loss factors derived from those established in Appendix C of the Coordinated Operations Agreement (COA) for the period March 1, 1994 through March 30, 1998; (2) adopt the ISO Loss Methodology effective as of March 31, 1998, the ISO Operations Date; (3) modify certain definitions in Article 8 of the EHV Contract; and (4) incorporate contract language into the EHV Contract to establish that the California Companies have certain rights under Section 205 and Sacramento Municipal Utility District has certain rights under Section 206 of the Federal Power Act to make unilateral changes or to seek changes to losses and loss methodology.

Copies of this filing have been served upon the parties on the service list and the California Public Utilities Commission.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

46. Southwestern Public Service Company

[Docket No. ER98–3371–000]

Take notice that on June 15, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credit resulting from its merger with Public Service company of Colorado required in its agreement with Roosevelt Electric Cooperative, Inc. (Roosevelt), filed in Docket No. ER97–3902–000.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

47. Minnesota Power & Light Company

[Docket No. ER98–3372–000]

Take notice that on June 15, 1998, Minnesota Power & Light Company tendered for filing a signed Service Agreement with Constellation Power Source Inc., Interstate Power Company and Wisconsin Public Service Corporation under its market-based Wholesale Coordination Sales Tariff (WCS–2), to satisfy its filing requirements under this tariff.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

48. Bonneville Power Administration

[Docket No. NJ97–7–000]

Take notice that on May 26, 1998, Bonneville Power Administration (Bonneville), filed a motion to withdraw its January 2, 1997, standards of conduct and substitute revised standards of conduct.

Bonneville states that it served a copy of its motion and revised standards of conduct on each party on the official service list in this proceeding.

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

49. Big Rivers Electric Corporation

[Docket No. NJ98–5–000]

Take notice that on May 29, 1998, Big Rivers Electric Corporation filed standards of conduct under Order Nos. 889 *et seq.*[1]

Comment date: July 2, 1998, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraph

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, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 18 CFR 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in

[1] Open Access Same-Time Information System (Formerly Real-Time Information Network) and Standards of Conduct, 61 FR 21737 (May 10, 1996), FERC Stats. & Regs., Regulations Preambles January 1991–1996 ¶ 31,035 (April 24, 1996); Order No. 889–A, *order on reh'g*, 62 FR 12484 (March 14, 1997), III FERC Stats. & Regs. ¶ 31,049 (March 4, 1997); Order No. 889–B, *reh'g denied*, 62 FR 64715 (December 9, 1997), III FERC Stats. & Regs. ¶ 31,253 (November 25, 1997).

determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of these filings are on file with the Commission and are available for public inspection.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17054 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Docket No. ER98–3199–000, et al.]

PacifiCorp, et al., Electric Rate and Corporate Regulation Filings

June 19, 1998.

Take notice that the following filings have been made with the Commission:

1. PacifiCorp

[Docket No. ER98–3199–000]

Take notice that on June 16, 1998, PacifiCorp, tendered for filing in accordance with 18 CFR 35 of the Commission's Rules and Regulations, umbrella Service Agreements with City of Mesa, Arizona; Morenci Water & Electric Co.; Nautilus Energy Company, LLC; and New Energy Ventures, L.L.C., under PacifiCorp's FERC Electric Tariff, First Revised Volume No. 12.

Copies of this filing were supplied to the Public Utility Commission of Oregon and the Washington Utilities and Transportation Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

2. Allegheny Power Service Corp., on Behalf of Monongahela Power Co., The Potomac Edison Company, and West Penn Power Company (Allegheny Power)

[Docket No. ER98–2497–000]

Take notice that on June 16, 1998, Allegheny Power Service Corporation on behalf of Monongahela Power Company, The Potomac Edison Company and West Penn Power Company (Allegheny Power), filed Amendment No. 1, to Allegheny Power's Open Access Transmission Tariff, Supplement No. RT–1, to fulfill the requirements of the Commission's letter order dated May 19, 1998.

Copies of the filing have been provided to the Pennsylvania Public Utility Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

3. Western Resources, Inc.

[Docket No. ER98–3332–000]

Take notice that on June 16, 1998, Western Resources, Inc., tendered for filing an agreement between Western Resources and Arizona Public Service Company and Western Resources and NP Energy Inc. Western Resources states that the purpose of the agreements is to permit the customers to take service under Western Resources' market-based power sales tariff on file with the Commission.

The agreements are proposed to become effective June 15, 1998.

Copies of the filing were served upon Arizona Public Service Company, NP Energy Inc., and the Kansas Corporation Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

4. Southwestern Public Service Company

[Docket No. ER98–3356–000]

Take notice that on June 15, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credits resulting from its merger with Public Service company of Colorado required in its agreement with Golden Spread Electric Cooperative, Inc. (Golden Spread), filed in Docket No. ER97–47–000.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

5. Southwestern Public Service Company

[Docket No. ER98–3363–000]

Take notice that on June 16, 1998, Southwestern Public Service Company (Southwestern), tendered for filing its proposed non-fuel and non-purchased power operations and maintenance expense savings credit resulting from its merger with Public Service company of Colorado required in its agreement with Farmers' Electric Cooperative, Inc. (Farmers'), filed in Docket No. ER97–3901–000.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

6. PECO Energy Company

[Docket ER98–3373–000]

Take notice that on June 16, 1998, PECO Energy Company (PECO), tendered for filing three agreements between PECO and Sun Company Inc. (R&M), (Sun), each entitled Authorization for Parallel Operation of Customer Owned Generation Equipment, dated November 26, 1997, December 31, 1997 and March 18, 1998.

PECO requests waiver of the Commission's Regulations to permit the agreements to be effective as of December 1, 1997, January 1, 1998 and April 1, 1998, respectively.

Copies of the filing were served on Sun and the Pennsylvania Public Utility Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

7. Metropolitan Edison Company

[Docket No. ER98–3374–000]

Take notice that on June 16, 1998, Metropolitan Edison Company (Met-Ed) (d/b/a GPU Energy), filed executed Retail Transmission Service Agency Agreements between GPU and mc2, Inc., dated May 29, 1998.

GPU Energy requests a waiver of the Commission's notice requirements for good cause shown and an effective date of November 1, 1997 through December 31, 1998, for the Retail Transmission Service Agency Agreements.

GPU Energy will be serving a copy of the filing on the Pennsylvania Public Utility Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

8. Pennsylvania Electric Company

[Docket No. ER98–3375–000]

Take notice that on June 16, 1997, Pennsylvania Electric Company (d/b/a GPU Energy), filed an executed Retail Transmission Service Agency Agreements between GPU Energy and mc2, Inc., dated May 29, 1998.

GPU Energy requests a waiver of the Commission's notice requirements for good cause shown and an effective date of November 1, 1997, for the Retail Transmission Service Agency Agreements.

GPU Energy will be serving a copy of the filing on the Pennsylvania Public Utility Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

9. Public Service Company of New Mexico

[Docket No. ER98–3376–000]

Take notice that on June 16, 1998, Public Service Company of New Mexico (PNM), submitted for filing an executed copy of the Interim Resolution of PNM's September 18, 1997, Section 211 request

for Transmission Service from the Western Area Power Administration (Western), as a supplement to the two existing contracts for reserved transmission capacity (i.e. Contracts Number 14–06–400–2425 and 8–07–40-PO695) between PNM and Western.

PNM requests waiver of the Commission's notice requirements to permit the Interim Resolution to become effective as of June 4, 1998.

Copies of the filing have been provided to Western, Plains Electric Generation and Transmission Cooperative, Inc., Southwestern Public Service Company, and the New Mexico Public Utility Commission, and are available for public inspection at PNM's offices in Albuquerque, New Mexico.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

10. Washington Water Power Company

[Docket No. ER98–3377–000]

Take notice that on June 16, 1998, the Washington Water Power Company tendered for filing a Termination of Contract, to be canceled by mutual agreement, for Firm Energy Exchange Agreement with Enron Power Marketing, Inc., under FERC Rate Schedule No. 232, in Docket No. ER96–2606–000.

Washington Water Power requests that this termination become effective October 1, 1998.

Copies of the filing have been served upon Enron Power Marketing, Inc.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

11. Astra Power, Inc.

[Docket No. ER98–3378–000]

Take notice that on June 16, 1998, Astra Power, LLC (Astra Power), petitioned the Federal Energy Regulatory Commission for acceptance of Astra Power's FERC Electric Rate Schedule No. 1; the granting of certain blanket authorizations; and the waiver of certain of the Commission's Regulations.

Astra Power intends to engage in power marketing transactions, purchasing and reselling electricity at wholesale, at rates and on terms and conditions that are negotiated with the purchasing party. Astra Power may engage in reassignment of transmission capacity. Astra Power does not own or control electric generating or transmission facilities or have any franchised electric service territories.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

12. Florida Power Corporation

[Docket No. ER98–3379–000]

Take notice that on June 16, 1998, Florida Power Corporation (Florida Power), tendered for filing a service agreement providing for firm point-to-point transmission service to Virginia Electric and Power Company (Virginia Power), pursuant to its open access transmission tariff. Florida Power requests that the Commission waive its notice of filing requirements and allow the agreement to become effective on June 17, 1998.

Florida Power respectfully requests Commission waiver of the notice requirements in order to allow the Agreements to become effective June 17, 1998.

Copies of the notice have been served upon Virginia Power, and the Florida Public Service Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

13. Carolina Power & Light Company

[Docket No. ER98–3380–000]

Take notice that on June 16, 1998, Carolina Power & Light Company (CP&L), tendered for filing an un-executed Service Agreement between CP&L and ConAgra Energy Services, Inc. Service to the eligible buyer will be in accordance with the terms and conditions of CP&L's Market-Based Rates Tariff, FERC Electric Tariff No. 4, for sales of capacity and energy at market-based rates.

Copies of the filing were served upon the North Carolina Utilities Commission and the South Carolina Public Service Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

14. Energetix, Inc.

[Docket No. ER98–3381–000]

Take notice that on June 16, 1998, Energetix, Inc. (Energetix), submitted an Application for amendment to its Market-Based Rate Tariff, FERC Electric Rate Schedule No. 1, and the Corporate Policies and Guidelines for Transactions Between Energetix and Rochester Gas and Electric Corporation (RG&E). Energetix states that the purpose of these proposed revisions is to permit Energetix to engage in energy and/or capacity transactions with its affiliate, RG&E, in a manner consistent with the precedent of the Federal Energy Regulatory Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

15. Rochester Gas and Electric Corporation

[Docket No. ER98–3382–000]

Take notice that on June 16, 1998, Rochester Gas and Electric Corporation (RG&E), submitted an Application for amendment to its Market-Based Rate Tariff, Market-Based Power Sales Tariff No. 3. RG&E submitted revised tariff sheets, as well as a revised form of Service Agreement.

In addition RG&E filed a service agreement between RG&E and its affiliate, Energetix, Inc. (Energetix), for approval of the Federal Energy Regulatory Commission (Commission). RG&E states that the purpose of the proposed revisions to its tariff and the Service Agreement is to permit RG&E to engage in energy and/or capacity transactions with Energetix, in a manner consistent with the precedent of the Commission.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

16. Maine Public Service Company

[Docket No. ER98–3383–000]

Take notice that on June 16, 1998, Maine Public Service Company (Maine Public), filed an executed Service Agreement with PG&E Energy Trading-Power, L.P.

Main Public requests waiver of the Commission's 60-day notice requirements so that the service agreement can become effective on May 29, 1998.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

17. Boston Edison Company

[Docket No. ER98–3384–000]

Take notice that on June 16, 1998, Boston Edison Company (Boston Edison), tendered for filing (a) a firm point-to-point transmission service agreement and (b) a non-firm point-to-point transmission service agreement with Merchant Energy Group of the Americas, Inc. Both agreements provide for service pursuant to Boston Edison's open access transmission tariff.

Boston Edison requests that the service agreements become effective August 16, 1998.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

18. American Electric Power Service Corporation

[Docket No. ER98–3399–000]

Take notice that on June 16, 1998, the American Electric Power Service Corporation (AEPSC), tendered for filing

executed service agreements under the Wholesale Market Tariff of the AEP Operating Companies (Power Sales Tariff). The Wholesale Market Tariff was accepted for filing effective October 10, 1997 and has been designated AEP Operating Companies' FERC Electric Tariff Original Volume No. 5. AEPSC respectfully requests waiver of notice to permit the service agreements submitted with this filing to be made effective for Oklahoma Gas & Electric Company on April 23, 1998; PP&L, Inc., on May 19, 1998; Puget Sound Energy, Inc., on May 4, 1998; Southern Company Energy Marketing, Inc., on May 19, 1998; Sempra Energy Trading Corporation on May 19, 1998; and Williams Energy Services Company on May 19, 1998.

A copy of the filing was served upon the Parties and the State Utility Regulatory Commissions of Indiana, Kentucky, Michigan, Ohio, Tennessee, Virginia and West Virginia.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

19. FirstEnergy System

[Docket No. ER98–3400–000]

Take notice that on June 16, 1998, FirstEnergy System filed Service Agreements to provide Firm Point-to-Point Transmission Service for Constellation Power Source, Inc., Commonwealth Edison Company, Entergy Power Marketing Corp., FirstEnergy Corp—Bulk Power, Illinois Power Company, Morgan Stanley Capital Group, Inc., Northeast Utilities Service Company, PECO Energy Company, Rainbow Energy Marketing Corp., Sonat Power Marketing L.P., Southern Company Energy Marketing L.P., Virginia Electric and Power Company, Williams Energy Services Co., Amoco Energy Trading Corp., Engage Energy US, L.P., NorAm Energy Services, Inc., and Wisconsin Electric Power Company, the Transmission Customers. Services are being provided under the FirstEnergy System Open Access Transmission Tariff submitted for filing by the Federal Energy Regulatory Commission in Docket No. ER97–412–000.

The proposed effective dates under these Service Agreements are May 18, 1998, June 1, 1998 and June 15, 1998, respectively, for the above mentioned Service Agreements in this filing.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

20. Kansas City Power & Light Company

[Docket No. ER98–3407–000]

Take notice that on June 16, 1998, Kansas City Power & Light Company (KCPL), tendered for filing a Service Agreement dated May 26, 1998, between KCPL and Entergy Power Marketing Corporation. KCPL proposes an effective date of May 27, 1998 and requests a waiver of the Commission's notice requirement to allow the requested effective date. This Agreement provides for the rates and charges for Short-term Firm Transmission Service.

In its filing, KCPL states that the rates included in the above-mentioned Service Agreement are KCPL's rates and charges in the compliance filing to FERC Order No. 888–A in Docket No. OA97–636–000.

Comment date: July 6, 1998, in accordance with Standard Paragraph E at the end of this notice.

Standard Paragraph

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, 888 First Street, N.E., Washington, D.C. 20426, in accordance with Rules 211 and 214 of the Commission's Rules of Practice and Procedure (18 CFR 385.211 and 18 CFR 385.214). All such motions or protests should be filed on or before the comment date. Protests will be considered by the Commission in determining the appropriate action to be taken, but will not serve to make protestants parties to the proceeding. Any person wishing to become a party must file a motion to intervene. Copies of these filings are on file with the Commission and are available for public inspection.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17030 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–P

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2659–011]

PacifiCorp; Notice of Intent To Prepare an Environmental Assessment and Conduct Public Scoping Meetings and a Site Visit

June 22, 1998.

The Federal Energy Regulatory Commission (Commission) is reviewing the hydropower application for a new license for the 6-megawatt Powerdale Hydroelectric Project, No. 2659–011. The project, owned and operated by PacifiCorp, is located on the Hood River, near the town of Hood River, in Hood River County, Oregon.

The Commission staff intends to prepare an Environmental Assessment (EA) for the project in accordance with the National Environmental Policy Act. In the EA, we will consider reasonable alternatives to PacifiCorp's proposed action, and analyze both site-specific and cumulative environmental impacts of the project, as well as economic and engineering impacts.

A draft EA will be issued and circulated to those on the mailing list for this project. All comments filed on the draft EA will be analyzed by the staff and considered in a final EA. The staff's conclusions and recommendations presented in the final EA will then be presented to the Commission to assist in making a licensing decision.

Scoping

We are asking agencies, Indian tribes, non-governmental organizations, and individuals to help us identify the scope of environmental issues that should be analyzed in the EA, and to provide us with information that may be useful in preparing the EA.

To help focus comments on the environmental issues, a scoping document outlining subject areas to be addressed in the EA will be mailed to those on the mailing list for the project. Those not on the mailing list may request a copy of the scoping document from the Project Coordinator, whose telephone number is listed below.

Those with comments or information pertaining to this project should file it with the Commission at the following address by August 24, 1998: David P. Boergers, Acting Secretary, Federal Energy Regulatory Commission, 888 First Street, NE., Washington, DC 20426.

All filings should clearly show the following on the first page: Powerdale Hydroelectric Project, FERC No. 2659–011.

Intervenors are reminded of the Commission's Rules of Practice and Procedure which require all intervenors filing documents with the Commission to serve a copy of that document on each person whose name appears on the official service list for the project. Further, if an intervenor files comments or documents with the Commission relating to the merits of an issue that may affect the responsibilities of a particular resource agency, they must also serve a copy of the document on that resource agency.

In addition to asking for written comments, we are holding two scoping meetings to solicit any verbal input and comments you may wish to offer on the scope of the EA. An agency scoping meeting will begin at 9:00 a.m. on July 22, 1998, at the Hood River Inn, 1108 East Marina Way, Hood River, OR 97031. A public scoping meeting will begin at 7:00 p.m. on July 22, 1998, at the Hood River Inn, 1108 East Marina Way, Hood River, OR 97031. The public and agencies may attend either meeting. There will also be a visit to the project site on July 23, 1998, to become more familiar with the project area. More information about these meetings and site visit is available in the scoping document.

Any questions regarding those notice may be directed to Mr. Bob Easton, Project Coordinator, at (202) 219–2782.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17033 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

[Project No. 2674—Vermont Vergennes Hydroelectric Project]

Green Mountain Power Corporation; Notice of Proposed Restricted Service List for a Programmatic Agreement for Managing Properties Included in or Eligible for Inclusion in the National Register of Historic Places

June 22, 1998.

Rule 2010 of the Federal Energy Regulatory Commission's (Commission) Rules of Practice and Procedure provides that, to eliminate unnecessary expense or improve administrative efficiency, the Secretary may establish a Restricted Service List for a particular phase or issue in a proceeding.[1] The Restricted Service List should contain the names of persons on the service list who, in the judgment of the decisional authority establishing the list, are active participants with respect to the phase or issue in the proceeding for which the list is established.

The Commission staff is consulting with the Vermont State Historic Preservation Officer (hereinafter, SHPO) and the Advisory Council on Historic Preservation (hereinafter, Council) pursuant to the Council's regulations, 36 CFR Part 800, implementing Section 106 of the National Historic Preservation Act, as amended, (16 U.S.C. Section 470 f), to prepare a Programmatic Agreement for managing properties included in, or eligible for inclusion in, the National Register of Historic Places at Project No. 2674.

The Programmatic Agreement, when executed by the Commission, the SHPO, and the Council, would satisfy the Commission's Section 106 responsibilities for all individual undertakings carried out in accordance with the license until the license expires or is terminated (36 CFR 800.13[e]). The Commission's responsibilities pursuant to Section 106 for the above project would be fulfilled through the Programmatic Agreement, which the Commission proposes to draft in consultation with certain parties listed below. The executed Programmatic Agreement would be incorporated into any Order issuing a license.

Green Mountain Power Corporation, as prospective Licensee for Project No. 2674, is invited to participate in consultations to develop the Programmatic Agreement and to sign as a concurring party to the Programmatic Agreement.

For purposes of commenting on the Programmatic Agreement, we propose to restrict the service list for Project No. 2674 as follows:

Don L. Klima, Advisory Council on Historic Preservation, The Old Post Office Building, Suite 809, 1100 Pennsylvania Avenue, NW, Washington, DC 20004

Emily Wadhams, State Historic Preservation Officer, Vermont Division for Historic Preservation, National Life Building, Drawer 20, Montpelier, VT 05620–0501

Giovanna Peebles, Vermont Division for Historic Preservation, National Life Building, Drawer 20, Montpelier, VT 05620–0501

Craig T. Myotte, Green Mountain Power Corporation, 25 Green Mountain Drive, South Burlington, VT 05402

Melvin S. Hawley, City Manager, City of Vergennes, P.O. Box 35, Vergennes, VT 05491

Jeffrey R. Cueto, Vermont Agency of Natural Resources, 103 South Main Street, Building 10 North, Waterbury, VT 05671–0408

Any person on the official service list for the above-captioned proceeding may request inclusion on the Restricted Service List, or may request that a Restricted Service List not be established, by filing a motion to that effect within 15 days of this notice date.

An original and 8 copies of any such motion must be filed with the Secretary of the Commission (888 First Street, NE, Washington, D.C. 20426) and must be served on each person whose name appears on the official service list. If no such motions are filed, the Restricted Service List will be effective at the end of the 15 day period. Otherwise, a further notice will be issued ruling on the motion.

David P. Boergers,

Acting Secretary.

[FR Doc. 98–17034 Filed 6–25–98; 8:45 am]

BILLING CODE 6717–01–M

[1] 18 CFR 385.2010.

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–5493–2]

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared June 08, 1998 Through June 12, 1998 pursuant to the Environmental Review Process (ERP), under Section 309 of the Clean Air Act and Section 102(2)(c) of the National Environmental Policy Act as amended. Requests for copies of EPA comments can be directed to the Office of Federal Activities AT (202) 564–7167.

An explanation of the ratings assigned to draft environmental impact statements (EISs) was published in FR dated April 10, 1998 (63 FR 17856).

Draft EISs

ERP No. D–FHW–E50290–NC Rating EO2, Mid-Currituck Sound Bridge, between U.S. 158 on the Currituck County Mainland and end at NC 12 on the Currituck Outer Banks, US Coast Guard Bridge Permit and COE Section 404 Permit, Currituck County, NC.

Summary: EPA expressed environmental objections due to degraded water quality, lost of submerged aquatic vegetation and the projects impact on efforts improve fishery resources. EPA requested that these and other issues be clarified and other less damaging alternative be fully assessed.

ERP No. D–FHW–K40231–AZ Rating LO, ed Mountain Freeway (Loop 202) Construction and Operation, between AR 87 (County Club Drive) and US–60 (Superstition Freeway), Funding, NPDES Permit and COE Section 404 Permit, City of Mesa, Maricopa County, AZ.

Summary: EPA expressed a lack of objections with the FHWA's Red Mountain Freeway (Loop) 202 project.

Final EISs

ERP No. F–AFS–K65200–CA San Juan Fuels and Wildlife Project, Implementation, Tahoe National Forest,

Nevada City Ranger District, Nevada County, CA.

Summary: Review of the Final EIS was not deemed necessary. No formal comment letter was sent to the preparing agency.

ERP No. F–URC–J39024–UT Provo River Restoration Project (PRRP), Riverine Habitat Restoration, Reconstruction and Realignment of the existing Provo River Channel and Floodplain System between Jordanell Dam and Deer River Reservoir, Wasatch County, UT.

Summary: Review of the Final EIS was not deemed ncessary. No formal comment letter was sent to the preparing agency.

ERP No. F–USA–C11014–NY Seneca Army Depot Activity Disposal and Reuse, Implementation, Seneca County and the City of Geneva, Ontario County, NY.

Summary: EPA commented that provided that more effective wetlands mitigation measures are developed and incorporated into the ROD, the proposed project should not result in significant adverse environmental impacts.

Dated: June 23, 1998.

William D. Dickerson,

Director, NEPA Compliance Division Office of Federal Activities.

[FR Doc. 98–17111 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–U

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–5493–1]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information (202) 564–7167 OR (202) 564–7153.

Weekly receipt of Environmental Impact Statements Filed June 15, 1998 Through June 19, 1998 Pursuant to 40 CFR 1506.9.

EIS No. 980236, FINAL EIS, FHW, NC, US 64 Bypass Transportation Improvements Project, from I–440 to US 64 west of Wendell and Eastern Wake Expressway from existing US 64 to NC–1007 (Poole Road), Funding and COE Section 404 Permit, Wake County, NC, Due: July 27, 1998, Contact: Tom Kendig (919) 733–7842.

EIS No. 980237, DRAFT EIS, FHW, IL, Fox River Bridge Crossings, To Construct up to Five-Bridges across the Fox River, NPDES Permit, COE Section 10 and 404 Permits, Kane County, IL, Due: August 10, 1998, Contact: Ronald C. Marshall (217) 492–4600.

EIS No. 980238, FINAL EIS, BLM, AZ, Yarnell Gold Mining Project, Construction and Operation on Open-pit Gold Mine and Ore Processing Facility, Yavapai County, AZ, Due: July 27, 1998, Contact: Ms. Shela McFarlin (602) 417–9568.

EIS No. 980239, DRAFT EIS, BLM, AZ, Yarnell Gold Mining Project, Construction and Operation an Open-pit Gold Mine and Ore Processing Facility, Yavapai County, AZ, Due: August 25, 1998, Contact: Connie Stone (602) 580–5517.

EIS No. 980240, DRAFT EIS, NPS, AK, Sitka National Historical Park, General Management Plan, Implementation, City and Borough of Sitka, AK, Due: August 26, 1998, Contact: Gary Garthier (907) 747–6281.

EIS No. 980241, DRAFT SUPPLEMENT, NOAA, Atlantic Sea Scallop, Placopecten Magellanicus, (Gmelin), Fishery Management Plan (FMP), Updated and Additional Information, Amendment No. 7, Due: August 10, 1998, Contact: Andrew Rosenberg (978) 281–9300.

EIS No. 980242, DRAFT EIS, NOA, ME, Atlantic Herring (Clupea harengus harengus) Fishery Management Plan (FMP), Management Measures, Exclusive Ecosystem Zone (EEZ), Gulf of Maine, George Bank, ME, Due: August 10, 1998, Contact: Andrew Rosenberg (978) 281–9300.

EIS No. 980243, DRAFT EIS, AFS, WA, Sand Ecosystem Restoration Project, Implementation, Wenatchee National Forest, Leavenworth Range District, Chelan County, WA, Due: August 10, 1998, Contact: Bob Stoehr (509) 548–6977.

EIS No. 980244, DRAFT SUPPLEMENT, FRC, AL, North Alabama Pipeline Facilities, Additional Information, To Amended Natural Gas Pipeline, Construction and Operation, COE Section 10 and 404 Permits, Right-of-Way and NPDES Permits, Morgan, Limestone and Madison, AL, Due: August 10, 1998, Contact: Paul McKee (202) 208–1088.

EIS No. 980245, FINAL EIS, FRC, ME, Maritimes Phase II Project, Construct and Operate on Interstate Natural Gas Pipeline, COE Section 10 and 404 Permits, Endangered Species Act (ESA) and NPDE's permits, US Canada border at Woodland (Burleyville) Maine and Westbrook Maine, Due: July 27, 1998, Contact: Paul McKee (202) 208–1088.

Amended Notices

EIS No. 980176, DRAFT EIS, FHW, MD, US–301 Transportation Study, Improvements, from US–301 North of US–301/MD–5 Interchange at T.B. to US 50 in Bowie, Northern Corridor Tier I, Prince George's County, MD, Due: July 15, 1998, Contact: George Frick (410) 962–4440. Published FR 05–15–98—Review Period extended.

Dated: June 23, 1998.

William D. Dickerson,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 98–17112 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–U

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6116–2]

National Advisory Council for Environmental Policy and Technology Reinvention Criteria Committee; Environmental Information and Public Access Committee; Environmental Capital Markets Committee; Public Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of public meeting.

SUMMARY: Under the Federal Advisory Committee Act, P.L. 92–463, EPA gives notice of a meeting of the following committees of the National Advisory Council for Environmental Policy and Technology (NACEPT) which provides advice and recommendations to the Administrator of EPA on a broad range of environmental policy issues.

The Reinvention Criteria Committee (RCC) has been asked to help the Agency understand how incentives can be used most successfully to inspire firms, companies, communities, and individuals to go beyond mere compliance with existing regulations and to begin the process of addressing outstanding environmental problems. In particular, the committee will focus on the following questions:

—What opportunities exist for EPA to use incentives to promote environmental stewardship in industry? In local communities? In the general public?

—How can EPA evaluate the effectiveness of incentives to encourage environmental stewardship that leads to improved environmental results? How can EPA measure the impact that incentives have on public confidence? What criteria should be used to decide whether the use of incentives is appropriate?

—How can the concept of performance ladders be used to tailor incentives most effectively?

The Environmental Information and Public Access Committee (EIPAC) will discuss issues relating to the newly created Center for Environmental and Information Statistics; workgroups will discuss data quality, public access and use, and intergovernmental relations needed for the Center.

The Environmental Capital Markets Committee (ECM) will provide stakeholder inputs on the potential utility of using Environmental Management Systems as an investment service. The ultimate goal of the committee is to identify concrete actions EPA can take, on its own or in cooperation with other Federal and State agencies, to help the financial services industry incorporate environmental information into its decision-making process.

These meetings are being held to provide the EPA with perspectives from representatives of state, local, and tribal governments, environmental, business, and financial organizations, academia, industry, and NGOs.

DATES: The RCC and EIPAC will hold a two-day public meeting at the Embassy Suites Hotel, 1250 22nd Street, NW, Washington, D.C. 20037, on Tuesday, July 7, and Wednesday, July 8, 1998 from 8:30 am to 5:00 pm.

The ECM will hold a one-day public meeting at the same location on Wednesday, July 8, 1998 from 8:00 am to 5:00 pm.

ADDRESSES: Materials or written comments may be transmitted to the committees through Gwendolyn Whitt, Designated Federal Officer, NACEPT, U.S. EPA, Office of Cooperative Environmental Management (1601F), 401 M Street, SW, Washington, D.C. 20460. There will also be an opportunity for the public to make comments directly to the committees during the first day of the meetings. Requests to make public comments must be submitted no later than June 30, 1998 to Gwendolyn Whitt, at the address above or faxed to (202) 260–6882.

FOR FURTHER INFORMATION CONTACT: Gwendolyn Whitt, Designated Federal Officer, NACEPT, at (202) 260–9484.

Dated: June 16, 1998.

Gwendolyn Whitt,

Designated Federal Officer.

[FR Doc. 98–16944 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–U

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6117–7]

National Advisory Council for Environmental Policy and Technology, Title VI Implementation Advisory Committee

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: Pursuant to the Federal Advisory Committee Act (Pub. L. 92–463), the U.S. Environmental Protection Agency (EPA) now gives notification of a meeting of the Title VI Implementation Advisory Committee of the National Advisory Council for Environmental Policy and Technology (NACEPT).

Title VI of the Civil Rights Act of 1964 prohibits recipients of federal financial assistance from discriminating on the basis of race, color, or national origin in their programs or activities.

The purpose of the Title VI Implementation Advisory Committee is to advise the Administrator and Deputy Administrator of EPA on techniques that may be used by EPA funding recipients to operate environmental permitting programs in compliance with Title VI. The Title VI Implementation Advisory Committee is one of several standing committees of NACEPT.

The Committee consists of 23 independent representatives drawn from among state and local governments, industry, the academic community, tribal and indigenous interests, and grassroots environmental and other non-governmental organizations.

DATES: The Committee will meet on July 27, 1998 from 1:30 p.m. to 8:30 p.m. and July 28, 1998 from 8:30 a.m. to 6:30 p.m. The public comment session will be held on July 27 from 6:30 p.m. to 8:30 p.m.

Members of the public who wish to make brief oral presentations should contact Jannell Young at (202) 260–1888 by July 21, 1998 to reserve time during the public comment session. The Committee is particularly interested in receiving public comments on how a state permitting agency can effectively identify and address Title VI concerns early in the permitting process. Individuals or groups making presentations will be limited to a total time of five minutes. Those who have not reserved time in advance may make comments during the public comment session as time allows.

ADDRESSES: The Penn Tower Hotel, Civic Center Boulevard at 34th Street, Philadelphia, Pennsylvania. The meeting is open to the public. However, seating will be limited and available on a first-come, first-served basis.

FOR FURTHER INFORMATION CONTACT: Mr. Gregory Kenyon, Designated Federal Officer, U.S. EPA, Office of Cooperative Environmental Management, telephone (202) 260–8169.

Dated: June 24, 1998.

Gregory Kenyon,

Designated Federal Officer, NACEPT Title VI Implementation Advisory Committee.

[FR Doc. 98–17284 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6116–7]

Proposed 42 U.S.C. Section 122(b) De Minimis Settlement; MIG/DeWane Landfill, Belvidere, IL

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed section 122(g) *de minimis* settlement.

SUMMARY: This document is provided pursuant to section 122(i) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (CERCLA), 42 U.S.C. 9601 *et seq.* and section 7003(d) of the Resource Conservation and Recovery Act (RCRA), 42 U.S.C. 6901–6992k. U.S. EPA proposes settlement of a claim under Section 122(g) of the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended (CERCLA), 42 U.S.C. 9601 *et seq.* with Gunite Corporation for past costs and costs that will be incurred during removal and remedial activities at the MIG/DeWane Landfill Site in Belvidere, Illinois. Respondent Gunite Corporation, a *de minimis* potentially responsible party, has agreed to pay a total of $30,476.00. The money will be used to reimburse the U.S. EPA for past costs and oversight costs that will be incurred during actions taken at the site. The proposed action is being taken to settle all liability related to the MIG/DeWane Landfill Site for this Respondent under sections 106 and 107(a) of CERCLA and section 7003 of RCRA.

DATES: Comments on this proposed settlement must be submitted to U.S. EPA on or before July 27, 1998.

ADDRESSES: Comments on the proposed settlement should be addressed to Diana Embil, (C–14J), Assistant Regional Counsel, U.S. Environmental Protection Agency, 77 West Boulevard, Chicago,

Illinois 60604–3590, (312) 886–7889. Comments should refer to: In the Matter of: MIG/DeWane Landfill Administrative Order on Consent. Please submit an original and three copies of any comments, if possible.

A copy of the proposed settlement is available at the following address for review: U.S. Environmental Protection Agency, Region V, Office of Superfund, 77 West Jackson Boulevard, Chicago, Illinois 60604–3590. Please telephone Diana Embil, at (312) 886–7889, before visiting the Region V Office.

PUBLIC MEETING: A public meeting in the affected area may be held upon request.

FOR FURTHER INFORMATION CONTACT: Diana Embil, (C–14J), Assistant Regional Counsel, U.S. Environmental Protection Agency, 77 West Boulevard, Chicago, Illinois 60604–3590, (312) 886–7889.

SUPPLEMENTARY INFORMATION: From 1969 to 1988, the MIG/DeWane Landfill received industrial and solid wastes, some of which contained hazardous substances. On August 30, 1990, U.S. EPA placed the Landfill on the National Priorities List. On March 29, 1991, U.S. EPA issued an administrative consent order concerning various responsible parties for a removal action at the Site. On May 15, 1995, U.S. EPA reached a *de minimis* settlement with other responsible parties. Gunite Corporation was not a signatory to either agreement.

Gunite Corporation is a potentially responsible party that may have arranged for the disposal of hazardous substances at the MIG/DeWane Landfill Site. Gunite Corporation's share of the waste delivered to the site is believed not to exceed 0.05% of the total waste delivered to the site.

Pursuant to section 122(i) of CERCLA, the 30-day period for comments on the proposed settlement with this Respondent begins on the date of publication of today's notice.

William E. Muno,

Director, Superfund Division.

[FR Doc. 98–16945 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–M

ENVRIONMENTAL PROTECTION AGENCY

[FRL–6117–1]

Characterization of Municipal Solid Waste in the United States: 1997 Update

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In recent years, community officials and the general public have increased their attention to the waste generated by households, institutions, and commercial businesses. They have used information about municipal solid waste (MSW) to plan for programs to reduce and recycle this waste and to properly dispose of the remainder. The ''Characterization of Municipal Solid Waste in the United States'' report was first prepared by EPA in 1986 in order to determine the amounts of waste generated, recovered, and discarded in the nation, and to project amounts of waste which will be managed in the future. The report has been updated six times since its initial publication in 1986. Planners nation-wide use this special study to estimate the amount and types of MSW that may be generated in their communities, and thus are able to plan more effectively for the management of the wastes generated, recovered, and/or discarded.

The Characterization of Municipal Solid Waste in the United States: 1997 Update report is now available. The 1997 Update is similar to the 1996 Update, but it contains updated information on the types and amounts of municipal solid waste generated, recovered, and discarded in the United States through 1996. Some new informational categories are also included in the 1997 Update. These include an expanded discussion of the markets for recovered recyclable materials.

Finally, due to sustained interest in tracking national generation, recovery, and discard rates for MSW, EPA plans to continue providing annual updates of this Report as a service to its stakeholders from State and local governments, industry, environmental groups, and the public.

DATES: June 26, 1998.

FOR FURTHER INFORMATION CONTACT:

A paper copy of Characterization of Municipal Solid Waste in the United States: 1997 Update (EPA Publication Number EPA530–98–R–007) or the Report's Executive Summary (EPA Publication Number EPA530–S–98–007) may be obtained by calling the RCRA Hotline at 1–800–424–9346. The Report is also available in electronic format on the Internet System through the EPA Public Access Server at www.epa.gov.

Dated: May 5, 1998.

Elizabeth A. Cotsworth,

Acting Director, Office of Solid Waste.

[FR Doc. 98–17123 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–M

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6114–7]

Massachusetts Marine Sanitation Device Standard; Receipt of Petition

Notice is hereby given that a petition has been received from the State of Massachusetts requesting a determination of the Regional Administrator, U.S. Environmental Protection Agency, pursuant to section 312(f)(3) of Public Law 92–500 as amended by Public Law 95–217 and Public Law 100–4, that adequate facilities for the safe and sanitary removal and treatment of sewage from all vessels are reasonably available for the coastal regions of the town of Harwich, State of Massachusetts, to qualify as a ''No Discharge Area'' (NDA). The areas covered under this petition include the major harbors and contiguous beaches between and including Allen , Wychmere and Saquatucket harbors and to the Herring River. The latitudes and longitude defining the boundaries are Town line of Dennis 70°07′03″, 41°39′16″, Herring River 70°06′33″, 41°40′08″, Allens Harbor 70°05′22″, 41°40′04″, Wychmere Harbor 70°03′56″, 41°40′04″, Saquatucket Harbor 70°03′31″, 41°40′09″, Town line of Chatham 70°02′17″, 41°39′58″, and the water boundaries are 70°02′55″, 41°39′52″,—70°04′38″, 41°39′46″,—70°06′00″, 41°39′35″.

The State of Massachusetts has certified that there are two facilities to service the town of Harwich. A stationary shore side pump-out facility at the Saquatucket Municipal Marina has a 60 gallon per cycle capacity with discharge to a 2,500 gallon tight tank. This facility provides access for vessels with 6 feet draft at mean low water. This facility is available daily from May 1st through November 15th, weather permitting and open during daylight hours. Harbormaster personnel will be available to demonstrate the self-service system Tuesday through Sunday, from 9 a.m, to 3 p.m. The Harwich Harbormaster's office number is (508) 430–7532. The second facility is a pump-out boat typically docked at Saquatucket Municipal Marina, unless the private marinas request it for a short period of time. This pump-out boat will come to individual boats by appointment, which can be made by calling the Harwich Harbormaster on channel VHF 68 or calling the office at (508) 430–7532. The pump-out boat will be available May 1st through November 15th , and service is normally available

Tuesday through Sunday, 9 a.m to 3 p.m., weather permitting.

In addition to these pump-out facilities, there is a town comfort station located on the Allen harbor town boat ramp parking area, and the Saquatucket Municipal Marina has on-shore bathroom and shower facilities available 24 hours a day. There are also private facilities at the Allen Harbor Yacht Club.

The waste from stationary shore side pump-out facility at the Saquatucket Municipal Marina and the pump-out boat is collected and stored in a Department of Environmental Protection approved, 2,500 gallon tigh tank. This tank is fitted with alarms that activate in time to ensure waste removal long before the capacity is reached. The town of Harwich has an annual agreement with a licensed waste hauler to pump-out, on demand by the Harbormaster, and then transport the septage to the Town of Yarmouth's Sewage Treatment Facility. The Town Harwich has a contract with the Town of Yarmouth for the use of the Yarmouth-Dennis Septage Treatment Facility.

There are approximately 753 boats either moored or docked within Herring Creek, Allens Harbor, Wychmere Harbor and Saquatucket Harbor and are primarily ''parking lot'' harbors where the majority of boats are under 27 feet. Of these 735 boats there are 35 commercial fishing vessels, and an estimated transient population of 68 vessels.

The resources of the Herring Creek, Allens Harbor, Wychmere Harbor and Saquatucket Harbor are recreational and commercial. Wychmere Harbor is used by both recreational and commercial shell fishermen for the harvest of quahogs, clams, oysters, and bay scallops. Saquatucket Harbor is also used by both recreational and commercial shell fishermen for the harvest of quahogs, clams, oysters and is the site of the Town's commercial aquaculture operations. The beaches are located on the contiguous boundary with Nantucket Sound.

Comments and reviews regarding this request for action may be filed on or before July 27, 1998. Such communications, or requests for information or a copy of the applicant's petition, should be addressed to Ann Rodney, U.S. Environmental Protection Agency—New England Region, Water Quality Unit (CWQ), JFK Federal Building, Boston, MA 02203. Telephone: 617–565–4885. E-Mail: RODNEY.ANN@EPAMAIL.EPA.GOV.

Dated: June 17, 1998.

John P. DeVillars,

Regional Administrator, Region I.

[FR Doc. 98–16799 Filed 6–25–98; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6116–3]

National Pollutant Discharge Elimination System (NPDES) General Permits for Discharges From Concentrated Animal Feeding Operations

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of proposed reissuance of NPDES general permits.

SUMMARY: Proposed reissuance of NPDES general permits for discharges from concentrated animal feeding operations (CAFOs) in (1) EPA Region 6 States of New Mexico (NMG800000), Oklahoma (OKG800000), and Texas (TXG800000); (2) all Indian Country Lands in Oklahoma, Texas, and New Mexico without certification authority; and (3) the following Indian Pueblos in New Mexico that have certification authority: Pueblo of Isleta, Pueblo of Nambe, Pueblo of Picuris, Pueblo of Pojoaque, Pueblo of Sandia, Pueblo of San Juan, Pueblo of Santa Clara, and Pueblo of Tesuque.

Also proposed in this action are watershed-specific NPDES general permits for CAFOs located in watersheds that have been impaired by CAFO-related activities in EPA Region 6 States of (1) New Mexico (NMG810000), Oklahoma (OKG810000), and Texas (TXG810000); (2) all Indian Country lands in Oklahoma, Texas, and New Mexico without certification authority; and (3) the following Indian Pueblos in New Mexico that have certification authority: Pueblo of Isleta, Pueblo of Nambe, Pueblo of Picuris, Pueblo of Pojoaque, Pueblo of Sandia, Pueblo of San Juan, Pueblo of Santa Clara, and Pueblo of Tesuque.

EPA Region 6 today proposes to (1) reissue NPDES general permits authorizing limited discharges from CAFOs in New Mexico, Oklahoma, and Texas; and (2) issue new NPDES general permits for all CAFOs within these States that are located in watersheds impaired by CAFO-related activities. The permits' requirements are based on NPDES regulations (40 CFR Parts 122 and 412). As proposed, the general permits prohibit discharges of process wastewater pollutants from CAFOs to waters of the United States except during catastrophic or chronic rainfall events. When effective, these permits will replace the general permits published at 58 FR 7610 (February 8, 1993). The requirements of the watershed-specific permits are designed to protect nutrient-impaired watersheds against further degradation and nutrient pollution resulting from CAFO-related activities, such as manure and wastewater land application activities and offsite land disposal of manure at rates that exceed crop agronomic requirements.

DATES: Written comments on this proposal may be submitted to EPA Region 6 until August 25, 1998.

ADDRESSES: Comments to EPA should be mailed to Ms. Wilma Turner (6WQ–CA), EPA Region 6, 1445 Ross Avenue, Dallas, Texas 75202–2733. The public record is located at the EPA Region 6 office, and is available upon request. Requests for copies of the public record should be addressed to Ms. Wilma Turner at the address provided above. A reasonable fee may be charged for copying.

FOR FURTHER INFORMATION CONTACT: For further information on the proposed draft permits or to request for a complete copy of the entire fact sheet and draft general permits, contact Ms. Wilma Turner at the address provided above or by telephone at (214) 665–7513. Also, the draft permits and the fact sheet can be obtained from the Internet at the following website address: www.epa.gov/region6/6wq/npdes/publicnotice.htm.

SUPPLEMENTARY INFORMATION:

Public Hearings

Informal Public Meetings and formal Public Hearings will be held in New Mexico, Oklahoma, and Texas to provide information on the draft permit conditions and to allow for public comment on the draft permits. Informal public meetings with question and answer sessions are scheduled, prior to each of the formal Public Hearings, to allow the public to make informal statements and comments before the formal Public Hearing sessions begin. The schedule for informal meetings and formal public hearings are as follows:

Monday August 3, 1998: Informal Public Meeting with question and answer session from 9:00 a.m. to 11:00 a.m., followed by a formal Public Hearing from 1:30 p.m. to 4:30 p.m., in the Oklahoma/Texas Rooms on the 12th floor of the EPA office, 1445 Ross Avenue, Dallas, Texas 75202–2733.

Thursday August 13, 1998: Informal Public Meeting with question and answer session from 3:00 p.m. to 5:00

p.m., followed by a formal Public Hearing from 7:00 p.m. to 10:00 p.m., in the Cherokee Room of the Clarion Hotel and Conference Center, 4345 N. Lincoln Blvd., Oklahoma City, OK 73105.

Thursday August 20, 1998: Informal Public Meeting with question and answer session from 3:00 p.m. to 5:00 p.m., followed by a formal Public Hearing from 7:00 p.m. to 10:00 p.m., in the Corbett Center Auditorium, Corbett Center Student Union, New Mexico State University Campus, South Jordan Street, P.O. Box 30004, Las Cruces, New Mexico 88003.

Information in this Notice is organized as follows:

I. General Statutory and Regulatory Background

Section 301(a) of the Clean Water Act (CWA), 33 U.S.C. 1311(a), prohibits the discharge of pollutants to waters of the United States in the absence of authorizing permits, including NPDES permits. CWA 402, 33 USC 1342, authorizes EPA (or EPA-approved states) to issue NPDES permits allowing such discharges on condition they will comply with requirements implementing CWA sections 301, 304, and 401 (33 U.S.C. 1311, 1314 and 1341). Among those requirements are effluent limitations reflecting levels of technological capability, water quality standards, and other more stringent requirements states may adopt under CWA 510, 33 U.S.C. 1370. Violation of a condition contained in an NPDES permit, whether an individual or general permit, is a violation of the Act and subjects the owner or operator of the permitted facility to the penalties specified in section 309 of the Act.

Most NPDES permits EPA issues are individual permits; i.e., they apply only to one facility and authorize discharges of pollutants only from that facility. EPA may also use ''general permits'' to regulate numerous facilities which have similar discharges and are subject to the same conditions and limitations within a geographic area. See 40 CFR 122.28; *NRDC* v. *Costle,* 568 F.2d 1369 (D.C. Cir. 1977). Using general permits conserves EPA resources and reduces the paperwork burden associated with obtaining discharge authorization for the regulated community. In issuing general permits, EPA does not use the procedural rules (40 CFR Part 124) it uses in individual permitting actions; instead, it uses procedures that are more commonly associated with rulemaking, i.e., publication in the **Federal Register**. General permits are not rules, however, and are subject to the same substantive requirements that apply to individual NPDES permits, many of which are found in 40 CFR Part 122. The draft CAFO general permits proposed here are general permits.

To control discharges of ''conventional pollutants'', such as pH, biochemical oxygen demand (BOD), oil and grease, total suspended solids (TSS) and fecal coliform, CWA 301(b)(1)(E) requires that NPDES permits include effluent limitations based on ''best conventional pollutant control technology'' (BCT). To regulate nonconventional and toxic pollutants, CWA section 301(b)(2)(A), (C), and (D) require that NPDES permits include effluent limitations based on ''best available technology economically achievable'' (BAT), a standard which generally represents the best performing existing technology in an industrial category or sub-category. BAT and BCT effluent limitations may never be less stringent than corresponding effluent limitations based on ''best practicable control technology currently available'' (BPT), a standard generally applicable to similar discharges prior to March 31, 1989, under CWA 301(b)(1)(A).

Frequently, EPA adopts nationally applicable ''effluent limitations guidelines'' identifying the BCT and BAT standards to which specific industrial categories and subcategories are subject. Until such guidelines are published, however, CWA section 402(a)(1) requires that EPA establish appropriate BCT and BAT effluent limitations in its NPDES permitting actions on the basis of its best professional judgment (BPJ). As further explained below, the permits proposed here include some effluent limitations based on effluent limitation guidelines codified at 40 CFR Part 412 and some limitations based on BPJ.

Pursuant to CWA 301(b)(1)(C), NPDES permits must include ''water quality based'' effluent limitations if BAT and BCT limitations which would otherwise be applied are not stringent enough to avoid discharges causing exceedances of applicable water quality standards adopted by states, Indian Tribes, and sometimes EPA. EPA is proposing additional requirements for CAFOs located in watersheds that have been impaired by CAFO-related activities to prevent further releases of nutrients, particularly phosphorus, from impacting these watersheds.

In addition to effluent limitations, NPDES permits frequently require that permittees implement ''best management practices'' (BMPs). NPDES permits may include BMPs to control toxic pollutants in accordance with CWA 304(e), when numeric effluent limitations are infeasible and/or when reasonably necessary to assure compliance with effluent limitations or standards or to carry out the purpose and intent of CWA. See 40 CFR 122.44(k). As explained below, the proposed CAFO general permits contain a number of BMPs.

What are CAFOs? CAFOs are facilities used to confine animals, including poultry, for meat, milk, or egg production, or stabling, in pens or houses, where the animals are fed or maintained at the place of confinement. *See* 40 CFR 412.11(b).

What pollutants are associated with CAFOs. The characteristics of waste from different CAFOs are substantially similar [*Development Document for Effluent Limitations Guidelines and New Source Performance Standards for the Feedlots Point Source Category* (Development Document), January 1974]. The most commonly recognized contaminants from CAFOs include biochemical oxygen demand (BOD), total suspended solids (TSS), organics, bacteria, and plant nutrients (nitrogen and phosphorus compounds). EPA encourages the proper utilization of such plant nutrients for agricultural production of crops and forage, but their improper storage and use may cause significant harm to the quality of surface and ground waters. The effluent limitations and requirements for all CAFOs covered by these general permits are intended to avoid water quality problems.

II. Permit Coverage

Who needs to be covered by these permits? As noted in Part I.B. of the draft permits, ''a permit is required for discharges from operations classified as CAFOs.'' All facilities with more than 1000 animal units [or the number and types of animals specified in 40 CFR part 122, Appendix B(a)] are eligible for coverage under the terms of these permits.

What constitutes a discharge? A discharge of pollutants is any addition of any pollutant or combination of pollutants from a point source to waters of the United States. *See* CWA section 502(12); 40 CFR 122.2. This includes, but is not limited to, contaminated runoff from corrals, stock piled manure, or silage piles; overflow from storage

ponds; overflow from animal watering systems which are contaminated by manure; drainage of wastewater from land application areas; contaminated runoff from land application fields in which wastewater is applied at greater than the agronomic rate, runoff from fields on which manure has been applied by placement on or in the soil if such runoff results in a direct discharge of manure to waters of the U.S.; and discharge of wastewater from retention structures to surface water via a hydrologic connection. ''Waters of the United States'' is a very broad term (defined at 40 CFR 122.2) which includes almost all surface water bodies in the United States.

In accordance with Part II.A of the draft permits, a CAFO may discharge waste or process wastewater only when rainfall events, either chronic or catastrophic, cause an overflow of process wastewater from a facility designed, constructed, and operated to hold all process wastewater plus the runoff from a 25-year, 24-hour rainfall event for the location of the CAFO. All other discharges are prohibited.

What are AFOs? Not all animal feeding operations (AFOs) are CAFOs. Storm water discharges from other types of animal feeding operations are generally exempt from NPDES regulation as point sources by CWA section 502(14). Discharges from such facilities may nevertheless be regulated under state laws.

Parts I.B. and VII.I. of the draft permits define ''CAFO'' in accordance with 40 CFR 122.23 and 40 CFR part 122, Appendix B. For an operation to be a CAFO, the facility must first qualify as an animal feeding operation (AFO). A facility is an AFO if:

(1) Animals are kept onsite for a total of 45 days or more during any 12-month period, and (2) crops, vegetation forage growth, or post-harvest residues are not sustained on the facility during the normal growing season.

The first part of this definition means that animals must be fed or maintained on the lot or facility for a minimum of 45 days. It does not mean that the *same* animals must remain on the lot for 45 days or more; only that *some* animals are fed or maintained on the lot 45 days out of any 12- month period. The 45 days do not have to be consecutive, nor does the 12-month period have to correspond to the calendar year. For example, the 12-month period may be counted from June 1 to the following May 31.

The second part of this definition distinguishes feedlots from pastures; pastures are not regulated as CAFOs. Feedlots with constructed floors, such as solid concrete or metal slats, clearly satisfy this part of the definition. Other feedlots may have open dirt areas. These ''open dirt'' feedlots may have some vegetation growth along the edges while animals are present or during months when animals are kept elsewhere, but such marginal growth does not render them pastures. *Pastures are themselves not generally CAFOs, but wastewater overflows from pastures used as land application sites for CAFO waste are discharges and operation of such a site is subject to the requirements of these permits.*

CAFO Criteria. An AFO is a CAFO if:

(1) It is used to confine more than the number of animal units listed at 40 CFR part 122, Appendix B(a) and Part VII.I(a) of the permit. For example, dairies with more than 700 mature dairy cows or feedlots with more than 1000 feeders are always CAFOs. These large CAFOs are ''new sources'' and must provide additional information for EPA to use in reviewing their operations for compliance with the National Environmental Policy Act of 1969 (NEPA) before obtaining coverage under these permits.

(2) It is used to confine the number of animal units listed in 40 CFR part 122, Appendix B(b) and Part VII.I(b) of the permit and it discharges through a manmade conveyance or discharges directly to surface waters. Conveyance of wastewater from the property to waters of the United States through a pipe, ditch, lateral, channel gully, etc., is a discharge through a manmade conveyance. Direct discharge occurs when a stream, creek, wetland or other water body runs through the facility where it may contact CAFO waste. If confined animals have direct access to such waters, a direct discharge is presumed. It should be noted that even intermittent conveyed or direct discharges render a facility in this category a CAFO. If an AFO has discharged in the past and/or may discharge in the future, it is a CAFO.

(3) It is designated a CAFO by the Regional Administrator of EPA Region 6 as a significant contributor of pollutants (SCP) in accordance with 40 CFR 122.23(c)(2). This allows case-by-case regulation of smaller, problem facilities which would not otherwise be considered CAFOs under the criteria described above. Such designations occur only after an onsite inspection and the facility must be notified before the designation is effective.

What are ''animal units?'' ''Animal unit'' is a term defined in 40 CFR Part 122, Appendix B and the number of animals constituting a unit varies according to animal type: one animal is not always equal to one animal unit. Conversion to animal units is a procedure used to determine pollution equivalents among the different animal types; one dairy cow produces more waste than one sheep. Conversion to animal units is also used in determining whether facilities with more than one animal type onsite are CAFOs. Animal units are incorporated in the CAFO criteria described above. Facilities with greater than 1000 animal units (large facilities) are CAFOs. Facilities with between 300 and 1000 animal units (medium-sized facilities) that discharge through a man-made conveyance or discharge directly into waters of the United States are also CAFOs.

Is there an exception to CAFO status? 40 CFR Part 122, Appendix B excludes AFOs which discharge *only* during a 25-year, 24-hour or greater storm event from CAFO status. Experience has shown that this exclusion has little practical effect, however. Even a facility properly designed to retain all the storm water generated by that statistical storm event plus all the waste accumulated at the facility may have to discharge as a result of less but longer duration storm events. It is also very difficult to show that a 25-year, 24-hour storm event has actually occurred at most AFOs. Unless it is authorized to discharge by an NPDES permit, even a properly designed and operated facility may thus be subject to enforcement action under CWA. *See Carr* v. *Alta Verde Industries,* 931 F.3d 1055 (5th Cir. 1991).

How do CAFOs obtain coverage under these general permits? Facility operators must submit a ''Notice of Intent (NOI) to be covered'' to obtain discharge authorization under these general permits to EPA Region 6 and to any State/Tribal agency with regulatory jurisdiction over the CAFO. *See* 40 CFR 122.28(b)(i). NOI submission requirements are outlined in Part I.E. of the permits.

Who is eligible for coverage? Facilities with 1,000 animal units or the number and types of animals specified in 40 CFR part 122, Appendix B(a) are eligible for coverage under these draft permits. Specific coverage requirements for existing, new, and expanding CAFOs are specified in Part I.C (1), (2), and(3) of the proposed general permits. Offsite operators wanting to dispose of manure at rates that exceed phosphorus agronomic needs of crops in impaired watersheds must apply for separate permit coverage in accordance with Part I.C (4) of the watershed-specific draft permits.

Are there limitations on obtaining permit coverage? In accordance with 40 CFR 122.28, EPA may determine that

providing coverage under a general permit is inappropriate for a particular CAFO and EPA may require such a facility to apply for an individual NPDES permit. Such an individual permit might be required, for example, to assure that applicable water quality standards are protected by imposing additional conditions on authorized discharges. Part I.F of the draft permits lists circumstances in which an individual permit (instead of a general permit) may be appropriate.

EPA conducts a NEPA review of all new CAFOs with more than 1000 AUs before providing them coverage under the CAFO NPDES general permit. The operator of such a proposed facility must submit an environmental information document to EPA with its NOI. EPA will then conduct a NEPA review to determine whether to provide permit coverage for the proposed facility. EPA's decision will be subject to public participation and documentation. Permittees must obtain documentation of the Agency's final NEPA decision (e.g., a record of decision or finding of no significant impact) before operating the CAFO and must maintain that documentation onsite.

New CAFOs that will be located within one mile of the Texas Coastal Zone Management Area are not eligible for coverage under the proposed permits. Such CAFOs must apply for individual permits.

When will these permits expire? Since the terms of all NPDES permits are limited to five years, pursuant to CWA section 402(b)(1)(B) and 40 CFR 122.46(a), these permits will expire five years after they are issued. If the permits are not reissued before they expire, however, discharge authorization for CAFOs which obtained coverage before the expiration date will continue until the agency makes final decision on reissuance.

III. Permit Conditions

Today, EPA is proposing to reissue general permits originally issued on February 3, 1993 (see 58 FR 7610). Most of the effluent limitations and conditions of the reissued draft permits are the same ones contained in those original permits and are based on the same factors considered and described in the 1993 final publication. Though these ''carryover'' conditions of the draft permits are nevertheless subject to reconsideration in this action, EPA may impose less stringent conditions only for reasons listed at CWA section 402(o) and 40 CFR 122.44(l). Some new record-keeping requirements have been added to the draft permits to better assure compliance with the effluent limitations and BMPs of the permits.

EPA is also proposing to issue watershed-specific general permits for all CAFOs located in watersheds that have been impaired by CAFO-related activities. The watershed-specific general permits include requirements that are designed to protect the impaired watersheds against further degradation resulting from manure and wastewater land application fields.

The following water bodies and associated watersheds have been impaired by CAFO-related activities and have been reported to EPA by the States of Oklahoma and Texas in accordance with Section 303(d) of the Clean Water Act:

State	Segment no.	Segment name
Texas	1255	Upper North Bosque River.
Oklahoma	OK120400010060	Arkansas River.
	OK220200020010	Arkansas River.
	OK120400010010	Arkansas River.
	OK621010010160	Arkansas River, Salt Fork.
	OK121700020310	Baron Fork.
	OK121700050010	Baron Fork.
	OK121700050170	Baron Fork.
	OK121700060040	Battle Creek.
	OK311210000010	Beaver Creek.
	OK410600010010	Blue Ridge.
	OK410600020010	Blue Ridge.
	OK220100030010	Brazil Creek.
	OK520600010010	Canadian River.
	OK121600030360	Carey Bay, Grand Lake.
	OK121600030340	Cave Springs Branch.
	OK121600030220	Chigger Cove, Grand Lake.
	OK620920020010	Cimmaron River.
	OK120410010100	Cloud Creek.
	OK310830060010	Cobb Creek.
	OK121600030260	Court House Hollow Cove, Grand Lake.
	OK520620010080	Deer Creek.
	OK520620060010	Deer Creek.
	OK121600030300	Dillar Cove.
	OK121600030080	Duck Creek Cove, Grand Lake.
	OK620920040010	Eagle Chief Creek.
	OK121600030350	Echo Bay, Grand Lake.
	OK121600050070	Eucha Lake.
	OK121600070110	Fivemile Creek.
	OK121700060010	Flint Creek.
	OK220100040010	Fourche Maline Creek.
	OK410210080010	Glover Creek.
	OK621010010020	Great Salt Plains Lake.
	OK121600030170	Horse Creek Cove.
	OK121700030010	Illinois River.
	OK121700030080	Illinois River.
	OK121700030280	Illinois River.
	OK121700030350	Illinois River.
	OK310820010160	Ionine Creek.
	OK310820010200	Ionine Creek East.

State	Segment no.	Segment name
	OK310820010210	Ionine Creek West.
	OK410310010020	Jackfork Creek.
	OK410300010010	Kiamichi River.
	OK410300020010	Kiamichi River.
	OK310830060040	Lake Creek.
	OK121600030020	Lake O' of the Cherokees (Grand).
	OK121600030060	Lake O' of the Cherokees (Grand).
	OK121600030290	Lake O' of the Cherokees, Honey Creek.
	OK121600030150	Lake O' of the Cherokees, Lower Middle.
	OK121600030280	Lake O' of the Cherokees, Middle.
	OK311210000050	Little Beaver Creek.
	OK121600070120	Little Fivemile Creek.
	OK410210020010	Little River.
	OK410400050010	Muddy Boggy Creek.
	OK121600030010	Neosho (Grand) River.
	OK121600030050	Neosho (Grand) River.
	OK121600030140	Neosho (Grand) River.
	OK121600030270	Neosho (Grand) River.
	OK620910040260	Northwood Lake.
	OK121700050120	Peacheater Creek.
	OK220100020010	Poteau River.
	OK121600050150	Spavinaw Creek.
	OK620900040010	Stillwater Creel.
	OK310800010050	Texoma Lake, Washita.
	OK620910020030	Turkey Creek.
	OK620910060010	Turkey Creek.
	OK310800020010	Washita River.
	OK310820010010	Washita River.
	OK310830010010	Washita River.
	OK310830020010	Washita River.
	OK310830030010	Washita River.

EPA is requesting comments from the public on whether the watershed-specific general permits should be applicable to all nutrient-impaired watersheds irrespective of the source of the nutrients.

Effluent limitations. Part II.A of the draft permits prohibits discharges of CAFO wastewater except as a result of catastrophic or chronic rainfall events. This ''no discharge'' effluent limitation is based on the effluent limitations guidelines for the feedlot category promulgated at 39 FR 5704 (February 14, 1994) and codified at 40 CFR Part 412. CWA § 402(a)(1)(A) requires that EPA include this limitation in NPDES permits for CAFOs with more than 1,000 animal units. In the 1993 permit proceedings, EPA Region 6 found it appropriate to apply the same effluent limitations to smaller CAFOs on the basis of BPJ exercised under CWA Section 402(a)(1)(B).

Under the ''no discharge'' effluent limitation, permitted CAFOs may discharge only during catastrophic or chronic rainfall conditions. A catastrophic event is generally equivalent to a 25-year, 24-hour storm event, but may also include tornadoes, hurricanes, or other catastrophic conditions that would cause an overflow from a properly designed and operated waste retention structure. Chronic rainfall is a series of wet weather conditions that preclude dewatering of properly maintained retention structures.

In most cases, the technology to achieve the ''no discharge'' limit is containment of all contaminated liquid runoff resulting from rainfall and subsequent application of these liquids, along with the generated solid wastes, to productive crop land at agronomic rate, i.e., a rate which will provide adequate moisture and nutrients that can be utilized by the crops. To implement this technology requires a wastewater retention structure, such as a lagoon, and provisions for land application of the wastes to cropland, such as sprinklers.

Part II.B(1) of the draft permits prohibits the discharge of process wastewater from retention structures to waters of the United States by means of a hydrologic connection through ground water. This prohibition is required to assure compliance with the ''no discharge'' effluent limitation and the purposes of CWA. Different federal courts have reached different conclusions on whether EPA may regulate such discharges, but the EPA Region 6 position is reflected by such cases as *Quivera Mining Co.* v. *USEPA*, 765F. 2d 126(10th Cir. 1985); *McClellan Ecological Seepage* v. *Weinberger*, 707 F. Supp. 1182, 1194 (E.D. Cal. 1988); *Sierra Club* v. *Colorado Refining Co.*, Civ. No. CIV.A.93–K–1713 (D. Col. Dec. 8, 1993). Although this prohibition on discharging through a groundwater connection is included in the broader ''no discharge'' limitation at Part II.A of the draft permits, Region 6 also includes it separately at Part II.B(1) to make its intentions clear in this area.

The control of discharges through hydrologic connection is best handled in the design phase of the control facility. The draft NPDES general permits require the use of procedures recommended by the Natural Resource Conservation Service of the U.S. Department of Agriculture (USDA–NRCS) when designing control facilities. Installation of liners is required as a part of facility construction.

Part II.B(2) of the draft permits prohibits the discharge of contaminated runoff or drainage of land applied wastewater from land application areas to waters of the United States. Wastewater must not be applied at such a rate or under conditions that it runs off from the application fields to waters of the U.S. Wastewater may not, for example, be applied when the soil is saturated or frozen. Where process-generated wastewater is used for irrigation of crops, application rates shall not exceed the nutrient uptake of the crops being produced on the land application areas.

Part II.B(3) of the draft permits prohibits the discharge of contaminated runoff from land application areas where manure has been placed on the soil surface, if such runoff will result in a direct discharge of pollutants to waters of the United States. Manure should be incorporated into the soil to minimize runoff, and edge-of-field grass strips should be used to separate water courses from runoff. Timing and rate of application must be in response to crop needs, weather conditions, and soil conditions. Manure will not be applied to land when the ground is frozen or saturated or during rainfall.

Part II.B(4) of the watershed-specific draft permits prohibits the direct discharge of contaminated runoff from offsite land disposal areas where manure is land applied at rates that exceed phosphorus agronomic rates. Operators of facilities that intend to land apply CAFO-generated manure or wastewater offsite at non-agronomic rates must submit a separate NOI for coverage under these permits.

IV. Best Management Practices

Part II.D of the draft permits requires that all permittees develop and implement site-specific BMPs specifically designed to assure compliance with the permits' ''no discharge'' limitations. There are two types of BMPs that must be implemented by all CAFOs: those BMPs for management and control of wastes and wastewaters generated at the animal confinement and maintenance areas of the CAFO, and BMPs for properly disposing of waste/wastewater by land application at rates based on agronomic needs of crops. The BMP requirements for the confinement and maintenance areas and land application areas are described below.

1. BMPs for Animal Confinement and Maintenance Areas

Part II.D(1) of the draft permits includes a description of BMPs for (1) minimizing wastewater volumes generated from animal confinement and maintenance areas, (2) management of precipitation runoff from animal confinement and maintenance areas, and (3) ensuring that control structures for wastewater containment are adequately designed, constructed, operated, and maintained. The following are the BMPs that must be implemented at the animal confinement and maintenance areas: (1) all control structures must be designed, constructed, operated, and maintained to contain all process-generated wastewaters plus the runoff from a 25-year, 24-hour rainfall event for the particular location of the CAFO; calculations must include allowances for surface retention, infiltration, and other site-specific factors; (2) wastewater control and retention structures or holding pens for new CAFOs may not be located in the 100-year flood plain; wastewater control and retention structures or holding pens for existing CAFOs that are located within the 100-year flood plain must be protected by berms to prevent inundation and damage that may occur during that flood event; (3) CAFOs must not expand their operations prior to expanding their retention control structures or holding pens; (4) no waters of the U.S. shall come into direct contact with animals confined on the CAFO; open lots must be isolated from outside surface drainage by ditches, dikes, berms, terraces or other such structures designed to carry peak flows expected at times when the 25-year, 24-hour rainfall event occurs; (5) CAFO-related activities must not cause water quality impairment to public or private drinking water wells; waste handling, treatment, and management shall not create an environmental or a public health hazard and shall conform with State/Tribal guidelines and/or regulations for the protection of surface water quality; (6) potentially hazardous or toxic chemicals shall be handled and disposed of in a manner such as to prevent pollutants from entering the waters of the U.S.; (7) all discharges to containment structures shall be composed entirely of wastewaters from the proper operation of a CAFO and the precipitation runoff from the CAFO areas; (8) dead animals must be disposed of in a manner to prevent contamination of waters of the U.S. or create a public health hazard; and (9) appropriate measures necessary to prevent spills and to clean up spills of any toxic pollutants shall be taken; any spills that may occur must be reported to EPA and State/Tribal agencies as specified in Parts III.A and IV.D of the draft permits.

2. BMPs for Onsite Land Application of Waste/Wastewater

(a) Introduction

Numerous studies have shown that continued land application of manure at rates based on nitrogen agronomic rates results in a build up of soil phosphorus levels (Sharpley, et al, 1994). A recent publication by the USDA–NRCS and EPA (Lander et. al., 1998) indicates that AFOs produce more manure nutrients (nitrogen and phosphorus) than can be utilized by crops in many parts of the U.S., suggesting that there is a potential for nutrients, particularly phosphorus, to accumulate in soils and eventually impact the surrounding water bodies. Information submitted to EPA Region 6, in accordance with Section 303(d) of the CWA and recent studies conducted by the Texas Institute for Applied Environmental Research (TIAER) indicate that many watersheds in Region 6 have been impaired by CAFO-related activities. For example, the surface water monitoring study conducted by TIAER (1997) showed a strong correlation between the concentration of phosphorus in the upper North Bosque River and the acreage of land application fields in the watershed, upstream of the surface water monitoring stations. Based on these data, the TIAER report concluded that the upper North Bosque River watershed in Erath County, Texas, has been impaired by land application activities.

EPA's objective, as specified in a recent draft of the EPA Strategy for AFOs which was released in March 1998, is to include adequate controls in NPDES permits to reduce the quantities of nutrients entering water bodies. Several EPA Region 6 States, including Texas and Oklahoma, have already established soil phosphorus concentration limits in their State permits for CAFOs as a means of controlling nutrient pollution. Texas, for example, has established a critical soil phosphorus concentration of 200 mg/kg above which manure must be applied based on phosphorus agronomic rates. Research has demonstrated that a concentration of about 200 mg/kg phosphorus in the surface soil is the critical level above which the concentration of phosphorus in the runoff becomes environmentally significant. Sharpley and others (1996) demonstrated that a soil phosphorus concentration of 200 mg/kg (as determined by the Mehlich 3 Method) resulted in a phosphorus concentration of 1,000 micrograms per liter in the runoff. According to Wood (1998), the proposed allowable dissolved phosphorus limit for agricultural runoff is 1000 micrograms per liter.

Another approach for determining when to switch from the nitrogen-based manure application rate to a phosphorus-based rate is to determine the percentage of phosphorus saturation in the land application area soil. Dutch scientists have demonstrated that a soil phosphorus saturation of 25% is the critical level above which the phosphorus concentration in the soil is considered to be environmentally unacceptable, because at this concentration, the concentration of

phosphorus in the runoff increases and may exceed 1,000 micrograms per liter. The phosphorus saturation index provides an indication of how much of the phosphorus sorption capacity of a particular land application area soil has been used up.

Hence, the phosphorus saturation measurement provides information on both the potential of a soil to enrich runoff with dissolved phosphorus (high degree of phosphorus saturation) and also helps to predict how much of the phosphorus added to the land application area soil as manure may be retained by the soil in a form that is relatively resistant to be released into the runoff (low degree of phosphorus saturation). However, the procedures for determining the soil phosphorus saturation percentage have not been widely tested in the United States.

The USDA–NRCS is currently developing a procedure for identifying environmentally sensitive land application fields that could promote phosphorus enrichment in water bodies when manure or wastewater is applied to such fields (Lemunyon and Gilbert, 1993). The USDA–NRCS procedure uses site-specific characteristics of the land application site, including (1) potential soil erosion rates, potential runoff, soil phosphorus concentration, and (2) manure management practices (i.e., application rates and application methods) to assess the capacity of the land application site to adsorb the phosphorus and prevent it from impacting any surrounding water bodies. However, before the USDA–NRCS completes its research, EPA Region 6 is proposing, as specified in Part II.D(2)(d) of the watershed-specific general permits, that rates of manure application in impaired watersheds be based on phosphorus agronomic requirements of crops. Also, EPA Region 6 is proposing to regulate offsite disposal of manure by land application at rates that exceed phosphorus needs of crops as specified in Part II.D(4) of the watershed-specific general permits.

(b) Waste Management Plan

Part II.D(2) of the draft permits requires all CAFOs that dispose of wastes by land application to develop and implement a waste management plan as specified in Part II.D(2). All wastes, including Solids, sludges, manure, and other pollutants generated at the facility shall be managed and disposed of in accordance with procedures specified in such a site-specific waste management plan. Each waste management plan shall describe the methods for, and account for, the disposal of all manure and wastewater generated by the facility. If the proposed methods of disposal include onsite or offsite land application of manure and wastewater, the facility must develop a site-specific nutrient utilization plan as described in Part II.D(2)(b).

(c) Nutrient Utilization Plan

If the waste management plan developed by the CAFO provides for land application of the manure and wastewater generated at the facility, the permittee must develop and implement a nutrient utilization plan to minimize release of nutrients into waters of the U.S. Such a plan must include the following information: (1) a site map showing the proposed land application areas, including the major soil types within the proposed land application areas; (2) crop rotations to be implemented during the permit term; (3) methods and procedures for analyzing nutrients in the land application area soils, manure, and wastewater; (4) predicted yield goals for the particular crops that will be grown; (5) procedures for calculating nutrient budgets that must be used to determine waste application rates based on phosphorus crop needs; equipment to be used during land application of manure and wastewater and the procedures for inspecting and maintaining such equipment; (6) projected rates and timing of application of the manure and wastewater as well as other sources of nutrients that may be applied to the land application areas to supplement the manure.

The permittee must maintain records of the actual rates and dates of application of the manure, wastewater, or other nutrients applied to the land application areas throughout the entire permit term. If the manure and wastewater are to be sold or given away or disposed of in areas that are not described in the facility's nutrient utilization plan, the facility must keep records of landowner agreements for the lands that will receive the manure and wastewater, and the nutrient contents of the manure and wastewater applied to such lands.

The nutrient utilization plan must include (1) specific details for nutrient sampling and testing of the land application soils, manure, and wastewater [Part II.D(2)(c)], and (2) the basis and procedures for determining agronomic rates of manure and wastewater application rates [Part II.D(2)(b)].

Existing CAFOs must develop and implement a nutrient utilization plan within one year following reissuance of the CAFO general permit. New CAFOs must develop and implement a nutrient utilization plan immediately following reissuance of the CAFO general permit. Designated CAFOs must develop and implement a nutrient utilization plan within two years following designation.

(d) Nutrient Sampling and Testing

Each permittee must conduct analytical tests to determine the nutrient contents of the (1) manure and wastewater generated by the facility, and (2) soils within the land application areas prior to the first land application event at new CAFOs and the first seasonal land application event at existing facilities, then once per quarter thereafter. Frequencies can be increased when significant variations in nutrient levels are experienced at a facility between sampling events, or if there are identified or suspected water quality standards violations. The permittee must then compare the nutrient contents of the manure and wastewater with the nutrient contents of the land application area soils to determine the needed fertility and application rates for pasture production or production of other targeted crop yields. The permittee must maintain records of all nutrient sampling and analyses data, calculations, application rates and utilized acreage of the land application area.

(e) Basis for Determining Agronomic Rates Outside of Impaired Watersheds

According to Part II.D(2)(d) of the draft CAFO general permits, manure and wastewater application rates must be based on agronomic crop requirements for nitrogen or phosphorus, as determined from results of nutrient sampling and testing. Application rates should be based on nitrogen until the concentration of phosphorus in the soil increases to the critical (threshold) level established by the State/Tribe in which the CAFO is located or by the USDA–NRCS. Once the phosphorus threshold is reached, the application rate must be based on phosphorus requirements of the crop. The threshold phosphorus holding capacity of the soil is the maximum concentration of phosphorus in the soil that will not create an unacceptable risk of water quality impairment. The CAFO operator must use the approach outlined below for determining agronomic rates of waste/wastewater application:

(i) Apply manure and wastewater at rates based on the agronomic crop needs of nitrogen if soil tests demonstrate that the concentration of phosphorus in the surface soil (0 to 6 inch-depth) is or will be consistently below the threshold level established by the State/Tribe during the permit term. The threshold

soil phosphorus level for Texas is 200 mg/kg, as determined by using procedures developed by Texas A&M University. If there is no threshold soil phosphorus concentration limit established by the State/Tribe or the USDA–NRCS, then continue to apply manure/wastewater at rates based on nitrogen requirements of crops.

(ii) Apply manure and wastewater at rates based on the agronomic crop needs of phosphorus if soil tests demonstrate that the concentration of phosphorus in the surface soil exceeds the threshold level recommended by the State/Tribe where the CAFO is located.

(iii) If soil tests indicate that the soil phosphorus concentration will exceed the threshold phosphorus level during the permit term, the permittee should begin to seek access to additional cropland or make other adjustments that are necessary to comply with the phosphorus limit established by the State/Tribe in which the CAFO is located.

(f) Basis for Determining Agronomic Rates in Impaired Watersheds

As specified in Part II.D(2)(d) of the watershed-specific general permits, manure and wastewater must be land applied at rates based on phosphorus agronomic requirements of crops to minimize risks of further water quality impairments due to phosphorus. The CAFO operator must develop and implement a phosphorus nutrient budgeting system to monitor and balance the quantities of manure phosphorus added to the soil and those removed in the harvestable portions of the crops produced on the land application areas during the growing season. The quantities of the phosphorus added to the land application area as manure should be approximately equal to the quantities of phosphorus removed in the harvestable portions of the crops if the CAFO operator is applying the manure at phosphorus agronomic requirements of the crops being produced on the land application areas.

3. Offsite Land Application

According to Part II.D(3) of both the reissued draft permits and the proposed watershed-specific draft general permits, offsite land application of manure at agronomic rates is not regulated. However, whenever CAFO-generated manure is to be sold or given away for offsite disposal by land application at agronomic rates, the CAFO operator must provide current and accurate manure testing data that can be used by the offsite applicator to establish agronomic rates of manure application. The CAFO operator must provide information to the offsite applicator concerning the voluntary measures and procedures for applying the manure based on agronomic rates. The CAFO operator should obtain, from the offsite applicator, information concerning the location and acreage of the proposed offsite land application areas. The CAFO operator must keep all records, including the information provided by the offsite applicator, the dates, and the quantities of the manure sold or given away. These records must be kept at the facility. The CAFO operator must provide this information to the Director whenever requested.

4. Offsite Disposal of Waste/Wastewater at Non-Agronomic Rates

When CAFO-generated manure or wastewater is land applied offsite at non-agronomic rates, i.e., rates that exceed phosphorus agronomic requirements of crops, pollutants are likely to be discharged to waters of the United States as precipitation runoff. CAFO operators and third-party operators of privately owned treatment works that land apply CAFO-generated manure or wastewater offsite at non-agronomic rates are, therefore, required to obtain permit coverage as specified in Part I.C.(4) of the general permits for CAFOs in impaired watersheds, unless they certify that the manure/wastewater will be applied at rates based on phosphorus agronomic requirements of crops and that the agronomic rates will be calculated by using a nutrient budgeting system.

5. Pollution Prevention Plan (PPP)

A site-specific PPP that includes a manure management plan, and a nutrient utilization plan must be developed by each CAFO. Each PPP must describe measures and practices to assure compliance with the limitations and conditions of this permit. Large CAFOs with more than 1000 animal units must have, on site, and must implement a PPP immediately following the effective date of the proposed general permits. Medium-size CAFOs with less than 1000 animal units shall have, on site, and must implement a PPP immediately following the effective date of the general permits. Small CAFOs (with less than 300 animal units) that have been designated by EPA as CAFOs shall have, on site, and must implement a PPP within one year following designation.

V. Discharge Monitoring and Reporting Requirements

Monitoring and discharge requirements are included in Part III of the draft permits. Monitoring data serve a number of functions under the NPDES program. Discharge monitoring data can be used to assist in the evaluation of the risk of the discharge by indicating the types and the concentrations of pollutant parameters in the discharge. Discharge monitoring data can be used in evaluating the potential of the discharge to cause or contribute to water quality impacts and water quality standards violations.

Discharge monitoring data can also be used to evaluate the effectiveness of controls on reducing pollutants in discharges. This function of monitoring can be important in evaluating the effectiveness of source control or pollution prevention measures as well as evaluating the operation of end-of-pipe treatment units. Where numeric or toxicity effluent limits are incorporated into permits, discharge monitoring data play a critical role by providing EPA and authorized NPDES States with data to evaluate compliance with effluent limits. The use of discharge monitoring data to determine permit compliance greatly enhances the ability of EPA and authorized NPDES States to enforce permit conditions.

Permits for industrial process discharges and discharges from POTWs traditionally have incorporated numeric and/or toxicity effluent limitations as permit conditions. Monitoring reports for these discharges provide a direct indication of whether the discharge complies with permit conditions. However, the proposed general permits for CAFOs will require no discharge of pollutants into waters of the U.S. Therefore, monitoring data will be required only in case of a discharge from the retention system.

1. Discharge Notification

If there is a discharge, Part II.A of the draft permits requires the permittee to notify the Director and the State/Tribe within 24 hours of the discharge from the retention facility, and to provide a written notification to the Director and the State/Tribe within 14 working days of the discharge. The standard notification requirements are specified in 40 CFR 122.44(i), 122.41(l)(4), and 122.41(l)(6). A copy of the notification must be kept together with the PPP. The discharge notification report should include the following:

(a) Description of the Discharge

A description and cause of the discharge, including an estimate of the discharge volume; the period of discharge, including exact dates and times, and, if not corrected, the anticipated time the discharge is

expected to continue, and steps being taken to reduce, eliminate and prevent recurrence of the discharge; and if caused by a precipitation event, information from the facility and the nearest National Weather Service station concerning the size and duration of the precipitation event.

(b) Analysis of the Discharge

The discharge must be analyzed for all conventional pollutants associated with feedlot operation, including pH, biochemical oxygen demand (BOD), total suspended solids (TSS), oil and grease, and fecal coliform as well as nonconventional pollutants, including nutrients such as phosphorus and nitrogen. High numbers of Fecal Coliform bacteria are an indicator of the amount of pathogenic bacteria that are being discharged to the receiving water. TSS is a common pollutant found in discharges that can have significant impacts on receiving waters. The biochemical oxygen demand measurement will help the permitting authority evaluate the oxygen depletion potential of the discharge. Five day Biochemical Oxygen Demand (BOD5) is the most commonly used indicator of oxygen demand. The pH will provide important information on the potential availability of metals to the receiving flora, fauna, and sediment. In some cases it will provide information regarding material management. In addition to conventional pollutants, nutrients, such as total phosphorus, total Kjeldahl nitrogen (TKN), and nitrate plus nitrite nitrogen must be measured because nutrients can significantly impact water quality. Measurements taken for the purpose of monitoring shall be representative of the monitored discharge. Discharge monitoring and reporting requirements also include the need to monitor for any pollutants the facility uses or stores on site which have a potential to be in the discharge; for example, frequently used cleaning agents and pesticides.

2. Discharge Reporting Requirements

All discharge information and data shall be made available to the Director upon request as specified in Part III.B of the draft permits. Signed copies of monitoring reports shall be submitted to EPA and the State/Tribe, if requested. Signatory requirements are specified in Part III.H of the draft permits. Penalties for falsification of data are specified in Part III.C of the draft permits. The permittee shall retain copies of all records of discharge monitoring for at least three years from the date reported as specified in Part III.D of the draft permit.

The permittee must also notify EPA and the State/Tribe within 30 days of a change in facility ownership or operational control. The permittee must give advance notice to the Director of any planned changes in the permitted facility or activity which may result in noncompliance with permit requirements. The permittee must also report all instances of noncompliance within 24 hours to the Director and State/Tribe in accordance with the notification requirements of these draft permits. The draft general permits have an ''adverse climatic conditions'' provision in Part III.A(b) allowing a discharger to submit a description of why samples could not be collected (in lieu of sampling data) when the discharger is unable to collect samples due to climatic conditions which prohibit the collection of samples, including weather conditions that create dangerous conditions for personnel, such as flooding, high winds, hurricane, tornadoes, and electrical storms.

The requirements for the type of samples taken vary, depending on the nature of the retention structure. A minimum of one grab sample must be taken to characterize discharges from overflow structures, such as ponds or other impoundments.

CAFOs are not required to submit discharge monitoring reports unless specifically requested by the Director. However, these facilities must maintain records of sampling data collected during the term of the permit as specified in Part III.D of the draft permits. The permittee is required to retain records of all monitoring information, copies of all reports required by these permits, and records of all data for a period of at least three years from the date of the measurement, report, or application. This period may be extended by the Director.

VI. Pollution Prevention Plan Requirements

Part VI of the draft permits includes requirements for pollution prevention plans (PPPs). Each CAFO covered by the draft general permits must prepare, retain, and implement a PPP developed to allow the implementation of site-specific measures for controlling pollutants associated with CAFOs. At a minimum, the following requirements should be addressed in the PPP to reduce pollutants in runoff from the facility: (1) Identification of potential pollutant sources, (2) waste management controls, (3) employee training, (4) inspection and recordkeeping, (5) preventive maintenance, (6) discharge reporting and notification procedures, (7) housekeeping procedures, (8) sedimentation and erosion prevention measures, and (9) spill response procedures. The key elements of the PPP are described below:

(a) Identification of Pollutant Sources

PPPs must be based on an accurate understanding of the pollution potential of the site. The first part of the plan requires an evaluation of the potential sources of pollution at the site. The permittee must identify all activities and significant materials which may potentially be significant pollutant sources. The PPP must include a site or topographic map showing the drainage pattern at the facility; arrows indicating the direction of surface water flow from the facility; each existing structure to control precipitation runoff; and surface water bodies which could receive the runoff.

(b) Wastewater Retention Facilities

The permittee shall keep documentation at the facility supporting the adequacy of waste management control structures used to contain wastewaters and storm waters from the animal confinement and maintenance areas. The documentation must include all calculations used to support design, construction, and the size of retention structures, as well as all factors and calculations used in determining land application rates, acreage, and crops. This documentation may be developed by the NRCS or a professional consultant. This information will allow the EPA to determine if the containment structure is adequately designed to contain the required 25-year, 24-hour storm event and whether waste is being land applied at agronomic rates. CAFOs located in impaired watersheds must provide additional waste/wastewater retention capacity to protect water quality. All CAFOs in impaired watersheds must redesign their retention structures to include a top freeboard of three feet and in no case the top freeboard must not be less than two feet.

(c) Liner Requirement

In general, surface water flow in most of EPA Region 6 States is sustained throughout much of the year by ground water inflow. As a result, contaminants from containment structures may leak into the ground water and eventually move toward local streams and rivers. Therefore, the permittee must maintain, on site, documentation indicating that no hydrologic connection exists between the contained wastewater and surface waters of the United States. The permittee is given two options to

demonstrate the lack of hydrologic connection: (1) Document that there can be no significant leakage from the retention structure; or (2) document that leakage from the retention structure would not migrate to surface waters. These two options allow the permittee to take into account the natural situation beneath the retention structure (such as natural materials or isolated ground waters). Man made connections from ground waters to surface waters via wells and irrigation must be taken into account when determining hydraulic connections. If the permittee cannot document the absence of a hydrologic connection, the containment structure must have a liner (constructed of either man-made or natural materials or a combination of the two) which will prevent the potential contamination of surface waters. Liners for retention structures should be constructed in accordance with good engineering practices and must be certified by a certified professional scientist with knowledge and experience in hydrogeology. Liner maintenance shall include inspection at least once every two years. Liner design may be in accordance with a NRCS plan.

Although the requirement in these draft permits for liner installation is to protect surface waters, the permittee is strongly encouraged to provide a liner for any containment structures to comply with existing Federal, State or Tribal regulations for ground water protection.

(d) Manure and Pond Solids Handling and Land Application

Requirements of the draft permits and the PPP do not allow the storage of wastes where there is the potential for inadvertent release to any surface water. Storage areas cannot be placed so as to be threatened by flood waters. Wastes cannot be applied to land during or immediately preceding rain events to avoid contaminated runoff. Land application rates and procedures that are developed for the facility in accordance with State/Tribe guidelines, may be made part of the PPP. The PPP must include documentation indicating that the procedures for the handling and disposal of wastewater, manure and pond solids comply with permit requirements. Documentation of waste storage protocol, land application procedures, and manure handling activities is a requirement of the draft general permits to ensure that pollutants are not discharged to waters of the United States. Permittees may use the wastewater or manure as fertilizer. However, the permittee must limit the application rate to the crop uptake rate of (1) phosphorus in watersheds that have been impaired by CAFO-related activities, and (2) nitrogen or phosphorus in non-impaired watersheds, depending on whether the soil phosphorus concentration is below or above the phosphorus threshold level for that State/Tribe.

(e) Preventive Maintenance

A preventive maintenance program involves inspection and maintenance of all management devices as well as inspecting and testing equipment and systems to uncover conditions that could cause breakdowns or failures resulting in discharges of pollutants to surface waters. A good preventive maintenance program includes identifying equipment or retention systems used; periodically inspecting or testing equipment and retention systems; adjusting, repairing, or replacing items; and maintaining complete records on the equipment and retention systems.

(f) Good Housekeeping

Good housekeeping requires the maintenance of a clean, orderly facility. Good housekeeping includes establishing housekeeping protocols to reduce the possibility of mishandling chemicals or equipment and training of employees in housekeeping techniques. Pollutants that may enter retention structures at CAFO sites due to poor housekeeping include oils, grease, paints, gasoline, truck washdown, solvents, litter, debris, pesticides, insecticides, and sanitary wastes. Good housekeeping protocol will include: (1) designating areas for equipment maintenance and repair; (2) providing waste receptacles at convenient locations for waste collection and disposal; (3) locating equipment washdown areas on site and providing appropriate control of washwaters; (4) providing protected storage areas for chemicals, paints, solvents, fertilizers and other potentially toxic materials; and (5) providing adequately maintained sanitary facilities.

(g) Spill Prevention and Response Procedures

Areas where potential spills can occur, and their accompanying drainage points should be identified in the PPP. Where appropriate, specifying material handling procedures and storage requirements in the plan should be considered. Procedures for cleaning up spills should be identified in the plan and made available to the appropriate personnel. The necessary equipment to implement a clean up should be available. Spill response procedures should avoid discharging to retention structures unless necessary because of immediate safety considerations. The following information should be included in the PPP: (1) A written description of materials that are used, stored, or disposed of at the CAFO (such as pesticides, cleaning agents, fuels, etc.), (2) information on spills, including a list of spills and leaks of toxic or hazardous pollutants that occurred at the facility beginning one year prior to the effective date of these permits and have the potential to contribute pollutants to runoff waters, (3) a summary of any existing sampling data describing pollutants in previous discharges, (4) other information to consider, if applicable, include the manner and frequency in which pesticides, herbicides, fertilizers or soil enhancers are applied at the site and an evaluation of significant spills or leaks of conventional, toxic and hazardous pollutants based on a description of the materials released, an estimate of the volume of the release, the location of the release, and any remediation or cleanup measures taken.

(h) Sediment and Erosion Prevention

The PPP shall identify areas which, due to topography, activities, or other factors, have a high potential for significant soil erosion and measures to limit erosion.

(i) Employee Training

Employee training programs are necessary to inform personnel, at all levels, of the responsibility of the requirements of the permit and of the procedures outlined in the PPP. Training should address topics such as spill response, good housekeeping and material management practices. A PPP should identify periodic dates for such training.

(j) Inspections and Recordkeeping

The facility operator or a responsible person will be named in the PPP to develop the plan and to conduct the required inspections and reporting. This person will assist the facility manager in the implementation, maintenance, and revision of the PPP. The activities and responsibilities of the designated person should include all aspects of the facility's PPP. However, the facility manager, not the employee, should have overall responsibility and accountability for the quality and implementation of the PPP.

Incidents such as spills, leaks and improper dumping, along with other information describing the quality and quantity of discharges should be included in the records. Inspections and

maintenance activities such as cleaning oil and grit separators or catch basins should be documented and recorded.

Typical inspections should include visual examination of pipes, pumps, tanks, supports, foundations, dikes, and drainage ditches. Material handling areas should be inspected for evidence of, or the potential for, pollutants entering the drainage system. A tracking or follow up procedure must be used to ensure that appropriate and adequate response and corrective actions have been taken. Records of inspections are required to be maintained.

It is important that permittees conduct annual site inspections to verify that the description of potential pollutant sources is accurate, the site drainage map has been updated or otherwise modified to reflect current conditions; and the controls outlined in the PPP to reduce pollutants are being implemented and are adequate. Records documenting significant observations made during the site inspection must be retained as part of the PPP for a minimum of three years. This allows EPA access to records of permit compliance much the same as all self-reported information required in other NPDES permits.

(k) Consistency With Other Plans

Facilities which have requirements for retention capacity and land application of wastes provided in site specific plans developed by NRCS, or BMP programs developed by a professional consultant may incorporate any part of such plans into the PPP by reference.

VII. Other Permit Requirements

1. Standard Permit Conditions

The draft permits include all of the standard conditions used in NPDES permitting to insure proper implementation of the permit requirements. Part IV of the proposed permit includes standard conditions and requirements.

2. State Certification

Under CWA Section 401(a)(1), EPA may not issue an NPDES permit until the State/Tribe in which the discharge originates grants or waives certification to ensure compliance with appropriate requirements of the Act and State or Tribal law. Section 301(b)(1)(C) of the Act requires that NPDES permits contain conditions that ensure compliance with applicable State/Tribal water quality standards or limitations. The proposed permits contain limitations intended to ensure compliance with State/Tribal water quality standards and has been determined by EPA Region 6 to be consistent with the applicable State or Tribal water quality standards and the corresponding implementation plans. EPA Region 6 has requested that the (1) New Mexico Environmental Department provide certification of general permits Nos. NMG80000 and NMG810000, (2) Oklahoma Department of Agriculture provide certification of general permits Nos. OKG8000 and OKG810000, and (3) Texas Natural Resources Conservation Commission provide certification of general permits Nos. TXG80000 and TXG810000. EPA has also requested the following Pueblos in New Mexico: Pueblo of Isleta, Pueblo of Nambe, Pueblo of Picuris, Pueblo of Pojoaque, Pueblo of Sandia, Pueblo of San Juan, Pueblo of Santa Clara, and Pueblo of Tesuque to provide certification of general permits Nos. NMG80000 and NMG810000.

3. Reopener Clause

EPA reserves the right to revise, revoke or modify the draft permits to meet any applicable water quality standards if (1) effluent limitations or guidelines are established or modified in an approved State/Tribe Water Quality Management Plan or Waste Load Allocation and if they are more stringent than those listed in these permits or control a pollutant not listed in these permits; (2) a total daily maximum load (TDML) is developed to address pollution from CAFOs in a particular watershed. Permittees in that watershed may be required to obtain individual permits or to obtain coverage under an alternative general permit or the permits may be modified to include different limitations and/or requirements; (3) a particular watershed is identified by the State/Tribe as having been impaired by CAFO-related activities. Permittees in that watershed may be required to obtain individual permits or to obtain coverage under watershed-specific general permits or the permits may be modified to include different limitations and/or requirements.

The proposed permits are no discharge permits. In addition, the BMPs specified in Part II.D, when implemented as specified in the draft permits, will ensure that the State/Tribal water quality standards are protected. Any CAFO that is determined to be contributing to a violation of a water quality standard will not be eligible for coverage under this permit and may be required to apply for an individual or alternative general permit in accordance with Part I.F of these draft permits.

If and when a particular watershed is identified by the State/Tribe as having been impaired by CAFO-related activities, permittees in that watershed may be required to obtain individual permits or to obtain coverage under the watershed-specific general permits or the permits may be modified to include different limitations and/or requirements. Also, the watershed-specific general permits may be reopened or modified to reflect changes in the State/Tribe's listing of CAFO-impaired watersheds. Permit modification or revocation will be conducted according to 40 CFR 122.62, 122.63, and 122.64.

VIII. Economic Impact

EPA believes that the proposed general permits will be economically beneficial to the regulated community. The proposed general permits provides an economic alternative to the individual NPDES permit application process that facilities covered by these permits would otherwise be required to follow. The requirements are consistent with those already imposed by effective Federal regulations and State/Tribal requirements. The suggested management practices and PPPs give the regulated facilities guidelines and options which may save them time and money.

IX. Compliance With Other Federal Regulations

1. NEPA Finding of No Significant Impact

For each new CAFO with more than 1000 animal units or the number and types of animals specified in Part VII.I(a) of the permit [40 CFR part 122, Appendix B(a)] and any existing CAFO planning to expand to the number and types of animals specified in Part VII.I(a), EPA will conduct a preliminary environmental review pursuant to the requirements of CWA Section 511(c) and the environmental review procedures found at 40 CFR Part 6, ''Procedures for Implementing the Requirements of the Council on Environmental Quality on the National Environmental Policy Act'' for NPDES New Source Program. Therefore, new CAFOs and existing CAFOs subject to National Effluent Guidelines (40 CFR part 412) will be required to complete the form included in Addendum C of the proposed general permits and submit this information to EPA prior to coverage under the permits. The permittee must have documentation of ''No Significant Impact'' or a completed Environmental Impact Statement in accordance with an environmental

review conducted by EPA as a condition of permit coverage. This documentation must be retained on site.

2. Endangered Species Act

The proposed general permits will authorize no discharge, other than during catastrophic or chronic rainfall events which are relatively infrequent occurrences. Therefore, reissuance of these general permits is unlikely to adversely affect any listed threatened or endangered species or designated critical habitat. EPA will conduct an environmental review for each new CAFO with 1000 or more animal units and all existing CAFOs planning to expand to the numbers of animals specified in Part VII.I(a) of the draft permits [40 CFR part 122, Appendix B(a)]). This review will include an evaluation of the potential impact on endangered species due to the proposed activities.

EPA Region 6 has submitted copies of the proposed permits to the U.S. Fish & Wildlife Service. During the comment period of these proposed permits, EPA will seek the Fish & Wildlife Service's concurrence in its ''unlikely to adversely affect'' determination. In the absence of such concurrence, EPA will initiate formal consultation in accordance with Section 7(a)(2) of the Endangered Species Act.

3. National Historic Preservation Act

Facilities which adversely affect properties listed or eligible for listing in the National Register of Historical Places are not eligible for coverage under these draft permits. During the application process, EPA will conduct an environmental review for each new CAFO with 1000 or more animal units and all existing CAFOs planning to expand to the number and types of animals specified in Part VII.I(a) of the draft permits [40 CFR Part 122, Appendix B(a)]). This review will include an evaluation of the potential effects on historic sites and properties due to the proposed activities. If, at any time during the operation of the CAFO, a permittee becomes aware that historic properties may be affected by CAFO-related activities not identified during the application process, the permittee must contact the State Historic Preservation Officer (SHPO) or the Tribal Historic Preservation Officer (THPO) to determine whether additional actions are required to meet the eligibility requirements of the draft permits. This may result in initiation of consultation with the SHPO or THPO and the development or modification of a written agreement or the PPP. Therefore, reissuance of these general permits will not adversely affect any listed properties or properties that are eligible for listing in the National Register of Historical Places.

All existing CAFOs with less than 1000 AUs will not be eligible for coverage under the reissued permit if such facilities are already affecting properties that are listed in the National Register of Historic Properties. Existing CAFOs must comply with Part I.D(3) of the draft permit.

4. Paperwork Reduction Act

The Office of Management and Budget (OMB) has approved the information collection requirements related to the NOI and discharge monitoring activities under the provisions of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.* (OMB Nos. 2040–0086 and 2040–0004, respectively). EPA is currently developing the information collection request (ICR) (EPA ICR no.1868.01) for the PPP-related activities and will submit the ICR to OMB for approval.

5. Coastal Zone Management Act Reauthorization Amendment

Pursuant to Section 307 of the Coastal Zone Management Act (CZMA), federal agency activities that affect the coastal zone of a state with an approved coastal zone management plan must be carried out in a manner consistent, to the maximum extent practable, with the enforceable policies of that plan. To assure such consistency, EPA is proposing to require individual permits for CAFOs located within a mile of the Texas Coastal Zone Management Area. Applications for such individual permits will be subject to CZMA Section 307(c)(3)(A) and will receive the same type of review by the Coastal Coordination Council of the Texas General Land Office (Administrator of Texas' approved Coastal Zone Management Program) as corresponding permits issued by the Texas Natural Resources Conservation Commission receive under 31 Texas Administrative Code Section 505(11)(a)(6).

6. Unfunded Mandates Reform Act

Section 201 of the Unfunded Mandates Reform Act (UMRA), P.L. 104–4, generally requires Federal agencies to assess the effects of their ''regulatory actions'' on State, local, and tribal governments and the private sector. UMRA uses the term ''regulatory actions'' to refer to regulations. (*See*, e.g., UMRA section 201, ''Each agency shall * * * assess the effects of Federal regulatory actions * * * (other than to the extent that such regulations incorporate requirements specifically set forth in law)'' (emphasis added)). UMRA section 102 defines ''regulation'' by reference to section 658 of Title 2 of the U.S. Code, which in turn defines ''regulation'' and ''rule'' by reference to section 601(2) of the Regulatory Flexibility Act (RFA). That section of the RFA defines ''rule'' as ''any rule for which the agency publishes a notice of proposed rulemaking pursuant to section 553(b) of [the Administrative Procedure Act (APA)], or any other law * * *''

NPDES general permits are not ''rules'' under the APA and thus not subject to the APA requirement to publish a notice of proposed rulemaking. NPDES general permits are also not subject to such a requirement under the CWA. While EPA publishes a notice to solicit public comment on draft general permits, it does so pursuant to the CWA section 402(a) requirement to provide ''an opportunity for a hearing.'' Thus, NPDES general permits are not ''rules'' for RFA or UMRA purposes but are treated with rule-like procedures.

Signed this 18, day of June, 1998.

Oscar Ramirez, Jr.,

Deputy Director, Water Quality Protection Division (6WQ), EPA Region 6.

[FR Doc. 98–16943 Filed 6–23–98; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) submitted to OMB for Review and Approval

June 18, 1998.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burden invites the general public and other Federal agencies to take this opportunity to comment on the following information collection(s), as required by the Paperwork Reduction Act of 1995, Pub. L. 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. No person shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Comments are requested concerning: (a) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimate; (c) ways to enhance

the quality, utility, clarity of the information collected; and (d) ways to minimize the burden of the collection of information on the respondents, including the use of automated information techniques or other forms of information technology.

DATES: Written comments should be submitted on or before July 27, 1998. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: Direct all comments to Les Smith, Federal Communications, Room 234, 1919 M St., NW., Washington, DC 20554 or via internet to lesmith@fcc.gov.

FOR FURTHER INFORMATION CONTACT: For additional information or copies of the information collections contact Les Smith at 202–418–0214 or via internet at lesmith@fcc.gov.

SUPPLEMENTARY INFORMATION:

OMB Approval Number: 3060–0072.

Title: Airborne Mobile Radiotelephone License Application.

Form Number: FCC 409.

Type of Review: Revision of a currently approved collection.

Respondents: Business and other for-profit entities.

Number of Respondents: 3,000.

Estimated Time Per Response: 5 minutes.

Frequency of Response: On occasion reporting requirement.

Cost to Respondents: $135,000 ($45.00 filing fee).

Total Annual Burden: 252 hours.

Needs and Uses: The FCC Form 409 is used in applying for authority to operate an airborne mobile radio telephone by individual users who intend to become subscribers to a common carrier service. The form is subsequently used for modification and renewal of such licenses.

Form 409 is required by 47 CFR Part 22. The applicant may be subject to requirements in addition to those specified on the form.

The form has been redesigned to remove the fee filing data. FCC Form 159, Fee Remittance Advice, is required to be submitted with any payment to the FCC. Thus, we are removing the duplicative data collection from the FCC Form 409. This change will not affect the average estimated completion time of the form.

OMB Approval Number: 3060–0640.

Title: Construction of SMR Stations Request for Additional Information.

Form Number: FCC 800–I.

Type of Review: Revision of a currently approved collection.

Respondents: Individuals or households; Business and other for-profit entities; Not-for-profit institutions; State, Local or Tribal Governments.

Number of Respondents: 300.

Estimated Time Per Response: 2 hours 30 minutes.

Frequency of Response: On occasion reporting requirement; Others as requested.

Cost to Respondents: $0.

Total Annual Burden: 750 hours.

Needs and Uses: This data collection (letter format) is used as a method of verifying if licensee has placed station into operation and for notifying the Commission of the actual number of mobile units placed in operation after license grant. When a licensee provides conflicting information regarding the construction or operational status of radio facilities authorized to it, the Commission requires clarification/validation/explanation to substantiate the facilities' status so that it may enforce its regulatory responsibilities.

Such responsibilities include the allocation and assignment of radio frequency spectrum and determining the viability of the underlying radio license authorizations which provide for use of that spectrum.

The data requested in this collection are being revised to include requesting purchase order/invoices for the base station, transmitter(s) and antenna; Work order/invoices demonstrating completion of station construction; Name, address and phone number of individual(s) performing the station construction; model and serial numbers of mobiles in operation; and a list of users and phone numbers on this system at the time of construction.

The Commission's requirement that systems be permanently constructed and placed in operation is contained in 47 CFR, Rule Section 90.155, 90.313, 90.631, 90.633, 90.651, 90.725 and 90.737.

OMB Approval Number: 3060–XXXX.

Title: Application for DTV Broadcast Station License.

Form Number: FCC 302–DTV.

Type of Review: New collection.

Respondents: Business and other for-profit entities; Not-for-profit institutions.

Number of Respondents: 50.

Estimated Time Per Response: 19 hours (1.5 hours for applicant; 17.5 hours for engineer consultant).

Frequency of Response: On occasion reporting requirement.

Cost to Respondents: $163,625 (Consulting engineers and $210.00 license application fee).

Total Annual Burden: 75 hours.

Needs and Uses: Licensees and permittees of DTV broadcast stations are required to file FCC Form 302–DTV to obtain a new or modified station license, and/or to notify the Commission of certain changes in the licensed facilities of these stations.

The data are used by Commission staff to confirm that the station has been built to terms specified in the outstanding construction permit, and to update FCC station files. Data are then extracted from FCC Form 302–DTV for inclusion in the subsequent license to operate the station.

Federal Communications Commission.

Magalie Roman Salas,

Secretary.

[FR Doc. 98–17078 Filed 6–25–98; 8:45 am]

BILLING CODE 6712–01–F

FEDERAL COMMUNICATIONS COMMISSION

[DA 98–1194]

Notice of Telecommunication Relay Services (TRS) Certification; CC Docket No. 90–571

Released: June 19, 1998.

Notice is hereby given that the applications for certification of state Telecommunication Relay Services (TRS) programs of the states listed below have been granted, subject to the condition described below, pursuant to Title IV of the Americans with Disabilities Act of 1990, 47 U.S.C. 225(f)(2), and section 64.605(b) of the Commission's rules, 47 CFR 64.605(b). The Commission will provide further Public Notice of the certification of the remaining applications for certification once review of those states' applications has been completed. On the basis of the states applications, the Commission has determined that:

(1) The TRS program of the listed states meet or exceed all operational, technical, and functional minimum standards contained in section 64.604 of the Commission's rules, 47 CFR 64.604;

(2) The TRS programs of the listed states make available adequate procedures and remedies for enforcing the requirements of the state program; and,

(3) The TRS programs of the listed states in no way conflict with federal law.

The Commission also has determined that, where applicable, the intrastate funding mechanisms of the listed states are labeled in a manner that promotes national understanding of TRS and does not offend the public, consistent with

section 64.605(d) of the Commission's rules, 47 CFR 64.605(d).

On May 14, 1998, the Commission adopted a Notice of Proposed Rulemaking that proposes ways to enhance the quality of existing telecommunications relay services (TRS) and expand those services for better use by individuals with speech disabilities. See Telecommunications Relay Services and Speech-to-Speech Services for Individuals with Hearing and Speech Disabilities, CC Docket No. 98–67, FCC 98–90 (rel. May 20, 1998). Because the Commission may adopt changes to the rules governing relay programs, including state relay programs, the certification granted herein is conditioned on a demonstration of compliance with any new rules ultimately adopted by the Commission. The Commission will provide guidance to the states on demonstrating compliance with such rule changes.

This certification, as conditioned herein, shall remain in effect for a five year period, beginning July 26, 1998, and ending July 25, 2003, pursuant to 47 CFR 64.605(c). One year prior to the expiration of this certification, July 25, 2002, the states may apply for renewal of their TRS program certifications by filing documentation in accordance with the Commission's rules, pursuant to 47 CFR 64.605(a) and (b).

Copies of certification letters are available for public inspection at the Commission's Common Carrier Bureau, Network Services Division, Room 235, 2000 M Street, NW, Washington, DC, Monday through Thursday, 8:30 AM to 3:00 PM (closed 12:30 to 1:30 PM) and the FCC Reference Center, Room 239, 1919 M Street, NW, Washington, DC, daily, from 9:00 AM to 4:30 PM.

Fourth Group of States Approved for Certification

File No. TRS–97–07.
Applicant: Virginia Public Service Commission.
State of: Virginia.
File No. TRS–97–23.
Applicant: Department of Public Utilities.
State of: Massachusetts.
File No. TRS–97–38.
Applicant: North Carolina Department of Health and Human Services.
State of: North Carolina.
File No. TRS–97–44.
Applicant: Wisconsin Department of Administration.
State of: Wisconsin.

For further information contact: Al McCloud, (202) 418–2499, amccloud@fcc.gov: Helene Nankin, (202) 418–1466, hnankin@fcc.gov; or Kris Monteith, (202) 418–1098, kmonteit@fcc.gov, (TTY, 202–418–0484), at the Network Services Division, Common Carrier Bureau, Federal Communications Commission.

Federal Communications Commission.

Geraldine A. Matise,

Chief, Network Services Division, Common Carrier Bureau.

[FR Doc. 98–17077 Filed 6–25–98; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL RESERVE SYSTEM

Change in Bank Control Notices; Acquisitions of Shares of Banks or Bank Holding Companies

The notificants listed below have applied under the Change in Bank Control Act (12 U.S.C. 1817(j)) and § 225.41 of the Board's Regulation Y (12 CFR 225.41) to acquire a bank or bank holding company. The factors that are considered in acting on the notices are set forth in paragraph 7 of the Act (12 U.S.C. 1817(j)(7)).

The notices are available for immediate inspection at the Federal Reserve Bank indicated. The notices also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing to the Reserve Bank indicated for that notice or to the offices of the Board of Governors. Comments must be received not later than July 10, 1998.

A. Federal Reserve Bank of St. Louis (Randall C. Sumner, Vice President) 411 Locust Street, St. Louis, Missouri 63102-2034:

1. Sam Bryan Cook, St. Louis, Missouri, and Robert Marion Robuck, Jefferson City, Missouri, both individually and jointly through a trust; to acquire additional voting shares of Central Bancompany, Inc., Jefferson City, Missouri, and thereby indirectly acquire Central Trust Bank, Jefferson City, Missouri .

Board of Governors of the Federal Reserve System, June 22, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98–16981 Filed 6–25–98; 8:45 am]

BILLING CODE 6210–01–F

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act. Unless otherwise noted, nonbanking activities will be conducted throughout the United States.

Unless otherwise noted, comments regarding each of these applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than July 20, 1998.

A. Federal Reserve Bank of Dallas (W. Arthur Tribble, President) 2200 North Pearl Street, Dallas, Texas 75201-2272:

1. MetroCorp Bancshares, Inc., Houston, Texas, and Metro-Corp Delaware, Inc., Wilmington, Delaware; to become bank holding companies by acquiring 100 percent of the voting shares of MetroBank, N.A., Houston, Texas.

B. Federal Reserve Bank of San Francisco (Maria Villanueva, Manager of Analytical Support, Consumer Regulation Group) 101 Market Street, San Francisco, California 94105-1579:

1. InterWest Bancorp, Oak Harbor, Washington; to merge with Kittitas Valley Bancorp, Ellensburg, Washington, and thereby indirectly acquire Kittitas Valley Bank, N.A., Ellensburg, Washington.

Board of Governors of the Federal Reserve System, June 22, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98–16982 Filed 6–25–98; 8:45 am]

BILLING CODE 6210–01–F

FEDERAL RESERVE SYSTEM

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Committee on Employee Benefits of the Federal Reserve System.[1]

TIME AND DATE: 2:30 p.m., Wednesday, July 1, 1998.

PLACE: Marriner S. Eccles Federal Reserve Board Building, 20th and C Streets, NW., Washington, D.C. 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Proposals relating to Federal Reserve System benefits.
2. Issues relating to potential litigation.
3. Any items carried forward from a previously announced meeting.

CONTACT PERSON FOR MORE INFORMATION: Lynn S. Fox, Assistant to the Board; 202–452–3204.

SUPPLEMENTARY INFORMATION: You may contact the Board's Web site at http://www.bog.frb.fed.us for an electronic announcement of this meeting. (The Web site also includes procedural and other information about the meeting.)

Dated: June 24, 1998.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 98–17236 Filed 6–24–98; 12:40 pm]

BILLING CODE 6210–01–P

[1] The Committee on Employee Benefits considers matters relating to the Retirement, Thrift, Long-Term Disability Income, and Insurance Plans for employees of the Federal Reserve System.

FEDERAL RESERVE SYSTEM

[Docket No. R–0987]

Policy Statement on Privately Operated Multilateral Settlement Systems

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Policy statement.

SUMMARY: As part of its payment system risk reduction program, the Board of Governors is adopting a policy statement on Privately Operated Multilateral Settlement Systems, which integrates its existing policies on Privately Operated Large-Dollar Multilateral Netting Systems and Private Small-Dollar Clearing and Settlement Systems into one comprehensive policy.

EFFECTIVE DATE: January 4, 1999.

FOR FURTHER INFORMATION CONTACT: Jeffrey C. Marquardt, Assistant Director (202/452–2360) or Paul Bettge, Assistant Director (202/452–3174); Oliver Ireland, Associate General Counsel (202/452–3625); for the hearing impaired only, Telecommunications Device for the Deaf, Diane Jenkins (202/452–3544).

SUPPLEMENTARY INFORMATION:

I. The Proposed Policy Statement

In November, 1997, the Board issued for public comment a proposal to adopt a policy statement on Privately Operated Multilateral Settlement Systems (62 FR 60713, Nov. 12, 1997). The proposed policy statement was designed to integrate several of the Board's existing policies on payment system risk into a more comprehensive and consistent framework. The proposed policy statement addressed risks in multilateral settlement arrangements for both ''small-dollar'' payments, such as clearinghouses for checks and automated clearing house (ACH) payments and systems for settlement of ''large-dollar'' payments, which are typically used for interbank and financial market transactions. The proposal was intended to provide a flexible, risk-based approach to risk management in these systems and not mandate uniform, rigid requirements for all systems.

The proposed policy statement identified fundamental categories of risk, including credit, liquidity, operational, legal, and systemic risk, that may arise in different types of multilateral settlement arrangements. Systems would be expected to address any material risks in each category. For each type of risk, the policy statement included first, a discussion of risk factors designed to identify those multilateral settlement systems where risks may be heightened relative to other means of settlement. Second, threshold criteria were intended to identify more clearly systems in which these risk factors were not likely to arise. These criteria were intended to simplify administration of the policy and reduce potential regulatory burden on systems where the Board's analysis suggests that risks may be minimal. (An Appendix published with the proposed policy statement also provided examples of the likely application of the policy statement to specific types of systems.) Third, the proposed policy statement provided illustrations of the types of risk management measures that may be appropriate given the particular risk factors identified. Particularly for multilateral settlement systems that are not likely to raise systemic risk concerns, these illustrations were intended to provide flexible guidance rather than an exhaustive or prescriptive set of requirements, such that systems would be encouraged to implement risk management measures commensurate with the scale and scope of risks.

For multilateral settlement systems that were considered sufficiently large to raise potential systemic risk concerns, the proposed policy statement would have imposed higher risk management standards. Those larger systems that met proposed systemic risk criteria would have been expected to demonstrate robust policies and procedures for addressing settlement failures and disruptions. Certain of those larger multilateral settlement systems would also have been required to meet the same requirements of the Board's existing policy statement on Privately Operated Large-Dollar Multilateral Netting Systems (Large-Dollar Policy Statement), including meeting the Lamfalussy Minimum Standards.[1]

The Board also proposed to repeal its existing risk policies for certain ''small-dollar'' payments clearing and settlement arrangements. The earlier policies were designed to address specific situations that arose in the Federal Reserve's provision of net settlement services to depository institutions. The proposed policy statement would eliminate the need for such policies.

II. The Final Policy Statement

The Board is adopting a final policy statement that retains the structure and analytical approach of the original proposal. The policy statement replaces two existing components of the Board's Policy Statement on Payments System Risk, namely those for ''Privately Operated Large-Dollar Multilateral Netting Systems'' and ''Private Small-Dollar Clearing and Settlement Systems,'' which are being repealed concurrently with the effective date of this policy statement. As in the proposal, multilateral settlement systems subject to the policy would be required to address risk factors using a set of basic analytical risk categories. The final policy statement reflects important modifications to the original proposal designed to improve the clarity and effectiveness of the policy and to address concerns identified by commenters.

Scope and Administration of the Policy

The final policy statement includes a general threshold for application of the policy in order to eliminate potential administrative burden on those smaller

[1] *Report of the Committee on Interbank Netting Schemes of the Central Banks of the Group of Ten Countries* (Bank for International Settlements, November 1990) presented a set of minimum standards for netting schemes (Lamfalussy Minimum Standards).

systems that are not likely to pose systemic risks or other significant risk concerns. Specifically, the policy will apply to those multilateral settlement systems that settle payments with an aggregate gross value of more than $5 billion on any day. The Board believes that systems with activity below this threshold and their members may nonetheless find the framework and analysis of the policy statement helpful in evaluating and managing risks.

Risk Factors and Risk Management Measures

The final policy statement largely retains the discussions of credit, liquidity, operational, and legal risk factors and risk management measures in the proposal. Technical modifications have been made in a number of areas, however, to clarify the policy and address concerns of commenters, as discussed further below. In conjunction with the limitation on the scope of the policy discussed above, the final policy has been simplified by elimination of the proposed separate Systemic Risk category.

As in the proposed policy statement and the Board's existing Policy Statement on Payments System Risk, certain systems are required to meet the Lamfalussy Minimum Standards. However, under the final policy, the Board will use several factors to determine whether a system should meet the Lamfalussy Minimum Standards. These factors include the settlement of predominantly large-value, interbank or other financial market transactions, such as foreign exchange transactions, or the existence of credit or liquidity exposures that have the potential to raise significant systemic risk concerns. These factors should ensure that the Lamfalussy Minimum Standards will be applied where systemic risks exist, but allow for more flexible risk management in other systems. The Board may be required to make infrequent case-by-case determinations in this regard. In addition, the final policy strongly encourages systems, in meeting the Lamfalussy Minimum Standards, to establish real-time risk controls and other specific risk management measures, as currently described in the Board's existing Large-Dollar Policy Statement. However, alternative risk management measures that provide an equivalent level of assurance that the Lamfalussy Minimum Standards will be met will also be considered. The final policy also includes modified terminology in restating the Lamfalussy Minimum Standards to reflect the policy's broader application to ''settlement'' systems rather than to ''netting'' systems only.

III. Summary of Comments

The Board received 26 public comment letters on its proposed policy statement.[2] The commenters included nine commercial banking organizations, seven clearing organizations and associations, seven retail payment networks, and three trade associations.

General Comments

Commenters generally supported the policy's flexible approach to addressing risks in multilateral settlement arrangements. Many also supported the integration of the Board's existing policy statements within a unified, analytical framework. However, a number of commenters expressed concerns about the inclusion of clearinghouses for small-dollar or traditionally retail-oriented payments, such as checks, ACH payments, and automated teller machine (ATM) and credit card transactions, within a comprehensive policy on settlement risk. Many of these commenters focused on the requirements for real-time risk controls associated with the Lamfalussy Minimum Standards (discussed further below) and on the implication that small-dollar payments settlement arrangements may pose systemic risk. Three commenters felt that there was no rationale for unifying the large-and small-dollar policies for settlement arrangements.

A number of commenters described risk management measures used in their system and requested exemptions from the policy based on those measures. Several commenters requested that particular types of systems or payments be exempt from the policy altogether, such as credit card or ATM card settlement arrangements. Several commenters felt that the policy was too vague and did not provide sufficient guidance regarding measures that would be adequate for compliance with the policy.

The limitation on the scope of the policy to systems with daily payment activity above $5 billion should address concerns expressed by commenters about the potential burden of the policy statement on smaller, retail-oriented systems. Under the policy, only the largest systems will need to complete an analysis of credit, liquidity, operational, and legal risks.

For systems subject to the policy statement, the Board believes that the flexible approach set out in the policy, while requiring more careful analysis on the part of the clearinghouses than would a more rigid set of requirements, is the most likely to lead to appropriate risk management measures commensurate with the level and nature of risks in different systems. The Board emphasizes that the policy does not necessarily imply that any particular system needs to make changes to its policies or procedures. In particular, for some systems covered by the policy, the risk factors described in the policy statement may not be significant. For systems that do exhibit one or more risk factors, the types of risk management measures described by a number of commenters are likely to be sufficient to meet the requirements of the policy statement. Moreover, the new policy is likely to be less burdensome than the Board's existing payment system risk policies for small-dollar payments arrangements because it does not contain specific risk management requirements for these systems. The final policy also clarifies that, in general, the Board does not believe that retail-oriented systems need to meet fully the Lamfalussy Minimum Standards and implement real-time risk controls.

Six commenters requested that the Board reference and endorse other reports on payment system risk, including one report on settlement risk issued by a private-sector task force (the NACHA/NOCH Report) and a General Accounting Office report.[3] These reports include useful background information and insights on certain aspects of payment system risk. Although many of the findings of the NACHA/NOCH Report are consistent with those in this policy statement, the Board does not believe that it would be appropriate to attempt to incorporate these findings within this policy statement.

Specific Issues on Which the Board Sought Comment

1. Identification of Material Risks; Threshold Criteria

Most commenters felt that the risk categories and descriptions of risk factors and risk management measures reasonably captured the features of multilateral settlement systems likely to lead to greater settlement risk (with the exception of the Systemic Risk category, discussed below). Two commenters requested that definitions of major risks

[2] This total does not include comment letters from Federal Reserve Banks.

[3] National Organization of Clearing Houses and National Automated Clearing House Association, *Report of the Settlement Risk Management Task Force: Findings and Recommendations,* 1996; General Accounting Office, *Payments, Clearance, and Settlement: A Guide to the Systems, Risks, and Issues,* June 1997, GAO/GGD–97–73.

be included in the policy. The final policy includes brief definitions of credit, liquidity, operational, and legal risks in the context of settlement risk management.

As noted above, the proposed policy statement included ''threshold criteria'' for each risk category to distinguish systems not likely to pose material risk factors. Many commenters requested clarification of the definition of certain of the thresholds. A number of commenters described certain features of their system and requested that systems with these features be exempt from the policy. Others noted that certain risk factors, such as loss-sharing arrangements, would in many cases not give rise to material risks for participants given the small size of potential losses. A number of participants felt that the netting factor was not a useful indication of liquidity risk.

The original intent of the threshold criteria was to provide simple, de *minimis* exclusions for systems where risks were not likely to be material. Questions raised by commenters indicate that these criteria may not prove to be as simple to implement as originally intended. The limitation on the scope of the policy to systems with daily payment activity above $5 billion should address many of the concerns of commenters. The final policy thus does not include separate threshold criteria, although it retains the closely related discussion of risk factors.

Some commenters requested that the Board clarify that not all risk management measures listed under the discussion of risk management measures are required to address a particular risk factor. The final policy clarifies that this is the case.

Some commenters, such as ATM networks, requested greater specificity on which risk management measures would be required for their systems in order to be considered in compliance with the policy statement. Others requested that the Board confirm that certain risk measures used by their system would be considered sufficient to address a particular risk factor in all cases. For example, two commenters requested that the Board confirm that credit card systems do not exhibit legal risk by virtue of their operating rules; other commenters requested that use of the Federal Reserve's net settlement service be considered adequate protection against legal risk. Some commenters requested clarification on the acceptability of gross versus net recasts of payments in a settlement failure situation.

As noted above, the limitation on the scope of the policy to the largest systems should address many of the concerns of commenters. Even for these larger systems, the Board believes that because different systems may implement different risk management measures appropriate to the scale of risks and the nature of their operations, additional prescriptive requirements would not be appropriate for all systems and would undermine the flexible approach of the policy. Moreover, the Board is not in a position to confirm that particular measures adopted by particular systems, such as specific time frames for settlement, provisions of system rules, or use of any particular settlement services, would be sufficient to address particular risk factors independent of detailed knowledge of the operations and other features of the particular system on an ongoing basis. However, the final policy clarifies that a system that exhibits one or more risk factors does not necessarily need to enhance its risk management policies and procedures if existing arrangements are adequate to address the particular risk factor.

2. Systemic Risk Criteria and Risk Management Measures

The proposed policy set out dollar thresholds for identifying systems that have the potential to pose systemic risk. The Board requested comment on the thresholds used to identify those systems with the potential to pose systemic risk, as well as on the risk management measures specified for such systems. Commenters suggested a range of different criteria that may be indicative of systemic risk, including gross and net settlement volumes, settlements relative to individual participants' capital, and the characteristics of underlying payments. Some commenters noted that a uniform threshold was inappropriate, as systemic risk could depend on many factors. Commenters also requested clarification on risk management measures, including the application of the Lamfalussy Minimum Standards.

To simplify the analysis and assessment of risks and address concerns expressed by commenters, the final policy does not include a separate component for ''Systemic Risk.'' As noted earlier, the overall scope of the policy has also been limited to systems with aggregate gross daily payment activity above $5 billion. This threshold is also consistent with suggestions made by some commenters for identifying systems that may pose systemic risk. The Board considered other thresholds, such as those based on settlement exposures relative to the capital of participants, but concluded that such thresholds would be overly complex and burdensome as a means of identifying systems that are subject to the policy statement (as well as those that are not).

The Board continues to believe that the Lamfalussy Minimum Standards provide important guidance for addressing settlement risk in multilateral settlement systems where failure to settle net obligations as and when expected could have systemic consequences. However, the requirement that a system be capable of settling all positions in the event of the default of the largest single participant may not be necessary for certain systems. Although large check, ACH, and credit card settlement arrangements, for example, should demonstrate sound risk management measures, the Board does not believe that all of the requirements of the Lamfalussy Minimum Standards are generally necessary for these systems. Settlement obligations for individual participants are not of the same magnitude as in traditional large-value payment systems, and credit and liquidity exposures are typically diversified over large numbers of participants. In many cases, there are reliable and timely alternatives to settlement through the clearinghouse, particularly for check and ACH clearing and settlement arrangements.

The Board will, therefore, apply additional factors to determine whether systems must meet the Lamfalussy Minimum Standards. These factors include settlement of high volumes of large-value, interbank or other financial market transactions, such as foreign exchange transactions, or significant systemic credit or liquidity risks.

The proposed policy enumerated the five implementation measures, including real-time controls and net debit caps, required of systems currently subject to the Lamfalussy Minimum Standards. Many commenters felt that real-time interbank risk controls and bilateral credit limits were generally not feasible or desirable for retail payment systems.

The modifications to the proposal discussed above should obviate these concerns. In addition, to provide additional flexibility, the final policy has been modified to permit alternative risk management controls that provide an equivalent level of certainty that the Lamfalussy Minimum Standards can be met. The final policy also clarifies that, as in the Board's existing policy for large-dollar multilateral netting systems, centrally managed limits between the

system and each participant would be considered equivalent to bilateral limits when the system itself acts as a central counterparty or otherwise guarantees settlement. This is also consistent with the Board's approach under Regulation F, where institutions are required to set bilateral limits on credit and liquidity exposures to correspondents and other counterparties.

3. Usefulness of an Appendix

Most commenters felt that the Appendix to the proposed policy containing examples of application of the policy was useful, although several commenters disagreed. Given the limitation on the scope of the final policy, the Board does not believe that such examples are necessary. Thus, the final policy does not include an Appendix.

Other Comments

1. Administration and Enforcement of the Policy Statement

A number of commenters raised questions about the administration and enforcement of the policy statement. Two commenters stated that the Board should not apply or enforce the policy through provision of Federal Reserve net settlement services. Several commenters encouraged the development of interagency supervisory examination procedures to provide a consistent, objective approach to enforcement of the policy statement. A few commenters requested that the legal status of the policy statement be clarified, and that an appeals process be specified for actions taken under the policy statement.

Like other components of the Board's Policy Statement on Payments System Risk, this policy statement is not a regulation, but rather provides the framework that the Board expects to use when taking action on matters within its jurisdiction. The Board expects to administer the policy statement through its existing authority, including its supervisory jurisdiction over institutions such as state member banks and bank holding companies, as well as Federal Reserve service relationships, where appropriate. The assessment of compliance with the policy statement will not be based on the use of any particular type of Federal Reserve net settlement service, but rather on systems' risk factors and risk management policies. The avenues for appealing actions under the policy would be the same as in the Board's existing supervisory or service relationships. Given the limited scope of the final policy, the Board does not believe that interagency examination procedures are needed at this time.

Two commenters asked that the Board clearly specify any reporting requirements for gross and net settlement data and position data. The final policy includes a clarification as to the type of data that may be requested.

2. Repeal of Existing Small-Dollar Policies

Five commenters objected to the perceived withdrawal of the Board's approval under the Board's existing payment system risk policies for small-dollar systems. Some of these commenters requested that a program of certification of compliance with the policy statement be developed in lieu of these ''approvals.''

The ''approvals'' referred to by commenters represent previous determinations by the Board that particular systems may use the Fedwire-based net settlement services across multiple Federal Reserve Districts. In 1990, the Board established a set of conditions, embodied in the current Payments System Risk policy for ''small-dollar'' systems, for the use of this service. Subsequent applications for cross-District net settlement services have been reviewed under this policy. The conditions in the policy were designed in large part to address specific concerns about risk to the Federal Reserve in providing cross-District net settlement services.

Although the Board is repealing its existing small-dollar policies concurrently with the issuance of this policy statement, the Board is not repealing the prior approval of any system to use the Fedwire-based, cross-District net settlement service in conjunction with issuance of this policy. In general, such cross-District systems may continue to use the Fedwire-based net settlement service. As with any system subject to this policy, regardless of whether it uses the Fedwire-based net settlement service, another Federal Reserve net settlement service, or another settlement method, appropriate enforcement actions will be considered if the system is found to be not in compliance with the policy. The Board also notes that approval to use the cross-District net settlement service or any other Federal Reserve service does not imply Federal Reserve endorsement of a particular system or of its risk management arrangements, and should not be used to communicate any such endorsement to participants or potential participants. Moreover, the Board does not anticipate formally certifying compliance of systems under the policy, as this would be likely to reduce the normal incentives for participants to monitor and manage the risk in systems in which they participate.

Effective Date

The policy statement will be effective January 4, 1999 to permit systems subject to the policy a six-month period to assess and ensure their compliance. Although the Board does not expect that compliance with the policy statement will necessitate operational changes for the few systems that will fall within its scope, the Board recognizes that systems may currently have other critical efforts underway, such as preparation for the century date change. As a result, the Board will consider extending the effective date on a case-by-case basis for systems that can demonstrate significant resource demands due to other critical efforts.

Competitive Impact Analysis

The Board has established procedures for assessing the competitive impact of rule or policy changes that have a substantial impact on payments system participants.[4] Under these procedures, the Board will assess whether a change would have a direct and material adverse effect on the ability of other service providers to compete effectively with the Federal Reserve in providing similar services due to differing legal powers or constraints, or due to a dominant market position of the Federal Reserve deriving from such differences. If no reasonable modifications would mitigate the adverse competitive effects, the Board will determine whether the anticipated benefits are significant enough to proceed with the change despite the adverse effects.

The Board does not believe that the adoption of this policy statement will have a direct and material adverse impact on the ability of other service providers to compete effectively with the Reserve Banks' payments services. The repeal of the Board's existing policies for small-dollar payments clearing arrangements, together with the Board's proposal for an enhanced net settlement service, should reduce costs and other potential barriers for private check and ACH clearing and settlement arrangements that compete with the Federal Reserve. While the Reserve Banks are not subject to this policy statement, the Board notes that settlement risk exposures arising from services provided by central banking organizations are inherently different than for private-sector organizations. In

[4] These procedures are described in the Board's policy statement ''The Federal Reserve in the Payments System,'' as revised in March 1990. (55 FR 11648, March 29, 1990).

addition, the Reserve Banks are subject to Part I of the Policy Statement on Payments System Risk, which requires them to implement an extensive program of risk controls, including ongoing monitoring of all depository institution customers, net debit caps, and fees that are charged to depository institutions for the use of intraday credit.

Federal Reserve System Policy Statement on Payments System Risk

The Board is amending its ''Federal Reserve System Policy Statement on Payments System Risk'' (57 FR 40455, September 3, 1992) under the heading ''II. Policies for Private-Sector Systems'' by removing ''A. Privately Operated Large-Dollar Multilateral Netting Systems'' in its entirety and adding in its place ''A. Privately Operated Multilateral Settlement Systems'' and removing ''C. Private Small-Dollar Clearing and Settlement Systems'' in its entirety.

II. Policies for Private-Sector Systems

A. Privately Operated Multilateral Settlement Systems

Introduction

Multilateral settlement systems, such as clearinghouses and similar arrangements, may produce important efficiencies in the clearance and settlement of payments and financial contracts. Participants in such systems, typically depository institutions, exchange payments for their own account or the accounts of their customers in a coordinated fashion and settle the resulting obligations on a multilateral, often net, basis.

A variety of credit, liquidity, and other risks can arise in the clearing and settlement process that institutions must manage in the normal course of business, regardless of the method of clearing and settlement. Existing supervisory standards are generally directed at ensuring that institutions establish appropriate policies and procedures to manage such risks. For example, Federal Reserve Regulation F directs insured depository institutions to establish policies and procedures to avoid excessive exposures to any other depository institutions, including exposures that may be generated through the clearing and settlement of payments.[18]

However, the use of multilateral settlement systems introduces the risk that a failure of one participant in the system to settle its obligations when due could have credit or liquidity effects on participants that have not dealt with the defaulting participant. Multilateral settlement may, in some cases, also have the effect of altering the underlying bilateral relationships that arise between institutions during the clearing and settlement process. As a result, the incentives for, or ability of, institutions to manage and limit the risk exposures to other institutions, as required under Regulation F, may be reduced. In addition, in some cases, there may be no timely or feasible alternative to settlement through the multilateral system in the event that the system fails to complete settlement, due, for example, to a participant default. These factors may create added risks to participants in certain multilateral settlement systems relative to other settlement methods. As a result, a number of multilateral settlement systems and their participants have implemented a variety of risk management measures to control these risks.

Clearinghouses also may generate systemic risks that could threaten the financial markets or the economy more broadly. The failure of a system to complete settlement as and when expected could generate unexpected credit losses or liquidity shortfalls that participants in the system are not able to absorb. Thus, the inability of one participant to meet its obligations within the system when due could lead to the illiquidity or failure of other institutions. Further, the disruption of a large number of payments and the resulting uncertainty could lead to broader effects on economic activity. In addition, as the Federal Reserve has established net debit caps and fees for daylight overdrafts, along with other risk management measures for Federal Reserve payment services, the potential exists for intraday credit risks to be shifted from the Federal Reserve to private, multilateral settlement arrangements, either domestically or in other countries, that have inadequate risk controls.

The Board believes that these concerns warrant the application of a risk management policy to those multilateral settlement systems that have the potential to raise systemic risks, particularly in cases where risks may not be adequately addressed by existing supervisory guidance on management of exposures to other depository institutions. The Board recognizes that multilateral settlement systems differ widely in terms of form, function, scale, and scope of activities. Thus, risk management measures may be designed differently for different systems. This policy statement, therefore, is designed to permit market participants to determine the best means of addressing risks, within the guidelines provided. As a general rule, risk management measures should be commensurate with the nature and magnitude of risks involved.

The Board's adoption of this policy in no way diminishes the primary responsibilities of participants in, and operators of, multilateral settlement systems to address settlement and other risks that may arise in these systems. In addition, the Board encourages all multilateral settlement systems to consider periodically cost-effective risk management improvements, even if not specifically required under this policy. Insured depository institutions participating in multilateral settlement systems are also expected to limit any significant bilateral credit and liquidity exposures to other institutions as required under Federal Reserve Regulation F.

Scope and Administration of the Policy

This policy statement applies to privately operated multilateral settlement systems or arrangements with three or more participants that settle U.S. dollar payments, including but not limited to systems for the settlement of checks, automated clearinghouse (ACH) transfers, credit, debit, and other card transactions, large-value interbank transfers, or foreign exchange contracts involving the U.S. dollar where the aggregate gross value of payments is expected to exceed $5 billion on any day during the next 12 months.[19] Further, the policy does not apply to clearing and settlement systems for securities or exchange-traded futures and options, and is not intended to apply to bilateral relationships between financial institutions, such as those involved in traditional correspondent banking. The Board may also apply this policy to any non-U.S. dollar system based, or operated, in the United States that engages in the multilateral settlement of non-dollar payments among financial institutions and that would otherwise be subject to this policy.

[18] *See* 12 CFR 206.

[19] The gross value of payments settled refers to the total dollar value of individual payments or transactions that are settled in the system, which represents the sum of total debits or total credits to all participants *prior to* any netting of settlement obligations. ''On-us'' transactions that do not require interbank settlement, but may in some cases be processed by the system, may be excluded for purposes of these calculations. Where a system conducts multiple settlements per day, these settlements should be aggregated for purposes of this calculation if they are conducted among the same group of participants subject to the same rules and procedures.

The Board expects to be guided by this policy statement in taking action in its supervisory and operational relationships with state member banks, bank holding companies, and clearinghouse arrangements, including, for example, the provision of net settlement services and the implementation of the Bank Service Company Act.[20] Systems subject to this policy may be asked to provide to the Federal Reserve peak and daily average aggregate gross and net settlement data for the most recent 12-month period or calendar year, as well as peak and daily average settlement position data for individual participants.

Risk Factors and Risk Management Measures

An analysis of settlement risks in any multilateral settlement system should begin with the identification of key risks and exposures. For purposes of this policy, the general categories of settlement risk include credit risk—the risk to participants or to the system that a participant will be unable to meet fully its settlement obligation; liquidity risk—the risk that participants or the system will have insufficient funds available to meet settlement obligations as and when expected; operational risk—the risk that operational factors in the settlement process may cause or exacerbate these credit or liquidity risks or disrupt the settlement of payments; and legal risk—the risk that legal uncertainties in the settlement process may cause or exacerbate these credit and liquidity risks.

Systems subject to the policy that exhibit one or more risk factors should assess whether their policies and procedures adequately address those specific risks, including consideration of the risk management measures listed below. In general, risk management controls should be proportional to the nature and magnitude of risks in the particular system. The Board does not expect that all of the specific risk management measures listed below will be necessary or appropriate for all systems; moreover, there may be other risk management measures that will address a particular risk factor. Systems that exhibit one or more risk factors may not need to implement any additional risk controls as a result of this assessment if existing risk controls adequately address the particular risk.

If necessary, the Board and its staff will work with systems to determine whether changes in their policies or operations are required and, if so, whether steps proposed by the system would adequately address the risk factor. In some cases, an operational change may mitigate a particular risk factor. In other cases, systems may need to develop or modify written rules, policies, and procedures that specify the rights and obligations of participants, as well as other relevant parties, such as settlement agents for the system, in the event that a settlement cannot be completed as and when expected. Such rules and procedures should be disclosed to all participants and their primary regulatory authorities.

To facilitate the analysis under this policy, systems may need to develop the capability to simulate credit and liquidity effects on participants and on the system resulting from one or more participant defaults, or other possible sources of settlement disruption.[21] Systems may also need to test the operational capability to execute settlement failure procedures, where these differ from normal settlement procedures. Documentation of any significant legal analysis or agreements relevant to risk management may also be appropriate.

(1) Credit risk. Risk factors: A multilateral settlement system would give rise to credit risk if its rules or practices significantly increase or shift the bilateral obligations or credit exposures between participants in the clearing and settlement process. For example, a clearinghouse operator or agent that provides an implicit or explicit guarantee of settlement could shift bilateral exposures. Such a guarantee might be implemented through the establishment of a central counterparty for all transactions, or through other provisions in the system's rules, such as a guarantee of members' settlement obligations, third-party credit arrangements, or the system's ability to recover settlement-related losses from participants. Additionally, a system may expose participants to credit risk to one another, due for example, to agreements to mutualize any settlement losses.

Risk management measures: Measures that are commonly used to mitigate credit risk in a multilateral settlement system and provide support for settlement guarantees include monitoring of participants' financial condition, caps or limits on some or all participants' positions in the system, and requirements for collateral, margin, or other security from some or all participants. Systems in which participants have significant bilateral exposures to one another or to the system, such as through loss-sharing agreements, may need to implement mechanisms for participants to control these exposures if they are significant. Use of settlement methods with same-day finality may also shorten the duration of credit risk exposure in a system.

(2) Liquidity risk. Risk factors: A multilateral settlement system would give rise to liquidity risk for its participants if a delay, failure, or reversal of settlement would be likely to cause a significant change in settlement amounts to be paid or received by participants on the settlement date. The degree of liquidity risk in a particular system is likely to be greater (1) the larger are gross payment flows relative to netted amounts to be settled; (2) the larger are participants' settlement positions relative to their available funding resources; (3) the later that participants would be notified of a settlement disruption relative to the timing of activity in the money markets and other funding channels, and (4) the greater the likelihood that a settlement failure of the particular system would be accompanied by abnormal market conditions.

Risk management measures: One approach to mitigating liquidity risk is to implement measures to reduce significantly both the probability and the effect of a settlement disruption. For example, many of the measures described above that are commonly used to mitigate credit risk may reduce the probability and effect of a participant's inability to meet its settlement obligations when due. External liquidity resources available to the system and adequate operational contingency arrangements may also mitigate liquidity risk.

Some systems anticipate performing a recast of settlements in the event of a participant default, by recalculating multilateral net settlement obligations among participants. These systems are expected to assess, and where necessary address, the liquidity impact on participants of such a procedure.[22] For example, timely notification of settlement failure before or during the period of active money market trading should permit participants readily to borrow funds to cover any shortfalls due

[20] 12 U.S.C. 1861–67.

[21] Such simulations may include, if appropriate, the effects of changes in market prices, volatilities, or other factors.

[22] For example, in a ''recast'' of settlements, some or all transactions involving the defaulting participant would be removed from the system's settlement process, to be settled or otherwise resolved outside the system. A revised multilateral settlement with recalculated settlement obligations would then be conducted among the remaining participants. In an ''unwind,'' transactions or settlement obligations to be settled on the day of the default for all participants would be removed from the system.

to the recast. Individual participants may also take steps to limit their own liquidity exposures in the system or increase available liquidity resources.

(3) Operational risk. Risk factors: Operational risks, such as those relating to the reliability and integrity of electronic data processing facilities used in the clearing and settlement process, are addressed in standard supervisory guidance for depository institutions and their service providers. Operational risk factors for purposes of this policy statement include those that could hinder the timely completion of settlement or the timely resolution of a settlement disruption in a multilateral settlement system. For example, for a system that anticipates recasting settlement obligations in the event of a participant default, operational obstacles could make it difficult or impossible for participants to arrange settlement outside the system on a timely basis in the event of a settlement failure. As a result, those participants expecting to receive funds could face significant liquidity risk. In addition, in some cases, failure to complete settlement on a timely basis could change the rights of participants with respect to the underlying payments, creating potential credit or liquidity risks. For example, institutions that are unable either to return or to settle for checks presented to them on the same day may lose the right to return the checks for insufficient funds.

Further, certain risk control procedures implemented by a particular system may themselves entail operational risks. The ability of a system to execute a recast of settlements, implement guarantee provisions, or access lines of credit may depend on the operational reliability of the system's facilities.

Risk management measures: Multilateral settlement systems and their participants typically mitigate the risk of operational failure in their daily processing activities through standard techniques, such as contingency plans, redundant systems, and backup facilities. For purposes of this policy statement, systems should ensure the reliable operational capability to execute procedures used to resolve a participant default or other settlement disruption as well as to implement other risk management measures.

For example, if a system anticipates recasting settlements by excluding transactions of a defaulting participant, it should ensure that the system can perform any required processing, generate the necessary information, and provide the information to participants in a timely manner. To the extent that payments would be expected to be settled outside the system, procedures should be established to notify participants such that they have adequate time, settlement information, and operational capabilities to complete such settlements before the close of critical funds transfer systems. A system that does not anticipate recasting settlements but plans to settle all positions as and when expected should ensure that operational procedures to implement risk management measures are in place, such as means of access to lines of credit in a timely manner.

(4) Legal risk. Risk factors: Legal risk may exist in a multilateral settlement system if there is significant uncertainty regarding the legal status of settlement obligations or of the underlying transactions in the event of a settlement failure. Significant legal uncertainty could exacerbate efforts to achieve an orderly and timely resolution and could expose participants to significant credit and liquidity risks. For example, if the obligations of participants with respect to underlying transactions exchanged in the system have no enforceable legal status in the event of a system settlement failure, the ability of the participants to revert to other methods of settlement on a timely basis may be in doubt. Legal risk would also arise if the legal enforceability of any significant risk management measures, netting agreements, or related arrangements, is not well supported.

Risk management measures: Systems should address legal risk factors, where significant exposures may arise, by ensuring that operating rules or other agreements between participants will be enforceable in the event of a settlement failure. As part of this process, systems may wish to obtain legal opinions as to the enforceability of its rules and agreements under applicable legal regimes. Additionally, when the transactions settled through the system are not otherwise covered by an established body of law, the system should ensure that the rights and obligations of the participants are adequately addressed through the system's rules or participant agreements.

Application of the Lamfalussy Minimum Standards

Certain multilateral settlement systems are also required to meet the Lamfalussy Minimum Standards.[23] These standards were designed to address the main risk factors that may be present in multilateral settlement systems and to provide confidence that such systems can settle all positions as and when expected in the event that a participant cannot meet its settlement obligations, thereby reducing substantially the risk that a default by one participant will cause defaults by others. To determine whether a system is also required to meet the Lamfalussy Minimum Standards, the Board will consider additional factors that include the following: settlement of a high proportion of large-value, interbank or other financial market transactions, such as foreign exchange transactions; very large liquidity exposures that have potentially systemic consequences, such as by virtue of a high ratio of gross payments to net settlement obligations; or systemic credit exposures relative to participants' financial capacity.

Lamfalussy Minimum Standards for the Design and Operation of Privately Operated Large-Dollar Multilateral Settlement Systems: 1. Multilateral settlement systems should have a well-founded legal basis under all relevant jurisdictions.

2. Multilateral settlement system participants should have a clear understanding of the impact of the particular system on each of the financial risks affected by the netting process.

3. Multilateral settlement systems should have clearly-defined procedures for the management of credit risks and liquidity risks which specify the respective responsibilities of the netting provider and the participants. These procedures should also ensure that all parties have both the incentives and the capabilities to manage and contain each of the risks they bear and that limits are placed on the maximum level of credit exposure that can be produced by each participant.

4. Multilateral settlement systems should, at a minimum, be capable of ensuring the timely completion of daily settlements in the event of an inability to settle by the participant with the largest single net debit position.

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[23] The *Report of the Committee on Interbank Netting Schemes of the Central Banks of the Group of Ten Countries* (Bank for International Settlements, November 1990), known as the Lamfalussy Report, recognized that netting arrangements for interbank payment orders and forward-value contractual commitments, such as foreign exchange contracts, have the potential to improve the efficiency and the stability of interbank settlements through the reduction of costs along with credit and liquidity risks, provided certain conditions are met. That Report developed and discussed ''Minimum Standards for Netting Schemes'' (Lamfalussy Minimum Standards) and ''Principles for Co-operative Central Bank Oversight'' of such arrangements. These standards have been adopted by the central banks of the G–10 and European Union countries. The text included in this policy statement includes editorial modifications to the original standards.

5. Multilateral settlement systems should have objective and publicly-disclosed criteria for admission which permit fair and open access.

6. Multilateral settlement systems should ensure the operational reliability of technical systems and the availability of backup facilities capable of completing daily processing requirements.

Risk management measures: For systems that the Board has determined are required to meet the Lamfalussy Minimum Standards, systems and their participants should consider the following risk management measures: (1) to the extent that participants have significant credit and liquidity exposures to other participants, establish bilateral net credit limits vis-ă-vis each other participant in the system; (2) establish and monitor in real-time system-specific net debit limits for each participant; (3) establish real-time controls to reject or hold any payment or foreign exchange contract that would cause a participant's position to exceed the relevant bilateral and net debit limits; (4) establish liquidity resources, such as cash, committed lines of credit secured by collateral, or a combination thereof, at least equal to the largest single net debit position; and (5) establish rules and procedures for the sharing of credit losses among the participants in the netting system.[24]

Alternative risk management measures may provide an equivalent level of assurance that the Lamfalussy Minimum Standards are met, depending on the nature and scope of the system. However, the Board strongly encourages systems to develop real-time risk management controls where necessary to provide an appropriate level of risk control. The Board may also encourage or require higher risk management standards, such as the ability to ensure timely multilateral settlement in the event of multiple defaults, of individual systems that present a potentially high degree of systemic risk, by virtue of their high volume of large-value transactions or central role in the operation of the financial markets.

Offshore Systems

The Board has a long-standing concern that steps taken to reduce systemic risk in U.S. large-dollar payments systems may induce the further development of multilateral systems for settling U.S. dollar payments that are operated outside the United States. Such systems, if implemented with inadequate attention to risk management, may increase risks to the international banking and financial system. In addition, offshore arrangements have the potential to operate without sufficient official oversight.

As a result, the Board has determined that offshore, large-dollar multilateral settlement systems and multicurrency clearing and settlement systems should at a minimum be subject to oversight or supervision, as a system, by the Federal Reserve, or by another relevant central bank or supervisory authority. The Board recognizes that central banks have common policy objectives with respect to large-value clearing and settlement arrangements. Accordingly, the Board expects that it will cooperate, as necessary, with other central banks and foreign banking supervisors in the application of the Lamfalussy Minimum Standards to offshore and multicurrency systems. In this regard, the Principles for Co-operative Central Bank Oversight outlined in the Lamfalussy Report provide an important international framework for cooperation.

By order of the Board of Governors of the Federal Reserve System, June 18, 1998.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 98–16694 Filed 6–25–98; 8:45 am]

BILLING CODE 6210–01–P

[24] The term ''largest single net debit position'' means the largest intraday net debit position of any individual participant at any time during the daily operating hours of the netting system.

GENERAL SERVICES ADMINISTRATION

Environmental Considerations in Decisionmaking and Compliance With the National Environmental Policy Act

SUMMARY: The General Services Administration (GSA) has rewritten its Orders establishing policy and assigning responsibilities for implementing the National Environmental Policy Act (NEPA), its implementing regulations, related laws, executive orders, and regulations in the decisionmaking process of the GSA GSA. Order ADM 1095.1E, ''Environmental Preparation of Environmental Assessments and Environmental Impact Statements,'' July 24, 1985, have been revised and are to be reissued as GSA Order ADM 1095.1F and GSA PBS 1095.4C. Few changes were made to GSA Order ADM 1095.1E. Revisions to this document are mainly in the Responsibility section. Substantial changes were made to PBS P 1095.4B. The revision, PBS 1095.4C, was reduced to an overview of GSA's NEPA procedural requirements. The instructional step-by-step portion of the document has been removed and expanded into a new comprehensive PBS NEPA Desk Guide. The PBS NEPA Desk Guide, used in conjunction with PBS 1095.4C, is intended to provide an increased level of NEPA guidance to GSA.

WRITTEN COMMENTS/FURTHER INFORMATION: As part of the public review process required prior to the implementation of new orders by Title 40 CFR 1507.3, ''Agency Procedures'', GSA solicits your written comments on the revised orders at the following address: Colin Wagner, NEPA Liaison, GSA, PBS, PXSC, room 2312, 1800 F Street, Washington, DC 20007. Written comments should be received no later than July 27, 1998. Requests for the PBS NEPA Desk Guide and/or further information may also be forwarded to this address. Both the Orders and the accompanying PBS NEPA Desk Guide can be found and downloaded from the GSA NEPA CALL-IN web site at www.gsa.gov/pbs/pt/call-in/nepa.htm.

MAILING LIST: If you wish to be placed on the project mailing list to receive the final Orders and Desk Guide, contact Colin Wagner at the address noted above.

Dated: June 11, 1998.

Wm. Colin Wagner,

GSA NEPA Liaison.

ADM 1095.1F

GSA ORDER

SUBJECT: Environmental considerations in decisionmaking

1. Purpose. This order establishes policy and assigns responsibility for implementing the National Environmental Policy Act (NEPA), its implementing regulations, and related laws, executive orders, and regulations in the decisionmaking processes of the General Services Administration (GSA).

2. Cancellation. ADM 1095.1E, dated December 8, 1995, is canceled.

3. Background. The National Environmental Policy Act (NEPA) and the Government wide implementing regulations of the Council on Environmental Quality (40 CFR 1500–1508, hereinafter, the CEQ regulations) require that each Federal agency consider the impact of its actions on the human environment, and prescribes procedures to be followed in doing so. Other laws, executive orders, and regulations provide related direction. Each Federal agency is required to implement internal procedures to ensure that the requirements of NEPA are met. Existing orders are out of date and do not provide for current requirements.

4. Nature of revision. This revision reflects a thorough internal review of GSA's systems for implementing NEPA. It replaces an interim order, ADM 1095.1E, which was adopted to govern GSA's compliance with NEPA while this review took place. This revised order is issued in coordination with

PBS 1095.4C and an explanatory desk guide to NEPA review, which together provide GSA with an efficient, up-to-date NEPA compliance system that is consistent with principles of accountability, flexibility, and environmental responsibility.

5. Policy: In all its decisionmaking, GSA will attend carefully to the National Environmental Policy set forth in Section 101 of NEPA. To the maximum extent practicable, GSA will ensure that its actions protect and where possible improve the quality of the human environment, including the built and sociocultural environments of the nation's urban areas. GSA decisionmakers will use the NEPA review process prescribed in the CEQ regulations as a practical planning tool, and integrate both the NEPA review process and the Section 101 National Environmental Policy into decisionmaking in an efficient, cost-effective manner. The NEPA review process will be initiated at the earliest possible stage in planning any GSA action, and will be carried forward in coordination with other planning activities. Decisionmakers will ensure that they have reviewed and fully understand the environmental impacts of each decision, before making any such decision. All managers responsible for decisionmaking on GSA actions will be accountable for being knowledgeable about, and attendant to, the requirements of NEPA and the National Environmental Policy that these requirements are designed to advance.

6. Responsibilities.

6.a. Commissioner, Public Buildings Service (PBS). The Commissioner acts for the Administrator, GSA, on matters relating to NEPA implementation, and oversees implementation of this order. PBS orders and related direction governs GSA compliance with NEPA and related legal authorities.

6.b. Assistant Commissioner, Office of Business Performance (PX).

6.b.(1) Is the principal GSA advisor on NEPA-related requirements, including but not limited to compliance with NEPA and the coordination of NEPA compliance with the requirements of the laws and regulations listed in Appendix 1 of the NEPA Desk Guide.

6.b.(2) Provides expert advise on NEPA-related matters to GSA Heads of Services, Business Lines, and Regional Administrators.

6.b.(3) Provides intra-agency and interagency liaison and coordination on NEPA-related matters on a national basis.

6.b.(4) Provides and periodically updates GSA program guidance, after consultation with the General Counsel, Heads of Services, Business Lines, and Regional Administrators.

6.b.(5) Provides education and training within GSA pertinent to implementation of NEPA and related authorities.

6.b.(6) Coordinates with the Office of Business Performance's (PX) Environmental Executive regarding areas of shared or related responsibility, in maintaining a record of GSA's environmental activities, and in advancing the national environmental policy articulated in NEPA and other statutes and executive orders.

6.b.(7) Serves as GSA representative in coordination with outside groups at the national level regarding NEPA-related matters.

6.c. Regional Administrators.

6.c.(1) Are accountable for execution of GSA's responsibilities under NEPA and related authorities with respect to actions under their jurisdiction.

6.c.(2) Serve as the responsible agency official under CEQ regulations with respect to the environmental effects of actions under their jurisdiction.

6.c.(3) Maintain NEPA Regional Environmental Quality Advisors (REQA) within their staffs, augmented as necessary through interagency agreements and contracts, to ensure regional interdisciplinary competence in environmental matters. To promote nationwide consistency, the REQA should reside in Portfolio Management (PT), although each business line should maintain its own environmental expertise for project development and execution.

6.c.(4) In consultation with PT, ensure that all regional staff with responsibility for planning, approving, and implementing construction, repair, alteration, site and facility acquisition, real property management, maintenance, and real property disposal receive appropriate training in how to carry out GSA's responsibilities under NEPA and related authorities.

6.d. GSA Environmental Executive.

6.d.(1) Serves as GSA's Environmental Executive under Executive Order 12873.

6.d.(2) Coordinates with PT Liaison to ensure agency-wide consistency in areas of shared or related responsibility, and in advancing the national environmental policy articulated in NEPA and other statutes and executive orders.

6.e. Heads of Services and Business Lines.

6.e.(1) Serve as the responsible agency officials under CEQ regulations for actions subject to their approval.

6.e.(2) Ensure accountability for implementation of the policy set forth in this order.

6.e.(3) In consultation with PT, ensure that staff responsible for supporting the functions of the responsible agency official under CEQ and related authorities receive appropriate training in how to carry out GSA's responsibilities.

6.f. The Office of General Counsel.

6.f.(1) Is responsible for legal interpretation of NEPA and related authorities, and represents GSA in litigation under such authorities.

6.f.(2) Advises PT during the development and delivery of guidance and training.

7. Administrative Guidance.

7.a. Central Office, Office of Business Performance (PX) is the Agency center of expertise for NEPA and, as such, has overall program responsibility for establishing procedures, training, and professional standards, and for maintaining interagency administrative responsibilities and relationships. These functions will be carried out at the working level by a professional NEPA Liaison staff.

7.b. Heads of Services and Business Lines will assist and cooperate with PT in the development and delivery of training, as well as procedural and program guidance, and act as coordinators for program needs of the Services and Business lines on a national basis.

7.c. Regional Business Lines have responsibility for ensuring that NEPA compliance responsibilities are satisfied, and the policy articulated in paragraph 5 of this order is followed, with respect to their programs and projects. In consultation with the REQA, the Business Lines will utilize interdisciplinary professional expertise in their implementation of NEPA responsibilities.

8. Implementation of NEPA and related authorities.

8.a. In accordance with applicable regulations and standards, and with program guidance provided by PT, the responsible agency official shall:

8.a.(1) Ensure that the applicable requirements of NEPA and related authorities are met in a timely manner during planning for any GSA action, in a manner consistent with the policy articulated in paragraph 5 of this order.

8.a.(2) Ensure that mitigation measures established through review of actions under NEPA and related authorities are carried out as part of implementing the actions.

8.a.(3) Ensure that the means by which GSA has met its responsibilities, and the costs involved in doing so, are fully documented.

8.b. The procedures set forth in PBS Order P 1095.4C shall be followed in implementing NEPA and related authorities.

9. Effective Date. Every effort shall be made to implement the provisions of this order immediately.

Administrator

PBS 1095.4C

COMPLIANCE WITH THE NATIONAL ENVIRONMENTAL POLICY ACT

1. Purpose. This order provides direction for carrying out the procedural requirements of the National Environmental Policy Act (NEPA) and related legal authorities, in furtherance of the policy and direction provided in ADM 1095.1F.

2. Background. NEPA establishes as policy that the Federal government will: ''use all practicable means, consistent with other essential considerations of national policy, to improve and coordinate Federal plans, functions, programs, and resources to the end that the Nation may:

(1) Fulfill the responsibilities of each generation as trustee of the environment for succeeding generations;

(2) Assure for all Americans safe, healthful, productive, and esthetically and culturally pleasing surroundings;

(3) Attain the widest range of beneficial uses of the environment without degradation, risk to health or safety, or other undesirable and unintended consequences;

(4) Preserve important historic, cultural, and natural aspects of our national heritage, and maintain, wherever possible, an environment which supports diversity, and variety of individual choice;

(5) Achieve a balance between population and resource use which will permit high standards of living and a wide sharing of life's amenities; and

(6) Enhance the quality of renewable resources and approach the maximum

attainable recycling of depletable resources.'' (42 U.S.C. 4321(a))

As an important means of carrying out this policy, NEPA requires Federal agencies to analyze the impacts of their proposed actions (activities, programs, projects, legislation) on the environment, and on the relationship of people with the environment. This analysis is to be undertaken early in planning any such action, as an aid to deciding whether or not the action will go forward, and if so how. Consideration must be given to practicable alternative means of achieving the purpose and need for the proposed action, and to the alternative of not taking any action. The analysis is to be completed, and used to inform the decisionmaker and make the public aware of the action's potential impacts, before the decision is made about whether and how to proceed with the action.

Analysis of environmental impacts must:

''utilize a systematic, interdisciplinary approach which will insure the integrated use of the natural and social sciences and the environmental design arts in planning and in decisionmaking which may have an impact on man's environment'' (42 U.S.C. 4322(2)(A))

NEPA also requires that, to the fullest extent possible, analyses and consultations required by other environmental laws be coordinated with those required under NEPA, to reduce redundancy, paperwork, time, and cost.

Requirements for compliance with the procedural provisions of NEPA are set forth in regulations issued by the Council on Environmental Quality (40 CFR 1500–11508, hereinafter the CEQ regulations). ADM 1095.1.F contains GSA's general policy regarding NEPA implementation, and assigns responsibilities to the Administrator, the Regional Administrators, Heads of Services and Business Lines, the Commissioner, Public Buildings Service (PBS), and the Office of Business Performance (PX) in PBS. This order provides further detail regarding the conduct of NEPA impact analyses.

3. Responsibilities

3.a. Assistant Commissioner, Office of Business Performance (PX)

3.a.(1) Advises the Commissioner, other Heads of Services and Business Lines, Regional Administrators, and other GSA managers and staff regarding NEPA implementation and related matters.

3.a.(2) Maintains a professional NEPA Liaison staff to carry out this responsibility.

3.b. NEPA Liaison

3.b.(1) Coordinates compliance with NEPA and related authorities throughout GSA on a day-to-day basis.

3.b.(2) Provides advice and assistance to Regional Office NEPA Regional Environmental Quality Advisor (REQA).

3.b.(3) With the cooperation of Services, Business Lines, and Regional Offices, provides guidance, education and training, and advice about education and training standards and opportunities to GSA personnel who have responsibilities to which NEPA requirements may pertain.

3.b.(4) Coordinates with the Council on Environmental Quality (CEQ) and other national oversight bodies;

3.b.(5) Represents GSA in interagency coordination on NEPA and related matters on a national basis.

3.b.(6) Routinely solicits and acts upon the advice of REQAs in developing program direction and carrying out the responsibilities of the NEPA Liaison.

3.b.(7) Promulgates, maintains, and when necessary updates a ''NEPA Desk Guide'' providing detailed direction and advice regarding NEPA implementation.

3.c. Regional Administrators.

3.c.(1) Are the responsible officials for compliance with NEPA on actions under their jurisdiction.

3.c.(2) Maintain a NEPA Regional Environmental Quality Advisor (REQA) as described below.

3.c.(3) Ensure that the REQA is empowered to advise and assist in planning and decisionmaking on actions that could affect the human environment, in a way and at a time in the planning and decisionmaking process that maximizes the effectiveness of the REQA's advice and assistance.

3.c.(4) Ensure that all Regional program staff involved in planning and decisionmaking about actions that could affect the human environment are made aware of GSA's responsibilities under NEPA and related authorities, are acquainted with this order, ADM 1095.1F, and the NEPA Desk Guide, are held accountable for the quality of their actions and decisions, and are required to coordinate effectively with the REQA.

3.d. NEPA Regional Environmental Quality Advisor (REQA).

3.d.(1) Is the center of expertise maintained at the Regional Office (RO) in which expertise in NEPA and related authorities such as the National Historic Preservation Act and the Endangered Species Act is maintained.

3.d.(2) Is located within PT or elsewhere in the RO organizations where it can influence decisionmaking early in GSA's planning or preparation for any action subject to review under NEPA and related authorities.

3.d.(3) Is responsible for participation in GSA planning and decisionmaking, for advising the Regional Administrator (RA), Assistant Regional Administrator (ARA), and other decisionmakers, and for providing training and technical assistance to all pertinent GSA employees and contractors.

3.d.(4) Maintains interdisciplinary expertise in environmental matters, through the employment of qualified staff and/or by interagency agreement or under contract.

3.d.(5) Reviews all documentary products of GSA NEPA analyses, and assists program staff in ensuring that such products, and the analyses they report, are adequate and defensible.

3.d.(6) Maintains records of GSA NEPA compliance activities.

3.d.(7) Routinely interacts with and is assisted by, the NEPA Liaison.

3.d.(8) Maintains an up-to-date NEPA Desk Guide and other needed guidance material.

3.d.(9) Develops and maintains an up-to-date checklist for use in determining whether an action requires an environmental assessment or impact statement (the CATEX Checklist; see paragraph 4.b.(2)(a).

3.e. Program Staff.

3.e.(1) For the purposes of this order, include all GSA employees responsible for the management and implementation of program actions, such as project planning and development, project management, leasing, and disposal of real property.

3.e.(2) Are responsible for:

3.e.(2)(a) With the assistance of the NEPA Liaison and REQAs, developing and maintaining a thorough understanding of NEPA requirements and the requirements of related authorities, and of the policy articulated in ADM 1095.1F, as these pertain to their program areas.

3.e.(2)(b) Ensuring that NEPA and related authorities are complied with to the best of their abilities, as early as possible in planning any action within their program areas.

3.e.(2)(c) Coordinating their programs, activities, and projects with REQAs.

3.e.(2)(d) Implementing all mitigation and other commitments resulting from NEPA compliance for actions under their authority.

4. Implementation of NEPA and related authorities.

4.a. Classification of GSA actions.

4.a.(1) All GSA actions fall into one of the following three classes, in terms of requirements for review under NEPA: categorical exclusions, environmental assessments, and environmental impact statements.

4.a.(2) Program staff, in consultation with the REQA, are responsible for classifying actions and undertaking the level of analysis, consultation, and review appropriate to each.

4.b. Categorical Exclusions (CATEX)

4.b.(1) A categorical exclusion (CATEX) is a category of actions which do not individually or cumulatively have a significant effect on the human environment, except under extraordinary circumstances (42 CFR 1508.4). Because they lack the potential for effect, they do not require detailed analysis under NEPA.

4.b.(2) GSA recognizes two types of CATEX:

4.b.(2)(a) The Automatic CATEX: a category of action that is so unlikely to have an effect on the environment that an action falling into this category may be automatically assumed to require no further review under NEPA, unless the responsible program staff determine that an extraordinary circumstance may exist, whereupon a CATEX Checklist must be prepared (see below). The likelihood of such a circumstance is judged to be so low that no specific environmental analysis is required.

4.b.(2)(b) The Checklist CATEX: a category of action that is generally very unlikely to have a significant effect on the environment, but that requires a cursory review to ensure that no extraordinary circumstances exist. For an action falling into such a category, a CATEX Checklist is completed, leading to a conclusion by program staff, concurred in by the REQA, as to whether the action needs further review under NEPA. The CATEX Checklist is developed and maintained by the REQA, based on a model in the NEPA Desk Guide.

4.b.(3) Both Automatic and Checklist CATEXs are listed in Appendix 1 and in the NEPA Desk Guide.

4.c. Environmental Assessment (EA).

4.c.(1) An Environmental Assessment (EA) is a concise public document prepared by or on behalf of GSA that assists GSA in deciding whether there may be significant effects requiring a more detailed Environmental Impact Statement is necessary, and where such a Statement is not necessary, supports GSA's compliance with the requirements of NEPA and related authorities.

4.c.(2) The analysis required for an EA leads either to a Finding of No Significant Impact (FONSI) or a Notice of Intent (NOI) to prepare an Environmental Impact Statement.

4.c.(3) Directions for preparing an EA are found in the NEPA Desk Guide.

4.d. Environmental Impact Statement (EIS).

4.d.(1) An Environmental Impact Statement (EIS) is a detailed analysis and report, meeting standards set forth in the CEQ regulations, that details the environmental effects of a proposed action and its alternatives. An EIS is prepared for any GSA action that may have significant effects on the quality of the human environment.

4.d.(2) Certain actions always are likely to have significant effects on the quality of the human environment, and hence always require an EIS. These classes of action are listed in Appendix 2.

4.d.(3) Where an action does not fall into one of the classes listed in Appendix 2, the responsible GSA official shall ensure that an EIS is prepared if it appears that the action is likely to have significant effects on the quality of the human environment. An EA may be prepared to aid in deciding whether an EIS is needed, or the responsible official may decide to prepare an EIS without preparing an EA.

4.d.(4) Direction for preparing, circulating, finalizing, and using an EIS in decisionmaking are found in the NEPA Desk Guide, and in the CEQ regulations.

4.e. Using NEPA in decisionmaking.

4.e.(1) Each Head of Service, Business Line, and Regional Office shall establish internal systems to ensure that the requirements of NEPA, related authorities, the CEQ regulations, ADM 1095.1F, and this order are carried out.

4.e.(2) Each such system shall ensure that:

4.e.(2)(a) Compliance with NEPA and related authorities begins at the earliest point in planning any action, when the widest reasonable range of alternatives is open for consideration.

4.e.(2)(b) The NEPA review process is carried out in coordination with continued planning.

4.e.(2)(c) All personnel involved in planning actions should view NEPA review as part of effective planning, not as a mere documentation requirement.

4.e.(2)(d) Outside agencies, state and local governments, Indian tribes, and the public are afforded reasonable opportunities to participate in NEPA review, and to influence GSA decisions.

4.e.(2)(e) The results of NEPA review are fully considered by each GSA decisionmaker before making a decision on an action subject to such review.

4.e.(2)(f) Executives and other employees responsible for aspects of NEPA review are held accountable for the performance of such responsibilities, through performance reviews and other administrative mechanisms.

5. Coordination with other authorities.

5.1. To the maximum extent feasible, NEPA review shall be coordinated with review of proposed actions under other environmental legal authorities, including but not limited to the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA), the National Historic Preservation Act (NHPA), the Endangered Species Act (ESA), Executive Orders 11988 and 13006, and other authorities listed in the NEPA Desk Guide.

5.2. In effecting such coordination, responsible GSA officials will ensure that the substantive and procedural requirements of each other authority are met, together with the requirements of NEPA. It will be explicitly understood that compliance with NEPA does not substitute for compliance with another authority, nor does compliance with such other authority substitute for compliance with NEPA.

6. Public involvement.

6.1. As part of its system for NEPA compliance, each Head of Service, Business Line, and Regional Office shall provide for levels and kinds of public involvement appropriate to the class of action and its likely effects, taking into account the recommendations regarding public involvement found in the NEPA Desk Guide.

6.2. Where a related authority provides specific procedures for public involvement, the responsible GSA official shall ensure that such procedures are addressed in the process of NEPA review.

6.3. Public involvement in GSA decisionmaking shall have as its purpose the full disclosure of GSA actions and alternatives to the public, within the constraints of GSA program authorities, and giving the public a full opportunity to influence GSA decisions, subject to the same constraints and the requirements of the Federal Advisory Committees Act (FACA).

6.4. Pursuant to Executive Order 12898, special efforts will be made to involve members of potentially affected low-income and minority communities in NEPA review and decisionmaking. Such efforts may include, but are not limited to, special programs of community outreach, including cross-cultural programs, translations of pertinent documents, and ensuring that translators are available at public meetings.

7. Cooperating agencies.

7.1. The responsible GSA official may invite other agencies to serve as cooperating agencies in the conduct of NEPA review on a GSA action.

7.2. At a minimum, GSA will invite agency customers for GSA services to participate as cooperating agencies. Other agencies with jurisdiction by law or expertise may also be invited to serve as cooperating agencies.

8. GSA Participation in NEPA compliance by other agencies.

8.1. GSA may participate in the NEPA process as a cooperating agency for another lead agency's project, or as a commenter / reviewer of another agency's NEPA document. GSA may also participate in environmental studies carried out by non-federal parties (for example, a local government conducting studies under a State environmental policy law) where such studies are relevant to GSA's interests or may be incorporated by GSA into its own studies under NEPA. Where GSA will be responsible for a decision on a project that is the subject of such a study, and has the authority to do so, GSA will require that the study and its resulting documents meet the standards set forth in the NEPA Desk Guide and related GSA standards.

8.2. As a cooperating agency, GSA participates in the NEPA process as requested by the lead agency, in accordance with 40 CFR 1501.6 of the CEQ regulations. Tasks may include participating in meetings and providing specific information relevant to the matters over which it has jurisdiction by law or expertise.

8.3. The responsible GSA official (Head of Service, Business Line, or Regional Office) may provide comments and/or reviews of another agency's NEPA documents, and/or other Federal and State environmental documents. Such comments or reviews shall be provided where the other agency so requests and the responsible official determines that GSA has jurisdiction by law or special expertise, and may be provided in other cases where the responsible official or designee determines that GSA has an interest in the action covered by the environmental document.

8.4. GSA has jurisdiction by law or expertise on the following topics, as listed in 40 CFR Ch. V, Appendix II of the CEQ regulations: Federal land management, Community development, Historic, architectural, and archaeological resources.

8.5. GSA comments shall be in provided in accordance with 40 CFR 1503.3 of the CEQ regulations.

8.6. GSA comments shall be prepared in consultation with, or by, the pertinent REQA and/or the Central Office NEPA Liaison.

9. NEPA Desk Guide.

All Heads of Service, Business Lines, and Regional Offices will employ the NEPA Desk Guide issued and periodically updated by the NEPA Liaison as guidance in carrying out this order and ADM 1095.1F.

Robert Peck,

Commissioner.

Appendix 1: Categorical Exclusions

1.1 PURPOSE

The stated purpose of Categorical Exclusions (CATEXs) is to limit extensive NEPA analysis to those actions that may be major Federal actions significantly affecting the quality of the human environment, thus streamlining the NEPA process, saving time, effort, and taxpayer dollars.

1.2 DEFINITION

An action is categorically excluded from the requirement to prepare an EA or an EIS if it meets the following definition:

''Categorical exclusion'' means a category of actions which do not individually or cumulatively have a significant effect on the human environment and which have been

found to have no such effect in procedures adopted by a Federal agency [. . .] and for which, therefore, neither an Environmental Assessment nor an Environmental Impact Statement is required. 40 CFR 1508.4

GSA has identified two types of CATEXs: (1) the ''automatic'' CATEX, that by its very nature cannot be a major Federal action significantly affecting the quality of the human environment, and (2) the ''checklist'' CATEX, which requires completion of an environmental checklist to ensure no ''extraordinary circumstances'' exist indicating the need for an EA or EIS.

1.3 AUTOMATIC CATEXs

The following are automatic CATEXs, requiring no checklist.

(a) Issuance of easements, licenses, or outleases for use of space in existing Federal office buildings, where consistent with local planning and zoning, provided Section 106 of the NHPA is complied with where applicable.

(b) Acquisition of space within an existing structure, either by purchase or lease, where no change in the general type of use and only minimal change from previous occupancy level is proposed (previous occupant need not have been a Federal tenant).

(c) Relocation of employees into existing Federally controlled space, that does not involve a substantial change in the number of employees or motor vehicles.

(d) Reductions in force or other personnel, administrative, or ministerial actions, including bargaining with employee unions and managing routine activities normally conducted to protect or maintain GSA-controlled properties (e.g., security and custodial services).

(e) Lease extensions, renewals, or succeeding leases.

(f) Outlease or license of government-controlled space, or sublease of government-leased space to a non-Federal tenant when the use will remain substantially the same.

(g) Acquisition of land or easements that result in no immediate change in use and where subsequent compliance with NEPA and other applicable laws and regulations will take place as needed.

(h) Site characterization studies and environmental monitoring, including siting, construction, operation, and dismantling or closing of characterization and monitoring devices. Such activities include, but are not limited to:

(1) Site characterization and environmental monitoring activities under RCRA and CERCLA;

(2) Geological, geophysical, geochemical, and engineering surveys and mapping, including the establishment of survey marks;

(3) Installation and operation of field instruments, such as streamgauging stations or flowmeasuring devices, telemetry systems, geochemical monitoring tools, and geophysical exploration tools;

(4) Drilling of wells for sampling or monitoring of groundwater, well logging, and installation of waterlevel recording devices in wells;

(5) Aquifer response testing;

(6) Installation and operation of ambient air monitoring equipment;

(7) Sampling and characterization of water, soil rock, or contaminants;

(8) Sampling and characterization of water effluents, air emissions, or solid waste streams;

(9) Sampling of flora or fauna; and

(10) Archeological, historic, and cultural resource identification and evaluation studies in compliance with 36 CFR part 800 and 43 CFR part 7.

(i) Administrative actions such as procurement of consultant services for appraisal or environmental analysis.

(j) Repair and alteration projects involving, but not adversely affecting, properties listed on or eligible for the National Register of Historic Places, when there is no evidence of community controversy or other environmental issues. The process required by Section 106 of the National Historic Preservation Act (NHPA) must be followed; see ADM 1020.2.

(k) Repairs and alterations or modernization conducted in accordance with applicable plans, such as Facility Master Plans, where such plans have been reviewed under NEPA and there is no evidence of community controversy or unresolved environmental issues. The process required by Section 106 of the NHPA must be followed; see ADM 1020.2.

(l) Repair to or replacement in kind of equipment or components in GSA-controlled facilities without change in location, e.g. HVAC, electrical distribution systems, windows, doors or roof.

(m) Facility maintenance, custodial, and groundskeeping activities not involving environmentally sensitive areas (such as eroded areas, wetlands, cultural sites, etc.), including window washing, lawn mowing, trash collecting, and snow removal.

(n) Procurement contracts for professional services and supplies not addressed elsewhere here.

(o) Preparation of implementation guidance.

(p) Studies that involve no commitment of resources other than manpower and funding.

(q) Assisting Federal agencies in public utilities management (excluding communications), negotiating for public utility services on behalf of Federal agencies, and providing expert testimony before public utility regulatory bodies.

r. Federal real property utilization surveys in accordance with Executive Order 12348.

s. Real property inspections for compliance with deed restrictions.

t. Administrative action by GSA to remove clouds on titles.

u. Disposal of real property required by public law wherein Congress has specifically exempted the action from the requirements of NEPA.

1.4 CHECKLIST CATEXs

The following are categorical exclusions that require preparation of a checklist to ensure that no extraordinary circumstances exist that would require preparation of an EA or EIS.

a. Acquisition of land which is not in a floodplain or other environmentally sensitive area and does not result in condemnation.

b. Acquisition of space by Federal construction or lease construction, or expansion or improvement of an existing facility where all of the following conditions are met:

1. The structure and proposed use are substantially in compliance with local planning and zoning and any applicable State or Federal requirements;

2. The proposed use will not substantially increase the number of motor vehicles at the facility;

3. The site and the scale of construction are consistent with those of existing adjacent or nearby buildings; and

4. There is no evidence of community controversy or other environmental issues.

c. Property disposal actions undertaken for another Federal agency, where that agency has already documented compliance with applicable legal requirements such as NEPA, NHPA, CERCLA, Endangered Species Act. (See ADM 1095.1d.)

d. Transfers of real property to Federal, State, and local agencies, and Indian Tribes.

e. Assignments of real property to another Federal agency for subsequent conveyance to a State or local agency, or to eligible non-profit institutions for health, educational, or park and recreation uses.

f. Disposal of real property to State or local agencies for wildlife conservation and historic monument purposes.

g. Disposal of real property required by public law wherein Congress has not specifically exempted the action from the requirements of NEPA.

h. Issuance of easements, licenses, or outleases for use of space in Federal facilities other than existing office buildings.

i. Disposal of related personal property, demountable structures, transmission lines, utility poles, railroad ties, and track.

j. Disposal of properties where the size, area, topography, and zoning are similar to existing surrounding properties and/or where current and reasonable anticipated uses are or would be similar to current surrounding uses (e.g., commercial store in a commercial strip, warehouse in an urban complex, office building in downtown area, row house or vacant lot in an urban area).

k. Abrogation of use restrictions contained in the conveyance documents of previous disposals when:

l. Upon request of another Federal agency for concurrence, GSA only provides concurrence subject to the requesting agency's compliance with NEPA, or

m. GSA has no reason to believe that the abrogation will result in a significant change in property use, or

n. The abrogation is for a reduction in time only.

o. Sale of improvements to underlying property fee owner and disposal of fee ownership to parties who have had possession and/or use of the property for five years or more through permit, lease, license, or easement.

Appendix 2: Actions Requiring Environmental Impact Statement

The following actions are considered to be major Federal actions significantly affecting the quality of the human environment, and therefore must be the subjects of Environmental Impact Statements (EIS), as

must any other action that an Environmental Assessment (EA) indicates may have significant environmental effects:

- Master plans for Federally owned major buildings, building complexes, and sites (Note: EIS should be designed so that subsequent EISs and EAs can be tiered off it).
- Acquisition of space by Federal construction or lease construction, or expansion or improvement of an existing facility, where one or more of the following applies:

—The structure and/or proposed use are not substantially consistent with local planning and zoning or any applicable State or Federal requirements.
—The proposed use will substantially increase the number of motor vehicles at the facility.
—The site and scale of construction are not consistent with those of existing adjacent or nearby buildings.
—There is evidence of current or potential community controversy about environmental justice or other environmental issues.

- Space acquisition programs projected for a substantial geographical area (e.g., a metropolitan area) for a 3-to-5-year period or greater (Note: a PEIS is often appropriate here, off which subsequent EISs and EAs can be tiered).

[FR Doc. 98–16304 Filed 6–25–98; 8:45 am]

BILLING CODE 6820–BR–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Meeting of the National Bioethics Advisory Commission (NBAC)

SUMMARY: Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is given of a meeting of the National Bioethics Advisory Commission. The Commission will continue addressing (1) The protection of the rights and welfare of human subjects in research including research involving persons with mental disorders affecting decisionmaking capacity, (2) issues in the research use of human biological materials, and (3) a proposed project on the ethical and legal issues in international research supported and/or conducted by the United States. The Commission also plans to hear presentations on the ethical principles expressed in the seminal Belmont Report, the Inspector General's Report on Institutional Review Boards, and research concerns in Native American communities. The meeting is open to the public and opportunities for statements by the public will be provided on July 15, 1998 from 11:30 am to 12 Noon.

Dates/Times:

July 14, 1998, 1:00 pm–5:00 pm and July 15, 1998 8:00 am—5:00 pm.

Location:

Oregon Ballroom, Salon F, Portland Marriott, and 1401 Naito Parkway, Portland, Oregon.

SUPPLEMENTARY INFORMATION: The President established the National Bioethics Advisory Commission (NBAC) on October 3, 1995 by Executive Order 12975 as amended. The mission of the NBAC is to advise and make recommendations to the National Science and Technology Council, its Chair, the President and other entities on bioethical issues arising from the research on human biology and behavior, and from the applications of that research and makes its recommendations available to the public.

Public Participation

The meeting is open to the public with attendance limited by the availability of space on a first come, first serve basis. Members of the public who wish to present oral statements should contact Ms. Patricia Norris by telephone, fax machine, or mail as shown below at least 4 days before the meeting and as soon as possible. The Chair will reserve time for presentations by persons requesting to speak and requests that oral statements be limited to five minutes . The order of persons wanting to make a statement will be assigned on a first come, first serve basis. Individuals unable to make oral presentations can mail or fax their comments to the NBAC staff office at least five business days prior to the meeting for distribution to the Commission and inclusion in the public record. The Commission also accepts general comments at its website at bioethics.gov. Persons needing special assistance, such as sign language interpretation or other special accommodations, should contact NBAC staff at the address or telephone number listed below as soon as possible.

FOR FURTHER INFORMATION CONTACT: Ms. Patricia Norris, National Bioethics Advisory Commission, 6100 Executive Boulevard, Suite 5B01, Rockville, Maryland 20892–7508, telephone 301–402–4242, fax number 301–480–6900.

Henrietta D. Hyatt-Knorr,

Deputy Executive Director, National Bioethics Advisory Commission.

[FR Doc. 98–16623 Filed 6–25–98; 8:45 am]

BILLING CODE 4160–17–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Program Announcement 98046]

National Comprehensive Cancer Control Program; Notice of Availability of Funds for Fiscal Year 1998; Amendment

A notice announcing the availability of Fiscal Year 1998 funds for cooperative agreements to implement comprehensive cancer control plans was published in the **Federal Register** on May 13, 1998, (63 FR 26614). The notice is amended as follows:

On page 26614, in the announcement title, Announcement number is changed to 99046.

On page 26614, third column, under the heading Availability of Funds the first paragraph should read: Approximately $1.5 million is available in FY 1999 to fund approximately 5 awards * * * Line seven should read: on or about October 30, 1998 * * *.

On page 26619, under the heading Application Submission and Deadline the first paragraph should read: The original and two copies of the completed CDC 0.1246 must be submitted to * * * on or before July 27, 1998.

On page 26619, under the heading Where to Obtain Additional Information, the third paragraph should read: Please refer to Program Announcement Number 99046 when requesting information and submitting an application.

On page 26620, under the heading Eligibility Assurance Form, the third subparagraph, on the third line should read: an up-to-date detailed final draft ready for implementation by October 30, 1998.

All other information and requirements of the notice remain the same.

Dated: June 22, 1998.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

[FR Doc. 98–17089 Filed 6–25–98; 8:45 am]

BILLING CODE 4163–18–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

[Announcement 98037]

Initiatives by Organizations To Strengthen National Tobacco Control Activities in the United States; Notice of Availability of Funds for Fiscal Year 1998; Second Amendment

A notice announcing the availability of Fiscal Year 1998 funds for cooperative agreements for Initiatives by Organizations to Strengthen National Tobacco Control Activities in the United States was published in the **Federal Register** on April 23, 1998 [63 FR 20197]. The notice is amended as follows:

On page 20197, first paragraph, under the heading ''Introduction,'' the seventh line of the paragraph is amended to read:populations; African-Americans, Native Americans, * * *. On page 20198, second paragraph under the heading ''Availability of Funds,'' the fourth line is amended to read: African Americans, Native Americans, * * *.

All other information and requirements of the April 23, 1998, **Federal Register** notice remain the same.

Dated: June 22, 1998.

Joseph R. Carter,

Acting Associate Director for Management and Operations, Centers for Disease Control and Prevention (CDC).

[FR Doc. 98–17088 Filed 6–25–98; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Disease Control and Prevention

Ethics Subcommittee and the Advisory Committee to the Director, Centers for Disease Control and Prevention: Meetings

In accordance with section 10(a)(2) of the Federal Advisory Committee Act (Pub. L. 92–463), the Centers for Disease Control and Prevention (CDC) announces the following subcommittee and committee meetings.

Name: Ethics Subcommittee of the Advisory Committee to the Director, CDC.

Time and Date: 9 a.m.-3 p.m., July 16, 1998.

Place: CDC, Building 16, Room 5126, 1600 Clifton Road, NE, Atlanta, Georgia 30333.

Status: Open to the public, limited only by the space available. The meeting room accommodates approximately 25 people.

Purpose: This subcommittee will anticipate, identify, and propose solutions to strategic and broad ethical issues facing CDC.

Matters to be Discussed: Agenda items will include updates from the Associate Director for Science, Dixie E. Snider, M.D., M.P.H., a discussion on CDC's pandemic influenza plan, and ethical consultation on blinded HIV serosurveys.

Name: Advisory Committee to the Director, CDC.

Time and Date: 8:30 a.m.–3 p.m., July 17, 1998.

Place: CDC, Auditorium A, 1600 Clifton Road, NE, Atlanta, Georgia 30333.

Status: Open to the public, limited only by the space available.

Purpose: This committee advises the Director, CDC, on policy issues and broad strategies that will enable CDC, the Nation's prevention agency, to fulfill its mission of promoting health and quality of life by preventing and controlling disease, injury, and disability. The Committee recommends ways to incorporate prevention activities more fully into health care. It also provides guidance to help CDC work more effectively with its various constituents, in both the private and public sectors, to make prevention a practical reality.

Matters to be Discussed: Agenda items will include updates from CDC Acting Director, Claire V. Broome, M.D., a report from the Ethics Subcommittee, a discussion on counter terrorism and the public health infrastructure, and the agency's prevention research agenda.

Agenda items are subject to change as priorities dictate.

Contact Person for More Information: Linda Kay McGowan, Executive Secretary, Advisory Committee to the Director, CDC, 1600 Clifton Road, NE, M/S D–24, Atlanta, Georgia 30333, telephone 404/639–7080.

Dated: June 22, 1998.

Carolyn J. Russell,

Director, Management Analysis and Services Office, Centers for Disease Control and Prevention (CDC).

[FR Doc. 98–17090 Filed 6–25–98; 8:45 am]

BILLING CODE 4163–18–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Cardiovascular and Renal Drugs Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). At least one portion of the meeting will be closed to the public.

Name of Committee: Cardiovascular and Renal Drugs Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on July 9, 1998, 9 a.m. to 5:30 p.m., and July 10, 1998, 9 a.m. to 12 m.

Location: National Institutes of Health, Natcher Conference Center, 45 Center Dr., Bethesda, MD.

Contact Person: Joan C. Standaert, Center for Drug Evaluation and Research (HFD–110), Food and Drug Administration, 5600 Fishers Lane, Rockville MD 20857, 419–259–6211, or John M. Treacy (HFD–21), 301–827–7001, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 12533. Please call the Information Line for up-to-date information on this meeting.

Agenda: On July 9, 1998, the committee will review new drug application (NDA) 20–863 Pletal® (cilostazol) (Otsuka America Pharmaceutical Inc.) to be indicated for intermittent claudication. On July 10, 1998, the committee will discuss and review trade secret and/or confidential information.

Procedure: On July 9, 1998, from 9 a.m. to 5:30 p.m., the meeting is open to the public. Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by July 2, 1998. Oral presentations from the public will be scheduled between approximately 9 a.m. and 10 a.m. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before July 2, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Closed Committee Deliberations: On July 10, 1998, 9 a.m. to 12 m., the meeting will be closed to permit discussion and review of trade secret and/or confidential information (5 U.S.C. 552b(c)(4)). This portion of the meeting will be closed to permit discussion on pending investigational new drug application issues.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: June 22, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98–17211 Filed 6–24–98; 11:16 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Ophthalmic Devices Panel of the Medical Devices Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Ophthalmic Devices Panel of the Medical Devices Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on July 23, 1998, 8 a.m. to 5 p.m.

Location: Holiday Inn, Ballroom, Two Montgomery Village Ave., Gaithersburg, MD.

Contact Person: Sara M. Thornton, Center for Devices and Radiological Health (HFZ–460), Food and Drug Administration, 9200 Corporate Blvd., Rockville, MD 20850, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 12396. Please call the Information Line for up-to-date information on this meeting.

Agenda: The committee will discuss: (1) Premarket approval application (PMA) for a toric intraocular lens for primary implantation for the visual correction of aphakia, and (2) PMA for an excimer laser for the surgical correction of hyperopia, sphere only, using photorefractive keratectomy.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by July 15, 1998. Oral presentations from the public will be scheduled between approximately 8:30 a.m. and 9 a.m. An additional 30-minute time period will be given for public comment at the end of committee discussion and prior to voting on each PMA. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before July 12, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: June 18, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98–17075 Filed 6–25–98; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Circulatory System Devices Panel of the Medical Devices Advisory Committee Meeting; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; correction.

SUMMARY: The Food and Drug Administration (FDA) is correcting a notice that published in the **Federal Register** of June 11, 1998 (63 FR 32014). The notice announced a meeting of the Circulatory System Devices Panel of the Medical Devices Advisory Committee, which is scheduled for June 29 and 30, 1998. The notice published with an error. This document corrects that error.

FOR FURTHER INFORMATION CONTACT: Anita Prout, Committee Management Office (HFA–306), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–5503.

SUPPLEMENTARY INFORMATION: In the **Federal Register** of June 11, 1998 (63 FR 32014), in FR Doc. 98–15602, FDA announced that a meeting of the Circulatory System Devices Panel of the Medical Devices Advisory Committee would be held on June 29 and 30, 1998. The notice incorrectly published the agenda for June 30, 1998.

Beginning on page 32014, in the 2d column, under the *Agenda* portion of the meeting, the agenda for June 30, l998, should be corrected to read: ''On June 30, 1998, the committee will discuss and make recommendations on clinical issues related to antimicrobial coatings on permanent cardiovascular implants, such as heart valves and vascular grafts.''

Dated: June 22, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98–17143 Filed 6–23–98; 5:02 pm]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Nonprescription Drugs Advisory Committee; Notice of Meeting

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice.

This notice announces a forthcoming meeting of a public advisory committee of the Food and Drug Administration (FDA). The meeting will be open to the public.

Name of Committee: Nonprescription Drugs Advisory Committee.

General Function of the Committee: To provide advice and recommendations to the agency on FDA's regulatory issues.

Date and Time: The meeting will be held on July 28 and 29, 1998, 8:30 a.m. to 5 p.m.

Location: Holiday Inn, Versailles Ballrooms I and II, 8120 Wisconsin Ave., Bethesda, MD.

Contact Person: Rhonda W. Stover or Angie Whitacre, Center for Drug Evaluation and Research (HFD–21), Food and Drug Administration, 5600 Fishers Lane, Rockville, MD 20857, 301–827–7001, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 12541. Please call the Information Line for up-to-date information on this meeting.

Agenda: On July 28, 1998, the committee will discuss class labeling for over-the-counter (OTC) vaginal antifungal drug products. In the **Federal Register** of February 27, 1997 (62 FR 9024), the agency published a proposed rule intended to enable consumers to better read and understand OTC drug product labeling and to better apply this information in the labeling to the safe and effective use of such products. An important element of FDA's proposed rule is a standardized labeling format for OTC drug products. The agency has developed class labeling for OTC vaginal antifungal drug products in accordance with the February 27, 1997, proposed rule. The committee will also discuss the agency's draft guidance document for industry entitled ''Class Labeling of OTC Topical Drug Products for the Treatment of Vaginal Yeast Infections (Vulvovaginal Candidiasis)'' and other related issues. The draft guidance document is intended to provide guidance for both the carton and the educational brochure. In the next several weeks after publication of this notice, a copy of the draft guidance

document for industry will be on display in the Dockets Management Branch (HFA–305), Food and Drug Administration, 5630 Fishers Lane, rm. 1061, Rockville, MD 20852, between 9 a.m. and 4 p.m., Monday through Friday. A copy of the draft guidance document will also be available on the Internet at ''http://www.fda.gov/cder/guidance/index.htm''.

On July 29, 1998, the committee will discuss effectiveness testing for final formulations of health-care antiseptic drug products relative to performance expectations for these OTC drug products. In the **Federal Register** of June 17, 1994 (59 FR 31402 through 31452), the agency published a proposed rule for OTC health-care antiseptic drug products, i.e., patient preoperative skin preparations, surgical hand scrubs, and health-care personnel and antiseptic handwashes. Included in the proposed rule are key characteristics for each drug product class of health-care antiseptic drug products (i.e., definitions), a requirement for final formulation testing, effectiveness standards, and labeling of each of the drug product categories. In response to the proposed rule, the agency received comments to consider six drug product categories (preoperative skin preparation, surgical hand scrub, health-care personnel handwash, food handler handwash, antimicrobial handwash, and antimicrobial bodywash). Comments also proposed alternate: (1) Testing requirements, (2) key characteristics, and (3) labeling for each of the categories. FDA is seeking the recommendations of the committee and experts on appropriate performance expectations for OTC health-care antiseptic drug products and how these final formulations should be tested.

Procedure: Interested persons may present data, information, or views, orally or in writing, on issues pending before the committee. Written submissions may be made to the contact person by July 21, 1998. Oral presentations from the public will be scheduled between approximately 1 p.m. and 2 p.m. on July 28 and 29, 1998. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before July 21, 1998, and submit a brief statement of the general nature of the evidence or arguments they wish to present, the names and addresses of proposed participants, and an indication of the approximate time requested to make their presentation.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: June 18, 1998.

Michael A. Friedman,

Deputy Commissioner for Operations.

[FR Doc. 98–17074 Filed 6–25–98; 8:45 am]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[HCFA–R–224]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration, HHS.

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding this burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) The necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: Extension of a currently approved collection; *Title of Information Collection:* Collection of Managed Care Data Using the Uniform Institutional Providers Form (HCFA–1450/UB–92) and Supporting Statute Section 1853(a)(3) of the Balanced budget Act of 1997; *Form No.:* HCFA–R–224 (OMB No. 0938–0711); *Use:* Section 1853(a)(3) of the Balanced Budget Act (BBA) requires Medicare+Choice organizations, as well as eligible organizations with risk-sharing contracts under section 1876, to submit encounter data. Data regarding inpatient hospital services are required for periods beginning on or after July 1, 1997. These data may be collected starting January 1, 1998. Other data (as the Secretary deems necessary) may be required beginning July 1, 1998.

The BBA also requires the Secretary to implement a risk adjustment methodology that accounts for variation in per capita costs based on health status. This payment method must be implemented no later than January 1, 2000. The encounter data are necessary to implement a risk adjustment methodology.

Hospital data from the period, July 1, 1997–June 30, 1998, will serve as the basis for plan-level estimates of risk adjusted payments. These estimates will be provided to plans by March, 1999. Encounter data collected from subsequent time periods will serve as the basis for actual payments to plans for CY 2000 and beyond.

In implementing the requirements of the BBA, hospitals will submit data to the managed care plan for enrollees who have a hospital discharge using the HCFA–1450 (UB–92), Uniform Institutional Provider Claim Form. Encounter data for hospital discharges occurring on or after July 1, 1997 are required. While submission from the hospital to the plan is required, plans are provided with an alternate submission route for the start-up year.

Special procedures have been identified to ensure that hospital encounter data are submitted for discharges occurring between July 1, 1997 and June 30, 1998, the start-up year. HCFA has identified three alternatives for the submission of hospital encounter data for discharges during the star-up year, including the following:

Option 1: The Plan will have a hospital submit UB–92s or Medicare Part A ANSI ASC X12 837 (ANSI 837) records using the traditional HMO ''No Pay'' bill method.

Option 2: The Plan can currently produce a complete UB–92/ANSI 837 and will hold the data until the fiscal intermediary (FI) can accept it.

Option 3: The Plan will submit an abbreviated UB–92 data set via an alternative route.

During the start up year, the plan is expected to establish an electronic data linkage to a FI to be determined by HCFA. HCFA will assist Plans in initiating discussions with their FI. By July 15, 1998, the Plan is expected to have completed this linkage, including testing of the linkage, and to be capable of transmitting hospital encounter data to a FI. Data for the start-up year must be transmitted to the plan's FI by September, 18, 1998. All data with discharge dates after July 1, 1998 will be transmitted using this linkage. (See Appendix III for additional information on the transmission of data to HCFA.) Each plan and/or contract will use a single FI. HCFA will establish a series of interim deadlines to ensure that plans are making sufficient progress toward

accomplishing this linkage no later than July 15, 1998.

After plans have established linkages to a FI, hospitals will submit HCFA–1450 (UB–92) forms to the managed care plan. The HCFA–1450 (UB–92) form is identical to the one used by hospitals in billing for Medicare fee-for-service claims. After receiving the pseudo claim from the hospital, the plan attaches the plan identifier, which is the HCFA assigned managed care organization (MCO) Contract Number, and submits the pseudo-claim electronically to the fiscal intermediary (FI). The data processing flow by the FI is very similar to current claims processing for the fee-for-service system, except that no payment is authorized to the plan. Pseudo claims will flow though the FI to our Common Working File (CWF) and will be retained by HCFA.; *Frequency:* On occasion; *Affected Public:* Business or other for-profit, Not-for-profit institutions, and Federal government; *Number of Respondents:* 1.9 million; *Total Annual Responses:* 1.9 million; *Total Annual Hours:* 32,833.

To obtain copies of the supporting statement and any related forms for the proposed paperwork collections referenced above, access HCFA's Web Site address at http://www.hcfa.gov/regs/prdact95.htm, or E-mail your request, including your address, phone number, OMB number, and HCFA document identifier, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Attention: Louis Blank, Room C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: June 16, 1998.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 98–16989 Filed 6–25–98; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–R–243]

Agency Information Collection Activities: Proposed Collection; Comment Request

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services, is publishing the following summary of proposed collections for public comment. Interested persons are invited to send comments regarding the burden estimate or any other aspect of this collection of information, including any of the following subjects: (1) the necessity and utility of the proposed information collection for the proper performance of the agency's functions; (2) the accuracy of the estimated burden; (3) ways to enhance the quality, utility, and clarity of the information to be collected; and (4) the use of automated collection techniques or other forms of information technology to minimize the information collection burden.

Type of Information Collection Request: New Collection; *Title of Information Collection:* Medicare Agreement Application, Health Care Prepayment Plan; *Form No.:* HCFA–R–243; *Use:* An organization must meet certain requirements to be a Health Care Prepayment Plan that is eligible for a Medicare 1833 agreement. The application is the collection form used to obtain information from an organization that would allow HCFA staff to determine compliance with the regulations. This form includes requests for information about: the management of the applicant organization; arrangements for providing health care to beneficiaries; meeting Medicare requirements for appeals, hearings, advance directives, health benefits; risk sharing with other entities; the fiscal soundness of the applicant; the cost budget, which forms the basis for HCFA payment; prevention of duplicate payment; and the applicant's marketing strategy. Frequency: One time ; *Affected Public:* Business or other for-profit institutions, Not-for-profit institutions, and State, Local or Tribal Governments.; *Number of Respondents:* 15; *Total Annual Responses:* 15; *Total Annual Hours:* 1,125.

To obtain copies of the supporting statement for the proposed paperwork collections referenced above, or any related forms, E-mail your request, including your address and phone number, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326. Written comments and recommendations for the proposed information collections must be mailed within 60 days of this notice directly to the HCFA Paperwork Clearance Officer designated at the following address: HCFA, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Attention: John Rudolph, Room C2–26–17, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: June 18, 1998.

John P. Burke III,

HCFA Reports Clearance Officer, Division of HCFA Enterprise Standards, Health Care Financing Administration.

[FR Doc. 98–16999 Filed 6–25–98; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Agency Information Collection Activities: Proposed Collection: Comment Request

In compliance with the requirement for opportunity for public comment on proposed data collection projects (section 3506(c)(2)(A) of Title 44, United States Code, as amended by the Paperwork Reduction Act of 1995, Pub. L. 104–13), the Health Resources and Services Administration (HRSA) will publish periodic summaries of proposed projects being developed for submission to OMB under the Paperwork Reduction Act of 1995. To request more information on the proposed project or to obtain a copy of the data collection plans and draft instruments, call the HRSA Reports Clearance Officer on (301) 443–1891.

Comments are invited on: (a) whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the proposed collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology.

Proposed Project: Study of Health Care Services to Children in Foster Care Homes—New

The Maternal and Child Health Bureau of HRSA is planning to conduct a survey of health care services for children in foster care and other out-of-home care in the United States. This project is aimed at identifying the contributing factors affecting the delivery of health care services to these children.

The project will be carried out in two stages. In the first stage a survey will be conducted of the directors of child welfare programs and the directors of maternal and child health programs in all 50 States and the District of Columbia, in 5 counties in each of seven States with county administered child welfare systems, and in 30 large municipalities. The purpose of this initial data collection is to document the range of institutional arrangements, policies, and activities being undertaken to address the issue of health care for children in foster care and other out-of-home care.

The second stage will include a detailed follow-up survey of child welfare, maternal and child health, Medicaid, and juvenile court officials in a subset of 20 States (13 with State administered child welfare systems and 7 with county administered child welfare systems), 35 counties (5 from each of the 7 States with county administered child welfare systems), and 10 municipalities. The second stage will document (a) demographic characteristics of children in foster care, (b) health care policies, (c) characteristics of health assessments and ongoing care, (d) standards of care, (e) financial arrangements, and (f) interagency collaborations.

The second stage will also include a written survey sent to 220 advocacy, provider, and professional organizations in the subset of States and counties being surveyed. This component will collect information on the same 6 categories noted above from organizations with a broad base of experience working on health care issues for children in foster care and other out-of-home care.

Respondents	Number of respondents	Responses per respondent	Average burden per response (in hours)	Total burden (in hours)
Child welfare and maternal and child health directors	232	1	1	232
Child welfare, maternal and child health, Medicaid, and juvenile court officials	260	1	2.4	624
Advocacy and professional organizations	220	1	1.5	330
Total	712	1	1.67	1186

Send comments to HRSA Reports Clearance Officer, Room 14–33, Parklawn Building, 5600 Fishers Lane, Rockville, MD 20857. Written comments should be received within 60 days of this notice.

Dated: June 19, 1998.

Jane Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 98–17064 Filed 6–25–98; 8:45 am]

BILLING CODE 4160–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration (HRSA)

Agency Information Collection Activities: Submission for OMB Review; Comment Request

Periodically, the Health Resources and Services Administration publishes abstracts of information collection requests under review by the Office of Management and Budget. These data collection requirements are authorized by section 241 of the PHS Act (42 USC 238j). To request a copy of the clearance request submitted to OMB for review, call the HRSA Reports Clearance Office on (301) 443–1129.

The following request has been submitted to the Office of Management and Budget for review under the Paperwork Reduction Act of 1995:

Proposed Project: Healthy Schools, Healthy Communities Data System (OMB No. 0915–0188)

Extension—This is a request for extension of approval of the Healthy Schools Data System, which contains the annual reporting requirements for the Healthy Schools, Healthy Communities grantees funded by the Bureau of Primary Health Care (BPHC), HRSA. Authorizing legislation is found in Pub. L. 104–299, Health Center Consolidation Act of 1996, enacting Section 330 of the Public Health Service Act.

The BPHC collects data on its programs to ensure compliance with legislative mandates and to report to Congress and policymakers on program accomplishments. To meet these objectives with respect to the Healthy Schools, Healthy Communities grant program, BPHC requires a core set of information collected annually that is appropriate for monitoring and evaluating performance and reporting on annual trends. This data system, ''School Health Care Online (SHO)'', includes information on such specific program elements as:

—Student patient characteristics (e.g., age, grade level, gender, pre-existing conditions, disease chronicity, and insurance status.

—Service utilization (e.g., immunization rates, health screening, referrals).

—Referrals to the Women, Infant and Children (WIC) nutritional program and other social services providers.

—Information on provider productivity.

—Use of emergency rooms for non-emergency care.

There are to be no revisions to the data collection instruments.

The reporting burden has decreased slightly because reporting has been changed from quarterly to annually. Estimates of annualized reporting burden are as follows:

Type of report	Number of respondents	Hours per response	Total burden hours
Data Entry	30	0.2	3,600
User Profile	30	0.5	15
Data Export	30	0.5	15

Type of report	Number of respondents	Hours per response	Total burden hours
Total	30		3,630

Written comments and recommendations concerning the proposed information collection should be sent within 30 days of this notice to: Laura Oliven, Human Resources and Housing Branch, Office of Management and Budget, New Executive Office Building, Room 10235, Washington, DC 20503.

Dated: June 19, 1998.

Jane Harrison,

Director, Division of Policy Review and Coordination.

[FR Doc. 98–17065 Filed 6–25–98; 8:45 am]

BILLING CODE 4160–15–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

National Vaccine Injury Compensation Program; List of Petitions Received

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice.

SUMMARY: The Health Resources and Services Administration (HRSA) is publishing this notice of petitions received under the National Vaccine Injury Compensation Program (''the Program''), as required by section 2112(b)(2) of the Public Health Service (PHS) Act, as amended. While the Secretary of Health and Human Services is named as the respondent in all proceedings brought by the filing of petitions for compensation under the Program, the United States Court of Federal Claims is charged by statute with responsibility for considering and acting upon the petitions.

FOR FURTHER INFORMATION CONTACT: For information about requirements for filing petitions, and the Program generally, contact the Clerk, United States Court of Federal Claims, 717 Madison Place, N.W., Washington, D.C. 20005, (202) 219–9657. For information on HRSA's role in the Program, contact the Director, National Vaccine Injury Compensation Program, 5600 Fishers Lane, Room 8A35, Rockville, MD 20857, (301) 443–6593.

SUPPLEMENTARY INFORMATION: The Program provides a system of no-fault compensation for certain individuals who have been injured by specified childhood vaccines. Subtitle 2 of title XXI of the PHS Act, 42 U.S.C. 300aa–10 *et seq.*, provides that those seeking compensation are to file a petition with the U.S. Court of Federal Claims and to serve a copy of the petition on the Secretary of Health and Human Services, who is named as the respondent in each proceeding. The Secretary has delegated her responsibility under the Program to HRSA. The Court is directed by statute to appoint special masters who take evidence, conduct hearings as appropriate, and make initial decisions as to eligibility for, and amount of, compensation.

A petition may be filed with respect to injuries, disabilities, illnesses, conditions, and deaths resulting from vaccines described in the Vaccine Injury Table (the Table) set forth at section 2114 of the PHS Act or as set forth at 42 CFR 100.3, as applicable. This Table lists for each covered childhood vaccine the conditions which will lead to compensation and, for each condition, the time period for occurrence of the first symptom or manifestation of onset or of significant aggravation after vaccine administration. Compensation may also be awarded for conditions not listed in the Table and for conditions that are manifested after the time periods specified in the Table, but only if the petitioner shows that the condition was caused by one of the listed vaccines.

Section 2112(b)(2) of the PHS Act, 42 U.S.C. 300aa–12(b)(2), requires that the Secretary publish in the **Federal Register** a notice of each petition filed. Set forth below is a list of petitions received by HRSA on January 5, 1998, through March 31, 1998.

Section 2112(b)(2) also provides that the special master ''shall afford all interested persons an opportunity to submit relevant, written information'' relating to the following:

1. The existence of evidence ''that there is not a preponderance of the evidence that the illness, disability, injury, condition, or death described in the petition is due to factors unrelated to the administration of the vaccine described in the petition,'' and

2. Any allegation in a petition that the petitioner either:

(a) ''Sustained, or had significantly aggravated, any illness, disability, injury, or condition not set forth in the Table but which was caused by'' one of the vaccines referred to in the Table, or

(b) ''Sustained, or had significantly aggravated, any illness, disability, injury, or condition set forth in the Table the first symptom or manifestation of the onset or significant aggravation of which did not occur within the time period set forth in the Table but which was caused by a vaccine'' referred to in the Table.

This notice will also serve as the special master's invitation to all interested persons to submit written information relevant to the issues described above in the case of the petitions listed below. Any person choosing to do so should file an original and three (3) copies of the information with the Clerk of the U.S. Court of Federal Claims at the address listed above (under the heading **FOR FURTHER INFORMATION CONTACT**), with a copy to HRSA addressed to Acting Associate Administrator for Health Professions, 5600 Fishers Lane, Room 8–05, Rockville, MD 20857. The Court's caption (Petitioner's Name v. Secretary of Health and Human Services) and the docket number assigned to the petition should be used as the caption for the written submission.

Chapter 35 of title 44, United States Code, related to paperwork reduction, does not apply to information required for purposes of carrying out the Program.

List of Petitions

1. Stephanie and John Hatzenbuhler, on behalf of John Ross Hatzenbuhler Bismark, North Dakota, Court of Federal Claims Number 98–0008V
2. Basmah Zamrik and Mohammad Ramez Chawki on behalf of Hedaya Chawki, Broken Arrow, Oklahoma, Court of Federal Claims Number 98–0010V
3. Dennis Foster on behalf of Felisha Foster, Rockford, Illinois, Court of Federal Claims Number 98–0033V
4. Dolores Cohen-Lowry, Phoenixville, Pennsylvania, Court of Federal Claims Number 98–0034V
5. Pamela S. and Andrew L. Wilson on behalf of Daniel J. Wilson, Beaver, Pennsylvania, Court of Federal Claims Number 98–0040V
6. Christine E. Kramer, Mayfield Heights, Ohio, Court of Federal Claims Number 98–0053V
7. Thuy Yang on behalf of Chandra Ly, Deceased, Philadelphia, Pennsylvania, Court of Federal Claims Number 98–0054V

8. Susan and Leonard Queen on behalf of Maura Queen, Douglasville, Georgia, Court of Federal Claims Number 98–0055V
9. Vanya Seiss on behalf of Lola Seiss, Los Angeles, California, Court of Federal Claims Number 98–0062V
10. Rosemary J. Browne, Columbia, Maryland, Court of Federal Claims Number 98–0070V
11. Cathleen and Donald Marcelli on behalf of David Marcelli, Deceased, Burlington, Massachusetts, Court of Federal Claims Number 98–0103V
12. Eva D. Libby Smith on behalf of Aaron Lee Smith, Portsmouth, Oregon, Court of Federal Claims Number 98–0106V
13. UnMi and Jerry Tufo on behalf of Jerry Joseph Tufo, Jr., Eglin AFB, Florida, Court of Federal Claims Number 98–0108V
14. Gerald M. Taylor on behalf of Jennifer Sandoval, Ruskin, Florida, Court of Federal Claims Number 98–0113V
15. Erin and John Liable on behalf of Sierra Liable, Salem, New Jersey, Court of Federal Claims Number 98–0120V
16. Bernard Bisson, Bradford, Vermont, Court of Federal Claims Number 98–0121V
17. Sheena Ackley on behalf of Tabitha Ackley, Livingston, Texas, Court of Federal Claims Number 98–0122V
18. Marano Maldonado Ramirez on behalf of Maxi Maldonado Vasquez, Corocal, Puerto Rico, Court of Federal Claims Number 98–0133V
19. Blanca Buchno, Stockton, California, Court of Federal Claims Number 98–0134V
20. Robert D. Lovinger, M. D., Richmond, Virginia, Court of Federal Claims Number 98–0138V
21. Margaret Nichols on behalf of Elishama Nichols, Chicago, Illinois, Court of Federal Claims Number 98–0141V
22. Jason Ridgway on behalf Creighton Ridgway, Round Rock, Texas, Court of Federal Claims Number 98–0149V
23. Juli Levesque on behalf of Alex Levesque, Pleasant Hill, California, Court of Federal Claims Number 98–0162V
24. Carrie Snyder on behalf of Kayla Ann Snyder, Allentown, Pennsylvania, Court of Federal Claims Number 98–0163V
25. Francine and Emanuel Chaconis on behalf of Alyssa Chaconis, Pamona, New York, Court of Federal Claims Number 98–0165V
26. Irma L. Lopez, Long Branch, New Jersey, Court of Federal Claims Number 98–0189V
27. Daisy Rivera Rodriguez, Ponce, Puerto Rico, Court of Federal Claims Number 98–0202V
28. Jill Boehler, Lincoln, Nebraska, Court of Federal Claims Number 98–0205V
29. Janice A. Trygg (Simonsen) and Clifford G. Simonsen on behalf of Harriet A. Simonsen, Deceased, Portland, Oregon, Court of Federal Claims Number 98–0206V
30. Madeleine and Marcelo Guilis on behalf of Sage Guilis, Katonah, New York, Court of Federal Claims Number 98–0305V
31. Elias Tebcherani on behalf of Lena Marie Tebcherani, San Diego, California, Court of Federal Claims Number 98–0317V

Dated: June 19, 1998.

Claude Earl Fox,

Administrator.

[FR Doc. 98–17063 Filed 6–25–98; 8:45 am]

BILLING CODE 4160–15–U

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Cancer Institute Initial Review Group, Subcommittee A—Cancer Centers.

Date: August 6–7, 1998.

Time: August 6, 1998, 8:00 am to 6:00 pm—August 7, 1998, 8:00 am to 1:00 pm.

Agenda: To review and evaluate grant applications.

Place: Bethesda Hyatt Regency, One Bethesda Metro, Bethesda, MD 20814.

Contact Person: David E. Maslow, PhD, Scientific Review Administrator, Grants Review Branch, Division of Extramural Activities, National Cancer Institute, National Institutes of Health, 6130 Executive Boulevard—EPN 643A, Rockville, MD 20892–7405, (301) 496–2330.

(Catalogue of Federal Domestic Assistance Program Nos. 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control; 93.392, Cancer Construction, National Institutes of Health, HHS)

Dated: June 19, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17003 Filed 6–25–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Cancer Institute; Notice of Closed Meeting

Purusant to Section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting of the National Cancer Institute Initial Review Group:

Agenda/Purpose: To review, discuss and evaluate grant applications.

Committee Name: Subcommittee H–Clinical Trials.

Date: July 28–29, 1998.

Time: July 28–8:00 a.m. to recess; July 29–8:00 a.m. to adjournment.

Place: Hyatt Regency—Bethesda, One Bethesda Metro, Bethesda, MD 20814.

Contact Person: Deborah R. Jaffee, Ph.D., Scientific Review Administrator, National Cancer Institute, NIH, 6130 Executive Boulevard, North, Room 611C, Bethesda, MD 20892–7403, Telephone: 301/496–7721.

The meeting will be closed in accordance with the provisions set forth in secs. 552b(c)(4) and 552b(c)(6), Title 5, U.S.C. 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.

(Catalog of Federal Domestic Assistance Program Numbers: 93.393, Cancer Cause and Prevention Research; 93.394, Cancer Detection and Diagnosis Research; 93.395, Cancer Treatment Research; 93.396, Cancer Biology Research; 93.397, Cancer Centers Support; 93.398, Cancer Research Manpower; 93.399, Cancer Control)

Dated: June 19, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17004 Filed 6–25–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Deafness and Other Communication Disorders; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Deafness and Other Communications Disorders Special Emphasis Panel.

Date: July 31, 1998.

Time: 12:00 pm to 3:00 pm.

Agenda: To review and evaluate grant applications.

Place: 6120 Executive Blvd, Suite 400C, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: George M. Barnas, PhD, Scientific Review Administrator, Scientific Review Branch, Division of Extramural Activities/NIDCD, 6120 Executive Blvd., Bethesda, MD 20892, 301–496–8683.

(Catalogue of Federal Domestic Assistance Program Nos. 93.173, Biological Research Related to Deafness and Communicative Disorders, National Institutes of Health, HHS)

Dated: June 18, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17000 Filed 6–25–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Alcohol Abuse and Alcoholism; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Alcohol Abuse and Alcoholism Special Emphasis Panel.

Date: July 14–16, 1998.

Time: 7:00 pm to 5:00 pm.

Agenda: To review and evaluate grant applications.

Place: Radisson Barcelo Hotel, 2121 P St., NW, Washington, DC 20037.

Contact Person: Mark R. Green, PhD., Chief, Extramural Division Branch, National Institute on Alcohol Abuse and Alcoholism, Suite 409, 6000 Executive Blvd., Bethesda, MD 20892.

(Catalogue of Federal Domestic Assistance Program Nos. 93.271, Alcohol Research Career Development Awards for Scientists and Clinicians; 93.272, Alcohol National Research Service Awards for Research Training; 93.273, Alcohol Research Programs; 93.891, Alcohol Research Center Grants, National Institutes of Health, HHS)

Dated: June 19, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17001 Filed 6–26–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute on Drug Abuse; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and/or contract proposals and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications and/or contract proposals, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Training and Career Development Committee.

Date: June 29–July 1, 1998.

Time: June 29, 1998, 9:00 am to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Sheraton Crystal City Hotel, 1800 Jefferson Davis Highway, Arlington, VA 22202.

Contact Person: Mark Swieter, PhD, Health Scientist Administrator, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Land, Room 10–42, Rockville, MD 20857, (301) 443–2620.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Training and Career Development Committee.

Date: June 29, 1998.

Time: 5:30 pm to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Sheraton Crystal City Hotel, 1800 Jefferson Davis Highway, Arlington, VA 22202.

Contact Person: Mark Swieter, PhD, Health Scientist Administrator, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Land, Room 10–42, Rockville, MD 20857, (301) 443–2620.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Rodent and Monkey Testing for NIDA Medication Discovery Program.

Date: June 30, 1998.

Time: 10:30 am to Adjournment.

Agenda: To review and evaluate contract proposals.

Place: National Institute on Drug Abuse, 5600 Fishers Land, Room 10–49, Rockville, MD 20857, (301) (Telephone Conference Call).

Contact Person: Eric Zatman, Contract Review Specialist, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, 10–42, Rockville, MD 20857, (301) 443–1644.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Initial Review Group, Treatment Research Subcommittee.

Date: July 8–9, 1998.

Time: July 8, 1998, 8:30 am to 12:00 pm.

Agenda: To review and evaluate grant applications.

Place: Double Tree Hotel, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: Kesinee Nimit, MD, Health Scientist Administrator, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS,

5600 Fishers Lane, Room 10–22, Rockville, MD 20857, (301) 443–9042.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Research Dissemination.

Date: July 8, 1998.

Time: 9:30 am to Adjournment.

Agenda: To review and evaluate contract proposals.

Place: Parklawn Bldg., 3rd Floor, Conference B, 5600 Fishers Lane, Rockville, MD 20857.

Contact Person: Lyle Furr, Contract Review Specialist, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–42, Rockville, MD 20857, (301) 443–1644.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Treatment.

Date: July 9, 1998.

Time: 9:00 am to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Double Tree Hotel, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: William Grace, Phd, Deputy Director, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–42, Rockville, MD 20857, (301) 443–2755.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Initial Review Group, Health Services Research Subcommittee.

Date: July 9–10, 1998.

Time: July 9, 1998, 1:00 pm to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Double Tree Hotel, 1750 Rockville Pike, Rockville, MD 20852.

Contact Person: Kesinee Nimit, MD, Health Scientist Administrator, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–22, Rockville, MD 20857, (301) 443–9042.

This notice is being published less than 15 days prior to the meeting due to the timing limitations imposed by the review and funding cycle.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Center Review Committee.

Date: July 15, 1998.

Time: 8:30 am to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, MD 20814.

Contact Person: Rita Liu, PhD, Health Scientist Administrator, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–22, Rockville, MD 20857, (301) 443–9042.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Drug Abuse Prevention and Communication Research.

Date: July 21–22, 1998.

Time: July 21, 1998, 9:00 am to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.

Contact Person: Susan L. Coyle, PhD, Chief, Clinical, Epidemiological/Applied Sciences Review Branch, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–42, Rockville, MD 20857, (301) 443–2620.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Science Education Development Program.

Date: July 22, 1998.

Time: 9:00 am to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Bethesda Marriott Hotel, 5151 Pooks Hill Road, Bethesda, MD 20814.

Contact Person: Lyle Furr, Contract Review Specialist, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–42, Rockville, MD 20857, (301) 443–1644.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, Minority Institutions Drug Abuse Research Development Program.

Date: July 27, 1998.

Time: 9:00 am to 3:00 pm.

Agenda: To review and evaluate grant applications.

Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.

Contact Person: William Grace, PhD, Deputy Director, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–42, Rockville, MD 20857, (301) 443–2755.

Name of Committee: National Institute on Drug Abuse Special Emphasis Panel, HBCU Research Scient.

Date: July 27–28, 1998.

Time: July 27, 1998, 3:00 pm to Adjournment.

Agenda: To review and evaluate grant applications.

Place: Ritz-Carlton Hotel at Pentagon City, 1250 South Hayes Street, Arlington, VA 22202.

Contact Person: William Grace, PhD, Deputy Director, Office of Extramural Program Review, National Institute on Drug Abuse, National Institutes of Health, DHHS, 5600 Fishers Lane, Room 10–42, Rockville, MD 20857, (301) 443–2755.

(Catalogue of Federal Domestic Assistance Program Nos. 93.278, Drug Abuse National Research Service Awards for Research Training; 93.279, Drug Abuse Research Programs; 93.277, Drug Abuse Scientist Development Award for Clinicians, Scientist Development Awards, and Research Scientist Awards, National Institutes of Health, HHS)

Dated: June 19, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17002 Filed 6–25–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Institute of Nursing Research; Notice of Closed Meeting

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meeting.

The meeting will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), Title 5 U.S.C., as amended. The grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: National Institute of Nursing Research Special Emphasis Panel, NINR Career Transition Award Applicaitons.

Date: July 27, 1998.

Time: 2:00 pm to 4:00 pm.

Agenda: To review and evaluate grant applications.

Place: National Institutes of Health, Natcher Building 45, Room 3AN–18B, Bethesda, MD 20892, (Telephone Conference Call).

Contact Person: Mary J. Stephens-Frazier, PhD, Scientific Review Administrator, Natcher Building, Room 3AN–18B, National Institute of Nursing Research, Bethesda, MD 20892, 301–594–5971.

(Catalogue of Federal Domestic Assistance Program Nos. 93.361, Nursing Research, National Institutes of Health, HHS)

Dated: June 19, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17006 Filed 6–25–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institute of Health

Center for Scientific Review; Notice of Closed Meetings

Pursuant to section 10(d) of the Federal Advisory Committee Act, as amended (5 U.S.C. Appendix 2), notice is hereby given of the following meetings.

The meetings will be closed to the public in accordance with the provisions set forth in sections 552b(c)(4) and 552b(c)(6), title 5 U.S.C., as amended. the grant applications and the discussions could disclose confidential trade secrets or commercial property such as patentable material, and personal information concerning individuals associated with the grant applications, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel.
Date: July 7, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.
Contact Person: Bruce Maurer, PhD, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5108, MSC 7852, Bethesda, MD 20892, (301) 435–1167.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, LRG–5 AARR–4 (01)S.
Date: July 7, 1998.
Time: 8:30 am to 4:00 pm.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Bethesda, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Mohindar Poonian, Phd, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5110, MSC 7852, Bethesda, MD 20892, (301) 435–1168.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–4 (02).
Date: July 7, 1998.
Time: 4:30 pm to 6:30 pm.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Hotel, Bethesda, MD.
Contact Person: Mohindar Poonian, Phd, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5110, MSC 7852, Bethesda, MD 20892, (301) 435–1168.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–2 (02).
Date: July 8, 1998.
Time: 7:30 pm to 10:00 pm.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Bethesda, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Sami Mayyasi, Phd, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel.
Date: July 9–10, 1998.
Time: 8:30 a.m. to 5:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn, 5520 Wisconsin Ave., Chevy Chase, MD 20815.
Contact Person: Jean Hickman, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4194, MSC 7808, Bethesda, MD 20892, (301) 435–1146.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–5 (01).
Date: July 9, 1998.
Time: 8:30 a.m. to 5:00 p.m.
Agenda: To review and evaluate grant applications.
Place: Woodfin Suites Hotel, Conference Room, 1380 Piccard Drive, Rockville, MD 20850.
Contact Person: Bruce Mauer, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5108, MSC 7852, Bethesda, MD 20892, (301) 435–1167.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–02 (04).
Date: July 10, 1998.
Time: 8:30 a.m. to 4:30 p.m.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Hotel, Bethesda, MD.
Contact Person: Sami Mayyasi, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–1 (02).
Date: July 12, 1998.
Time: 7:30 p.m. to 9:30 p.m.
Agenda: To review and evaluate grant applications.
Place: Wyndham Bristol Hotel, 2430 Pennsylvania Ave., NW, Washington, DC 20037.
Contact Person: Bruce Maurer, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5108, MSC 7852, Bethesda, MD 20892, (301) 435–1167.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–01 (01).
Date: July 13–14, 1998.
Time: 8:30 am to 4:30 pm.
Agenda: To review and evaluate grant applications.
Place: Wyndham Bristol Hotel, 2430 Pennsylvania Ave, NW Washington, DC 20037.
Contact Person: Bruce Maurer, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5108, MSC 7852, Bethesda, MD 20892, (301) 435–1167.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–2 (03).
Date: July 16–17, 1998.
Time: 8:00 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn, 5520 Wisconsin Ave., Chevy Chase, MD 20815.
Contact Person: Sami Mayyasi, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–7 (01).
Date: July 21–22, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.
Contact Person: Gilbert W. Meier, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–7 (02).
Date: July 21, 1998.
Time: 1:00 pm to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Bethesda, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Sami Mayyasi, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–7 (02).
Date: July 22, 1998.
Time: 8:30 am to 10:30 am.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.
Contact Person: Gilbert W. Meier, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169

Name of Committee: Multidisciplinary Sciences Special Emphasis Panel.

Date: July 23–24, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Bethesda, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Bill Bunnag, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5124, MSC 7850, Bethesda, MD 20892, (301) 435–1177.

Name of Committee: Multidisciplinary Sciences Special Emphasis Panel.
Date: July 26–27, 1998.
Time: 7:30 pm to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Hyatt Regency Bethesda, One Bethesda Metro Center, Bethesda, MD 20814.
Contact Person: Eileen Bradley, DSC, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5120, MSC 7854, Bethesda, MD 20892, (301) 435–1179

Name of Committee: Cell Development and Function Initial Review Group, International and Cooperative Projects Study Section.
Date: July 27, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Embassy Suites Hotel, 1250 22nd Street, NEW, Washington, DC 20037.
Contact Person: Sandy Warren, DMD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5134, MDC 7840, Bethesda, MD 20892, (301) 435–1019.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–8 (01).
Date: July 28–29, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.
Contact Person: Gilbert W. Meier, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel, ZRG–5 AARR–8 (02).
Date: July 29, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.
Contact Person: Gilbert W. Meier, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5112, MSC 7852, Bethesda, MD 20892, (301) 435–1169.

Name of Committee: Microbiological and Immunological Sciences Special Emphasis Panel.
Date: July 29, 1998.
Time: 11:30 am to 1:00 pm.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).
Contact Person: William C. Branche, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 4182, MSC 7808, Bethesda, MD 20892, (301) 435–1148.

Name of Committee: Biological and Physiological Sciences Special Emphasis Panel, Special Emphasis Panel—Nutrition/Metabolism.
Date: July 30–31, 1998.
Time: 8:30 am to 5:00 pm.
Agenda: To review and evaluate grant applications.
Place: Holiday Inn Chevy Chase, 5520 Wisconsin Avenue, Chevy Chase, MD 20815.
Contact Person: Sooja K. Kim, PhD, RD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 6158, MSC 7892, Bethesda, MD 20892, (301) 435–1780.

Name of Committee: Biological and Physiological Sciences Special Emphasis Panel.
Date: July 31, 1998.
Time: 1:00 pm to 2:30 pm.
Agenda: To review and evaluate grant applications.
Place: NIH, Rockledge 2, Bethesda, MD 20892, (Telephone Conference Call).
Contact Person: Ramesh K. Nayak, PhD, Scientific Review Administrator, Center for Scientific Review, National Institutes of Health, 6701 Rockledge Drive, Room 5146, MSC 7840, Bethesda, MD 20892, (301) 435–1026.

(Catalogue of Federal Domestic Assistance Program Nos. 93.333, Clinical Research 93.333, 93.337, 93.393–93.396, 93.837–93.844, 93.846–93.878, 93.892, 93.893; 93.306, Comparative Medicine, 93,306, National Institutes of Health, HHS)

Dated: June 19, 1998.

LaVerne Y. Stringfield,

Committee Management Officer, NIH.

[FR Doc. 98–17005 Filed 6–25–98; 8:45 am]

BILLING CODE 4140–01–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. 4351–N–08]

Notice of Proposed Information Collection for Public Comment

AGENCY: Office of the Assistant Secretary for Policy Development and Research, HUD.

SUMMARY: The proposed information collection requirement described below will be 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 proposal.

DATES: Comments due: August 25, 1998.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name or OMB Control Number and should be sent to: Reports Liaison Officer, Office of Policy Development and Research, Department of Housing and Urban Development, 451 7th Street, SW., Room 8226, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Stacy Jordan, Economist, Office of Policy Development and Research, telephone (202) 708–0426 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION: The Department will submit the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35, as amended).

This Notice is soliciting comments from members of the public and affected agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, e.g. permitting electronic submission of responses.

This notice also lists the following information:

Title of Proposal: A survey of Low-Income Housing Tax Credit Developers and Owners.

Description of the need for the information and proposed use: The Low-Income Housing Tax Credit (LIHTC) program is the Federal government's most important but least well-understood affordable housing production program. This national survey will contribute to the now-limited but growing body of knowledge about how the program works and who is participating in it. It consists of a national probability sample of developer/owner entities that placed at least one LIHTC rental property in service between January 1992 and December 1994. Information will be gathered about: the types and characteristics of developer/owner entities that produce affordable rental housing in conjunction with the LIHTC

program; factors that were important to their decisions to develop affordable rental housing using the LIHTC; factors that were considered when deciding upon the location, scale, resident composition, and other characteristics of their properties; their post-development experiences with respect to the performance of their properties; and their longer-term plans with respect to their properties.

HUD is responsible for assessing the housing needs of low-income households and administering a variety of housing assistance programs to meet those needs. The LIHTC program operates in conjunction with and in the context of ongoing HUD programs. Although HUD is not directly responsible for the LIHTC program, it is important to an overall understanding of the affordable housing delivery system to know more about this program, including who develops, owns, and operates properties benefiting from LIHTCs, what affects their investment and development decisions, and their longer-term plans with respect to their properties. This information will assist the Department in better assessing and meeting the affordable housing needs of the Nation's low-income households.

Members of the affected public: A probability sample of development/ ownership entities that placed at least one LIHTC property in service between January 1, 1992 and December 31, 1994 will be surveyed.

Estimation of the total number of hours needed to prepare the information collection, including number of respondents, frequency of response, and hours of response: Information will be collected by a one-time telephone survey with 800 spokespersons representing developer/owner entities. Each interview will take an average of 30 minutes to complete, resulting in a total of approximately 400 hours of response time for the information collection.

Status of the proposed information collection: Pending OMB approval.

Authority: Section 3506 of the Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35, as amended.

Dated: June 19, 1998.

Paul L. Leonard,

Deputy Assitant Secretary for Pollicy Development.

[FR Doc. 98–17026 Filed 6–25–98; 8:45 am]

BILLING CODE 4210–62–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4356–N–12]

Notice of Proposed Information Collection: Comment Request

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

ACTION: Notice.

SUMMARY: The proposed information collection requirement described below will be 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 proposal.

DATES: Comments due date: August 25, 1998.

ADDRESSES: Interested persons are invited to submit comments regarding this proposal. Comments should refer to the proposal by name and/or OMB Control Number and should be sent to: Oliver Walker, Reports Management Officer, Department of Housing and Urban Development, 451 7th Street SW, Room 9116, Washington, DC 20410.

FOR FURTHER INFORMATION CONTACT: Lester J. West, Director, Albany Financial Operations Center, telephone number (518) 464–4200 (this is not a toll-free number) for copies of the proposed forms and other available documents.

SUPPLEMENTARY INFORMATION: The Department is submitting the proposed information collection to OMB for review, as required by the Paperwork Reduction Act of 1995 (44 U.S.C. chapter 35, as amended).

This Notice is soliciting comments from members of the public and affecting agencies concerning the proposed collection of information to: (1) Evaluate whether the proposed of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information; (3) Enhance the quality, utility, and clarity of the information to be collected; and (4) Minimize the burden of the collection of information on those who are to respond; including through the use of appropriate automated collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

This Notice also lists the following information:

Title of Proposal: Title I Financial Statement.

OMB Control Number, if applicable: 2502–0098.

Description of the need for the information and proposed use: The form is used by HUD to obtain information about a debtor's ability to pay the debt in full, pay in installments and/or compromise the debt. Failure to collect this information would result in uneducated decisions in respect to the handling of debtor's accounts.

Agency form numbers, if applicable: HUD–56142.

Members of affected public: Individuals.

Estimation of the total numbers of hours needed to prepare the information collection including number of respondents, frequency of response, and hours of response:

Number of Respondents: 1,258.

Frequency of Response: On occasion.

Total hours of response requested: 1.

Status of the proposed information collection: Extension of a currently approved collection.

Authority: The Paperwork Reduction Act of 1995, 44 U.S.C. Chapter 35, as amended.

Dated: June 19, 1998.

Ira G. Peppercorn,

General Deputy Assistant, Secretary for Housing-Deputy Federal Housing Commissioner.

[FR Doc. 98–17027 Filed 6–25–98; 8:45 am]

BILLING CODE 4210–27–M

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4341–N–16]

Federal Property Stuitable as Facilities To Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

FOR FURTHER INFORMATION CONTACT: Mark Johnston, room 7256, Department of Housing and Urban Development, 451 Seventh Street SW, Washington, DC 20410; telephone (202) 708–1226; TTY number for the hearing- and speech-impaired (202) 708–2565 (these telephone numbers are not toll-free), or call the toll-free Title V information line at 1–800–927–7588.

SUPPLEMENTARY INFORMATION: In accordance with 24 CFR part 581 and section 501 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C.

11411), as amended, HUD is publishing this Notice to identify Federal buildings and other real property that HUD has reviewed for suitability for use to assist the homeless. The properties were reviewed using information provided to HUD by Federal landholding agencies regarding unutilized and underutilized buildings and real property controlled by such agencies or by GSA regarding its inventory of excess or surplus Federal property. This Notice is also published in order to comply with the December 12, 1988 Court Order in *National Coalition for the Homeless* v. *Veterans Administration,* No. 88–2503–OG (D.D.C.).

Properties reviewed are listed in this Notice according to the following categories: Suitable/available, suitable/unavailable, suitable/to be excess, and unsuitable. The properties listed in the three suitable categories have been reviewed by the landholding agencies, and each agency has transmitted to HUD: (1) Its intention to make the property available for use to assist the homeless, (2) its intention to declare the property excess to the agency's needs, or (3) a statement of the reasons that the property cannot be declared excess or made available fror use as facilities to assist the homeless.

Properties listed as suitable/available will be available exclusively for homeless use for a period of 60 days from the date of this Notice. Homeless assistance providers interested in any such property should send a written expression of interest to HHS, addressed to Brian Rooney, Division of Property Management, Program Support Center, HHS, room 5B–41, 5600 Fishers Lane, Rockville, MD 20857; (301) 443–2265. (This is not a toll-free number.) HHS will mail to the interested provider an application packet, which will include instructions for completing the application. In order to maximize the opportunity to utilize a suitable property, providers should submit their written expressions of interest as soon as possible. For complete details concerning the processing of applications, the reader is encouraged to refer to the interim rule governing this program, 24 CFR part 581.

For properties listed as suitable/to be excess, that property may, if subsequently accepted as excess by GSA, be made available for use by the homeless in accordance with applicable law, subject to screening for other Federal use. At the appropriate time, HUD will publish the property in a Notice showing it as either suitable/available or suitable/unavailable.

For properties listed as suitable/unavailable, the landholding agency has decided that the property cannot be declared excess or made available for use to assist the homeless, and the property will not be available.

Properties listed as unsuitable will not be made available for any other purpose for 20 days from the date of this Notice. Homeless assistance providers interested in a review by HUD of the determination of unsuitability should call the toll free information line at 1–800–927–7588 for detailed instructions or write a letter to Mark Johnston at the address listed at the beginning of this Notice. Included in the request for review should be the property address (including zip code), the date of publication in the **Federal Register**, the landholding agency, and the property number.

For more information regarding particular properties identified in this Notice (*i.e.,* acreage, floor plan, existing sanitary facilities, exact street address), providers should contact the appropriate landholding agencies at the following addresses: GSA: Mr. Brian K. Polly, Assistant Commissioner, General Services Administration, Office of Property Disposal, 18th and F Streets, NW, Washington, DC 20405; (202) 501–2059; NAVY: Mr. Charles C. Cocks, Department of the Navy, Director, Real Estate Policy Division, Naval Facilities Engineering Command, Code 241A, 200 Stovall Street, Alexandria, VA 22332–2300; (703) 325–7342. (These are not toll-free numbers.)

Dated: June 18, 1998.

Fred Karnas, Jr.,

Deputy Assistant Secretary for Economic Development.

TITLE V, FEDERAL SURPLUS PROPERTY PROGRAM, FEDERAL REGISTER REPORT FOR 06/26/98

Suitable/Available Properties

Buildings (by State)

Hawaii

Facility No. 227
Naval Station
South Ave. & 7th St.
Pearl Harbor Co: Honolulu HI 96701–
Landholding Agency: Navy
Property Number: 779820128
Status: Excess
Comment: 23,200 sq. ft., possible asbestos, termite damage, most recent use—warehouse, off-site use only

Washington

747 Building Complex
805 Goethals Drive
Richland Co: Benton WA 99352–
Landholding Agency: GSA
Property Number: 549820005
Status: Surplus
Comment: 4 bldgs. (2 bldgs. utilized w/lease provisions), most recent use—labs/offices, presence of asbestos/lead paint
GSA Number: 9–B–WA–1145

Unsuitable Properties

Buildings (by State)

Florida

Quarters 9
Naval Air Station
Pensacola Cp: Escambia FL 32508–
Landholding Agency: Navy
Property Number: 779820124
Status: Unutilized
Reason: Extensive deterioration Secured Area

Quarters 10
Naval Air Station
Pensacola Co: Escambia FL 32508–
Landholding Agency: Navy
Property Number: 779820125
Status: Unutilized
Reason: Secured Area Extensive deterioration

Tennessee

15 Bldgs.
Naval Support Activity, Memphis
Millington Co: Shelby TN 38054–
Location: 329, 400–408, 1585, S–159, S–160, S–163, 1278
Landholding Agency: Navy
Property Number: 779820126
Status: Unutilized
Reason: Secured Area Extensive deterioration

18 Bldgs.
Naval Support Activity, Memphis
Millington Co: Shelby TN 38054–
Location: 2001–2002, 2048–2051, 2064–2070, 2107–2111
Landholding Agency: Navy
Property Number: 779820127
Status: Unutilized
Reason: Secured Area

[FR Doc. 98–16691 Filed 6–25–98; 8:45 am]

BILLING CODE 4210–29–M

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Information Collection Renewal To Be Submitted to the Office of Management and Budget (OMB) for Approval Under the Paperwork Reduction Act

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Information collection; request for comments.

SUMMARY: The collection of information described below has been submitted to OMB for renewal under the provisions of the Paperwork Reduction Act of 1995. Copies of specific information collection requirements, related forms and explanatory material may be obtained by contacting the Service Information Collection Clearance officer at the address and/or phone numbers listed below.

DATES: Consideration will be given to all comments received on or before July 27, 1998.

ADDRESSES: Comments and suggestions on specific requirements should be sent to the Service Information Collection Clearance Officer, U.S. Fish and Wildlife Service, MS 222 ARLSQ, 1849 C Street, NW., Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: E. LaVerne Smith, Chief, Division of Endangered Species, 703/358–2171.

SUPPLEMENTARY INFORMATION: The U.S. Fish and Wildlife Service (Service) has submitted the following information collection clearance requirements to the Office of Management and Budget (OMB) for renewal under the Paperwork Reduction Act of 1995, Pub. L. 104–13. A previous 60 day notice on this information collection requirement was published in the **Federal Register** on January 6, 1998 (63 FR 1490–91) inviting public comment. No comments on the previous notice were received as of March 10, 1998. Emergency approval for this information collection requirement was cleared on January 29, 1998 under OMB control number 1018–0096. Pursuant to this renewal, comments are invited on (1) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of burden, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. The information collections in this program will not be part of a system of records covered by the Privacy Act (5 U.S.C. 552(a)).

Experimental populations established under section 10(j) of the Endangered Species Act of 1973 (ESA), as amended, require information collection and reporting to the Service. Section 9 of the ESA describes prohibited acts involving threatened or endangered species (16 U.S.C. section 1538 (a)(1)(B)). There are three major categories of information collected under the already issued experimental population rules. To date these categories have encompassed information relating to: (1) The general taking or removal of individuals of an experimental population, and (2) the authorized taking of individuals related to reports of depredation on livestock or pets caused by individuals that are part of an experimental population and (3) the collection of specimens or the recovery of dead animals that are part of an experimental population. These three categories have adequately described the types of information needed to evaluate the efficacy of the program and are expected to continue to accurately describe activities under the program.

Because individuals of designated experimental populations for species listed as threatened or endangered under the ESA are categorically protected, documentation of human-related mortalities, recovery of dead specimens and other types of take related to the status of experimental populations is important to the Service in order to monitor the success of reintroduction efforts, and recovery efforts in general. In order to minimize potential conflict with humans which could undermine recovery efforts, livestock depredations connected with experimental populations of listed species require prompt attention for purposes of determining the location, timing, and nature of the predatory behavior involved, accurate determination of the species responsible for a livestock kill, and the timely application of necessary control measures.

The Service, in cooperation with the USDA/APHIS Division of Wildlife Services or other cooperating State or Federal agencies, relies on prompt public reporting of depredation in order to resolve livestock related problems, and therefore a time sensitive requirement for reporting problems (generally within 24 hours) to the appropriate Service office is necessary. Information collection is achieved primarily by means of telephone calls by members of the public to Service offices specified in the individual rules (some may choose to use facsimile or electronic mail). Information required is limited to the identity of the caller, species involved, time and place of an incident, the type of incident, and circumstances related to the incident described. The vast majority of the information supplied to the Service as a result of experimental population regulations, is provided by cooperating State and Federal agencies under cooperative agreement. However, some of the information collected by the Service under the experimental population rules is provided by the public.

The collected information can be separated into three categories; general take or removal, depredation related take, and specimen collection. General take or removal information refers to human related mortality including unintentional taking incidental to otherwise lawful activities (e.g. highway mortalities), take in defense of human life, take related to defense of property (if authorized) or take in the form of authorized harassment. Most contacts related to this type of information collection are in regard to sightings of experimental animals, or the inadvertent discovery of an injured or dead individual. Depredation related take refers to the reporting of take for management purposes, where livestock depredation has been documented or may include authorized harassment or lethal take of experimental animals in the act of attacking livestock. The information collection required by the rules for this type of take include the necessary follow-up reports after the Service has authorized harassment or lethal take of experimental animals in relation to confirmed instances of livestock depredation or in defense of human life. Specimen collection is for the purpose of documenting incidental or authorized scientific collection. Most of the information collection requirement for this take pertains primarily to the reporting of sightings of experimental population animals or the inadvertent discovery of an injured or dead individual. Information collection is required for necessary follow-up reports when the Service has authorized take of experimental animals for specimen collection.

The standard information collection includes the name, address, and phone number of the reporting party, location and time of the reported incident, species of experimental population involved. Reporting parties include, but are not limited to, individuals or households, farms, businesses, and other non-profit organizations. The reporting of specimen collections, recovery, or even the reporting of dead individuals from experimental populations is important to the Service's efforts in monitoring these individuals and for other scientific purposes.

Because the number of reports generated annually by the general public (rather than cooperating agencies or separately permitted individuals) under these rules is extremely small (far less than one report per year, per rule) and to assure thorough documentation of results, the Service is estimating the number of expected reports to assume a maximum number per year based on allowance for increased population size and public awareness of this experimental population.

The following nonessential experimental population rule for the Mexican wolf is described under Title 50 of the Code of Federal Regulations and contains information collection requirements:

50 CFR section	Species (scientific name)	Type of reporting
17.84(k) (63 FR1752).	Mexican wolf (Canis lupus baileyi).	Take in defense of human life, incidental take, take related to livestock depredation.

Title: Endangered and Threatened Wildlife, 50 CFR 17.84, Experimental populations.

Description of respondents: private individuals and households, businesses, not-for-profit organizations, and farms.

Bureau number: N/A.

Frequency of Collection: On occasion.

BURDEN ESTIMATES FOR REPORTING REQUIREMENTS FOR THE NONESSENTIAL EXPERIMENTAL POPULATION OF THE MEXICAN WOLF-ENDANGERED SPECIES

Type of report	Number of reports annually	Average time required per report (minutes)	Burden hours
General take or removal [a]	2	15	½
Depredation related take [b]	8	15	2
Specimen collection [c]	2	15	½

[a] General take or removal includes human related mortality including unintentional taking incidental to otherwise lawful activities (e.g. highway mortalities), take in defense of human life, take related to defense of property (if authorized) or take in the form of authorized harassment.
[b] Depredation related take is take for management purposes where livestock depredation has been documented and may include authorized harassment or authorized lethal take of experimental animals in the act of attacking livestock.
[c] Specimen collection, recovery, or reporting of dead individuals from experimental populations for documentation purposes or authorized scientific collection purposes.

Dated: May 14, 1998.

Richard Hannan,

Acting Assistant Director—Ecological Services.

[FR Doc. 98–16980 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–68–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Information Collection Renewal and Revision To Be Submitted to the Office of Management and Budget (OMB) for Approval Under the Paperwork Reduction Act

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Information collection; request for comments.

SUMMARY: The collection of information described below has been submitted to OMB for approval under the provisions of the Paperwork Reduction Act of 1995. Copies of specific information collection requirements, related forms and explanatory material may be obtained by contacting the Information Collection Clearance Officer of the U.S. Fish and Wildlife Service at the address and/or phone numbers listed below.

DATES: Consideration will be given to all comments received on or before July 27, 1998.

ADDRESSES: Comments and suggestions on specific requirements should be sent to the Information Collection Clearance Officer, U.S. Fish and Wildlife Service, MS 222 ARLSQ, 1849 C Street, NW., Washington, DC 20240.

FOR FURTHER INFORMATION CONTACT: E. LaVerne Smith, Chief, Division of Endangered Species, 703/358–2171

SUPPLEMENTARY INFORMATION: The U.S. Fish and Wildlife Service (Service) has submitted the following information collection requirements to the Office of Management and Budget (OMB) for review and approval under the Paperwork Reduction Act of 1995, Pub. L. 104–13. A previous 60 day notice on this information collection requirement was published in the **Federal Register** on January 6, 1998 (63 FR 1490–91) inviting public comment. No comments were received as a result of this notice. Emergency approval for this information collection requirement was cleared on January 29, 1998 under OMB control number 1018–0095. Pursuant to this renewal, comments are invited on (1) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (2) the accuracy of the agency's estimate of burden, including the validity of the methodology and assumptions used; (3) ways to enhance the quality, utility, and clarity of the information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. The information collections in this program will not be part of a system of records covered by the Privacy Act (5 U.S.C. 552(a)).

Experimental populations established under section 10(j) of the Endangered Species Act of 1973 (ESA), as amended, require information collection and reporting to the Service. Section 9 of the ESA describes prohibited acts involving threatened or endangered species (16 U.S.C. section 1538 (a)(1)(B)). There are three major categories of information collected under the already issued experimental population rules. To date these categories have encompassed information relating to: (1) The general taking or removal of individuals of an experimental population, and (2) the authorized taking of individuals related to reports of depredation on livestock or pets caused by individuals that are part of an experimental population and (3) the collection of specimens or the recovery of dead animals that are part of an experimental population. These three categories have adequately described the types of information needed to evaluate the efficacy of the program and are expected to continue to accurately describe activities under the program.

Because individuals of designated experimental populations for species listed as threatened or endangered under the ESA are categorically protected, documentation of human-related mortalities, recovery of dead specimens and other types of take related to the status of experimental populations is important to the Service in order to monitor the success of reintroduction efforts, and recovery efforts in general. In order to minimize potential conflict with humans which could undermine recovery efforts, livestock depredations connected with experimental populations of listed species require prompt attention for purposes of determining the location, timing, and nature of the predatory behavior involved, accurate determination of the species responsible for a livestock kill, and the timely application of necessary control measures. The Service, in cooperation with the USDA/APHIS Division of Wildlife Services or other cooperating State or Federal agencies, relies on prompt public reporting of depredation in order to resolve livestock related problems, and therefore a time sensitive requirement for reporting problems (generally within 24 hours) to the appropriate Service office is necessary. Information collection is achieved primarily by means of telephone calls by members of the public to Service offices specified in the individual rules (some may choose to use facsimile or electronic mail). Information required is limited to the identity of the caller, species involved, time and place of an incident, the type of incident, and circumstances related to the incident described. The vast majority of the information supplied to the Service as a result of experimental population regulations, is provided by cooperating State and Federal agencies under cooperative agreement. However, some of the information collected by the Service under the experimental population rules is provided by the public.

The collected information can be separated into three categories; general take or removal, depredation related take, and specimen collection. General take or removal information refers to human related mortality including unintentional taking incidental to otherwise lawful activities (e.g. highway mortalities), take in defense of human life, take related to defense of property (if authorized) or take in the form of authorized harassment. Most contacts related to this type of information collection are in regard to sightings of experimental animals, or the inadvertent discovery of an injured or dead individual. Depredation related take refers to the reporting of take for management purposes, where livestock depredation has been documented or may include authorized harassment or lethal take of experimental animals in the act of attacking livestock. The information collection required by the rules for this type of take include the necessary follow-up reports after the Service has authorized harassment or lethal take of experimental animals in relation to confirmed instances of livestock depredation or in defense of human life. Specimen collection is for the purpose of documenting incidental or authorized scientific collection. Most of the information collection requirement for this take pertains primarily to the reporting of sightings of experimental population animals or the inadvertent discovery of an injured or dead individual. Information collection is required for necessary follow-up reports when the Service has authorized take of experimental animals for specimen collection.

The standard information collection includes the name, address, and phone number of the reporting party, location and time of the reported incident, species of experimental population involved. Reporting parties include, but are not limited to, individuals or households, farms, businesses, and other non-profit organizations. The reporting of specimen collections, recovery, or even the reporting of dead individuals from experimental populations is important to the Service's efforts in monitoring these individuals and for other scientific purposes.

Because the number of reports generated annually by the general public (rather than cooperating agencies or separately permitted individuals) under these rules is extremely small (far less than one report per year, per rule) and to assure thorough documentation of results, the Service is estimating the number of expected reports to assume a maximum number per year based on allowance for increased population size and public awareness of experimental populations.

The following experimental populations described under Title 50 of the Code of Federal Regulations contain information collection requirements:

50 CFR section	Species (scientific name)	Type of reporting
17.84(c)	Red Wolf (Canis rufus)	Take in defense of human life, incidental take. Take related to livestock depredation.
17.84(g)	Black footed ferret (Mustela nigripes)	Incidental take, specimen collection/reporting.
17.84(h)	Whooping crane (Grus americana)	Specimen collection/reporting.
17.84(i)	Gray wolf (Canis lupus)	Take in defense of human life, incidental take. Take related to livestock depredation.
17.84(j)	California condors (Gymnogyps californianus)	Specimen collection/reporting, incidental take.
Proposed rules: 17.84(l) (62 FR 35762)	Grizzly bear (Ursus horribilis)	Take in defense of human life, incidental take. Take related to livestock depredation.

Title: Endangered and threatened Wildlife, 50 CFR 17.84, Experimental populations.

Description of respondents: private individuals and households, businesses, not-for-profit organizations, and farms.

Bureau form number: N/A.

Frequency of collection: On occasion.

BURDEN ESTIMATES FOR REPORTING REQUIREMENTS FOR EXPERIMENTAL POPULATIONS—ENDANGERED SPECIES

Type of report	Number of respondents	Average time required per report (minutes)	Total Annual burden (hours)
General take or removal [a]	16	15	4
Depredation related take [b]	12	15	3
Specimen collection [c]	16	15	4

[a] General take or removal includes human related mortality including unintentional taking incidental to otherwise lawful activities (e.g. highway mortalities), take in defense of human life, take related to defense of property (if authorized) or take in the form of authorized harassment.
[b] Depredation related take is take for management purposes where livestock depredation has been documented and may include authorized harassment or authorized lethal take of experimental animals in the act of attacking livestock.
[c] Specimen collection, recovery, or reporting of dead individuals from experimental populations for documentation purposes or authorized scientific collection purposes.

The number of expected reports and thus total burden hours is being revised to reflect expected increases due to the growth of existing experimental populations, and to accommodate additional releases of black-footed ferrets (under 50 CFR 17.84(g)) and grizzly bears (under 50 CFR 17.84 (l)) when final rules are published in the near future.

Dated: May 14, 1998.

Richard Hannan,

Acting Assistant Director, Ecological Services.

[FR Doc. 98–16983 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–55–P

DEPARTMENT OF THE INTERIOR

Geological Survey

Request for Public Comments on Proposed Information Collection Submitted to the Office of Management and Budget for Review Under the Paperwork Reduction Act

The proposed information collection described below has been submitted to the Office of Management and Budget for approval under the provisions of the Paperwork Reduction Act (44 U.S.C. Chapter 35). Copies of the proposed collection of information may be obtained by contacting the Bureau's clearance officer at the phone number listed below. OMB has up to 60 days to approve or disapprove the information collection but may respond after 30 days; therefore, public comments should be submitted to OMB within 30 days in order to assure their maximum consideration. Comments and suggestions on the proposal should be made directly to the Desk Officer for the Interior Department, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503 and to the Bureau clearance officer, U.S. Geological Survey, 807 National Center, 12201 Sunrise Valley Drive, Reston, Virginia 20192, (703) 648–7313).

Specific public comments are requested as to:

1. whether the collection of information is necessary for the proper performance of the functions on the bureaus, including whether the information will have practical utility;
2. the accuracy of the bureau's estimate of the burden of the collection of information, including the validity of the methodology and assumptions used:
3. the quality, utility, and clarity of the information to be collected; and
4. how to minimize the burden of the collection of information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other forms of information technology.

Title: Qualify of life in southwestern Colorado and northwestern New Mexico.

OMB Approval Number: New Collection.

Abstract: This study is one part of an integrated study of public knowledge of, preferences for, and responses to tourism and recreation development on the Colorado Plateau. The correlated information is designed to assist Federal, state, and local land and resource managers in their management decisions by providing information about the knowledge, needs, and desires of the affected publics surrounding public lands. Natural resource land managers and county government officials in seven counties, working as partners in this research, ran adjust management practices in response to citizens' knowledge and perceived values. The intended effect is to better inform managers and assist land managers in developing citizen involvement programs. This study is being conducted in partnership with the U.S. Forest Service, Bureau of Land Management, National Park Service, and as part of the Colorado Plateau Ecosystem Partnership Program (CPEPP). This study is part of a peer-reviewed research study plan of the Midcontinent Ecological Science Center in Fort Collins, Colorado and is part of the study plan of the CPEPP.

To build a picture of quality of life on the Colorado Plateau, we will measure the perceptions and preferences for the environment held by diverse residents at several locations in the region. Our objectives are to describe what resident populations perceive as the most salient elements of the region's natural landscapes, ecosystems, and human communities; what would have to be maintained, protected, or restored to attain conditions of community and ecosystem quality that residents desire. The first iteration of this research approach has been conducted by Utah State University for the Utah State Travel Council in partnership with the Canyon Country Partnership. The goal of that study was to help achieve the Travel Council's specific directive to relate tourism planning to local residents' quality of life. For this second iteration, surveys will be administered to a stratified random sample of citizens living in two counties in Colorado (Montezuma, an La Plata) and in San Juan County, New Mexico. The sampling design is being developed in partnership with the combined U.S. Fortes Service and Bureau of Land Management office in Durango, Colorado, and Fort Lewis College.

Respondents will be given 12 exposure, one-time use, 35mm cameras and will be asked to photograph areas of their community that either add to or detract from their quality of life. Respondents will receive complete sets of their photographs, accompanied by a short follow-up, mail survey instrument for the purposes of collecting demographic data and cross-checking the quality of life factors reflected in the photographs.

Bureau Form Number: None.

Frequency: One time.

Description of Respondents: Individuals or households.

Number of respondents: 420.

Burden hours: 1714 hours. (The burden hour estimate is based on a 70% return rate, with an average of 15 minutes to 4 hours to take the photographs and fill out the photo log plus an additional 10 minutes to complete the follow-up questionnaire plus any additional time to travel.) We estimate one-third of the 420 will not use any optional travel time to complete the survey; one-third will take 1 hour, and one-third will use up to 10 hours of optional travel time to complete the survey.

Dated: June 22, 1998.

Dennis B. Fenn,

Chief Biologist.

[FR Doc. 98–17047 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–Y7–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WO–250–18290–24 1A]

Extension of Approved Information Collection, OMB Number 1004–0119

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Bureau of land Management (BLM) announces its intention to request renewal of existing approval to collect certain information for recreation visitors to areas of the public lands, and related waters, where special recreation permits are required. This information allows BLM to authorize requested use, determine appropriate fees, and will also be used to tabulate recreation use data for the annual Federal Recreation Fee Report as required by the Land and Water Conservation Act.

DATES: BLM must receive comments on the proposed information a collection by August 25, 1998, to assure its consideration of them.

ADDRESSES: If you wish to comment, you may submit your comments by one of several methods. You may mail comments to Bureau of land Management, Administrative Record, Room 401LS, 1849 C Street, NW, Washington, DC 20240. You may also comment via the Internet to WOComment@wo.blm.gov. Please submit comments as an ASCII file avoiding the use of special characters and any form of encryption. Please also include ''ATTN: 1004–0119'' and your name and return address in your Internet message. If you do not receive a confirmation from the system that we have received your Internet message, contact at us directly on (202) 452–5030.

Comments, including names and street addresses of respondents, will be available for public review at this address during regular business hours (7:45 a.m.to 4:15 p.m), Eastern Time, Monday through Friday, except holidays.

Finally, you may hand-deliver comments to BLM at 1620 L. Street, NW, Room 401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Shirlean Beshir, Regulatory Affairs Group (WO–630), Bureau of land Management, Mail Stop 402LS, 1849 C Street, NW, Washington, DC 20240; telephone (202) 452–5033 (Commercial or FTS).

SUPPLEMENTARY INFORMATION: In accordance with 5 CFR 1320.12(a), BLM is required to provide 60-day notice in the **Federal Register** concerning a collection of information contained in BLM Form 8370–1. BLM will receive and analyze any comments sent in response to this notice and include them with its request for approval from the OMB under 44 U.S.C. 3501 *et seq.* We specifically request your comments on: (a) Whether the proposed collection of information is necessary for the pro per performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of collecting the information, including he validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of collecting the information, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Respondents supply identifying information and data on proposed commercial, competitive, or individual recreational use, respectively, when required, to determine eligibility for a permit. This information allows the BLM to authorize requested use, determine appropriate fees, and will also be used to tabulate recreation use data for the annual Federal Recreation Fee Report as required by the Land and Water Conservation Act.

Based on BLM's experience administering the activities descried above, the public reporting burden for the information collected is estimated to average about 27 minutes per response. The respondents are recreation visitors to areas of the public lands, an related waters, where special recreation permits are required. The frequency of response is on occasion. The number of responses per year is estimated to total 18,000. The estimated total annual burden on new respondents is bout 8,100 hours. BLM is specifically requesting your comments on its estimate of the amount of time that it takes to prepare a response.

BLM will summarize all responses to this notice and include them in the request for Office of Management and Budget approval. All comments will also become a matter of public record.

Dated: June 19, 1998.

Carole Smith,

Bureau of Land Management Clearance Officer.

[FR Doc. 98–16995 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–84–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[WO–130–1820–00–241A]

Extension of Approved Information Collection, OMB Number 1004–0133

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, the Bureau of Land Management (BLM) announces its intention to request renewal of existing approval to collect certain information for individuals desiring to use the campground. This information allows BLM to determine if all users have paid the required fee, the umber of users, and their State of origin.

DATES: BLM must receive comments on the proposed information collection by August 25, 1998, to assure its consideration of them.

ADDRESSES: If you wish to comment, you may submit your comments by one of several methods. You may mail comments to Bureau of Land Management, Administrative Record, Room 401LS, 1849 C Street, NW, Washington, DC 20240. You may also comment via the Internet to WOComment@wo.blm.gov. Please submit comments as an ASCII file avoiding the use of special characters and any form of encryption. Please also include ''ATTN: 1004–0133'' and your name and return address in your Internet message. If you do not receive a confirmation from the system that we

have received your Internet message, contact us directly on (202) 452–5030.

Comments, including names and street addresses of respondents, will be available for public review at this address during regular business hours (7:45 a.m. to 4:15 p.m.), Eastern Time, Monday through Friday, except holidays.

Finally, you may hand-deliver comments to BLM at 1620 L Street, NW, Room 401, Washington, DC.

FOR FURTHER INFORMATION CONTACT: Shirlean Beshir, Regulatory Affairs Group (WO–630), Bureau of Land Management, Mail Stop 401LS, 1849 C Street, NW, Washington, DC 20240; telephone (202) 452–5033 (Commercial or FTS).

SUPPLEMENTARY INFORMATION: In accordance with 5 CFR 1320.12(a), BLM is required to provide 60-day notice in the **Federal Register** concerning a collection of information contained in BLM Form 1370–36. BLM will receive and analyze any comments sent in response to this notice and include them with its request for approval from the OMB under 44 U.S.C. 3501 *et seq.* We specifically request your comments on: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility; (b) the accuracy of the agency's estimate of the burden of collecting the information, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information to be collected; and (d) ways to minimize the burden of collecting the information, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.

Respondents supply identifying information and data on the campsite number, data camping, number in party, ZIP Code, fee paid, vehicle license number, and primary purpose of visit. This information allows the BLM to determine if all users have paid the required fee, the number of users, and their State or origin.

Based on BLM's experience administering the activities described above, the public reporting burden for the information collected is estimated to average about 3 minutes per response. The respondents are individuals desiring to use the campground. The frequency of response is occasionally. The number of responses per year is estimated to total 108,000. The estimated total annual burden on new respondents is about 5,400 hours. BLM is specifically requesting your comments on its estimate of the amount of time that it takes to prepare a response.

BLM will summarize all responses to this notice and include them in the request for Office of Management and Budget approval. All comments will also become a matter of public record.

Dated: June 18, 1998.

Carole Smith,

Bureau of Land Management Clearance Officer.

[FR Doc. 98–16996 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–84–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[OR–050–1150–04: GP8–0196]

Closure of Public Lands; Oregon

AGENCY: Prineville District, Deschutes Resource Area, Interior.

SUMMARY: Notice is hereby given that, effective immediately, the area described below is closed to motor vehicle use.

EFFECTIVE DATE: June 16, 1998.

LEGAL DESCRIPTION: This closure applies to the area located in Township 15 South, Range 13 East, Section 15, Northeast quarter; Section 15, Northeast quarter of the Southeast quarter; Section 15, Lots 3 and 7. The area comprises 254.80 acres. The property is located south of antler Ave. and east of SE 9th Street.

The purpose of this closure is to deter the illegal dumping of trash and to minimize the public health risks associated with this activity. The extensive problem of illegal dumping in this area was recognized by the State Department of Environmental Quality as a hazard to public health. The Bureau of Land Management and Deschutes County have recently completed a major effort, at considerable expense, to remove trash and debris that has accumulated at the site. Deschutes County proposes to fence the perimeter of the property to curtail the continued dumping on the property. The tract is expected to be conveyed to Deschutes County by land exchange in 1998. The authority for this closure is 43 CFR 8364.1: Closure and Restriction Orders.

FOR FURTHER INFORMATION CONTACT: Philip Paterno, Realty Specialist, BLM Prineville District, PO Box 550, Prineville, Oregon 97754, telephone 541–416–6724.

Violation of this closure order is punishable by a fine not to exceed $1,000 and/or imprisonment not to exceed 12 months as provided in 43 CFR 8360.0–7.

Dated: June 16, 1998.

Shaaron Netherton,

Acting District Manager.

[FR Doc. 98–17029 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–33–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AZA 28631]

Notice of Availability of Final Environmental Impact Statement and Record of Decision for the Proposed Leach Facility Expansion Project, Cyprus Miami Mining Corporation, Miami, Arizona

AGENCY: Bureau of Land Management, Interior

ACTION: Notice of Availability, Final Environmental Impact Statement (FEIS) and Record of Decision (ROD).

SUMMARY: The Bureau of Land Management (BLM) Arizona State Office and Phoenix Field Offices (PFO), jointly with the Tonto National Forest, have prepared an Environmental Impact Statement (EIS) in response to a Mine Plan of Operations (MPO) filed by Cyprus Miami Mining Corporation (CMMC). The EIS was prepared in compliance with the Federal Land Policy and Management Act of 1976, as amended, 43 CFR 3809, and Section 102(2)(c) of the National Environmental Policy Act of 1969. The proposed action involves development of three leach pad facilities, one waste rock disposal site and associated facilities including access and utility corridors. This action will affect 350 acres administered by the BLM, PFO along with 420 acres of Tonto National Forest. Based on 57 comments received on the Draft EIS issued in April 1997, the agencies have prepared an abbreviated Final EIS. The Final EIS is to be read in conjunction with the Draft EIS. The agencies selected Alternative A—Modified Development Sequence to the Proposed Action—as the preferred alternative. The Final EIS is now available to the public as is the Record of Decision (ROD).

The ROD is issued as a separate document prepared and signed jointly by the BLM and Tonto National Forest. Filing the FEIS with EPA completes the environmental documentation process. Publication of the ROD through this NOA constitutes public notice of the decision. The BLM decision may be appealed to the Interior Board of Land

Appeals (IBLA), Office of the Secretary, in accordance with the regulations contained in 43 CFR Part 4 (see information below).

FOR FURTHER INFORMATION CONTACT: Copies of the Final EIS and ROD may be requested from: Shela McFarlin, Project Manager, BLM, Arizona State Office, 222 North Central, Phoenix, AZ 85004, or telephone (602) 417–9568. For information on the Tonto National Forest lands decision or appeal process, contact Paul Stewart, Tonto National Forest, 2324 East McDowell Road, Phoenix, AZ 85006 or telephone (602) 225–5200. Copies of the Final EIS are available for public use/review at the above offices and these additional locations: BLM, Phoenix Field Office, 2015 West Deer Valley Road, Phoenix, AZ 85027; Globe Ranger District, Six Shooter Canyon, Globe, AZ 85501; Cyprus Miami Mining Corporation Land Department 4342 East U.S. Highway 60/70, Claypool, AZ 85532; Mesa Public Library 64 East 1st Street, Mesa, AZ 85201; Globe Public Library, 339 South Broad, Globe, AZ 85501; Miami Memorial Library, 1052 Adonis Avenue, Miami, AZ 85539; and Arizona State University, Hayden Library, Government Documents, Tempe, AZ 85287–1006.

DATES AND APPEAL INFORMATION: If you choose to appeal BLM's decision, your notice of appeal must be filed in this office (BLM, Arizona State Office, 222 North Central Avenue, Phoenix, AZ 85004) within 30 days from this NOA. The appellant has the burden of showing that the decision appealed from is in error. If you wish to file a petition for a stay of the effectiveness of this decision, pursuant to regulation 43 CFR 4.21, during the time that your appeal is being reviewed by the IBLA, the petition for stay must accompany your notice of appeal. A petition for a stay is required to show sufficient justification based on the standards listed below. Copies of the notice of appeal and petition for a stay must also be submitted to each party named in this decision, the IBLA, and to the appropriate Office of the Solicitor (see 43 CFR 4.413) at the same time the original documents are filed with this office.

The Standards for Obtaining a Stay. Except as otherwise provided by law or other pertinent regulation, a petition for a stay of a decision pending appeal shall show sufficient justification based on the following standards:

(1) The relative harm to the parties if the stay is granted or denied;

(2) The likelihood of the appellant's success on the merits;

(3) The likelihood of immediate and irreparable harm if the stay is not granted; and,

(4) Whether the public interest favors granting the stay.

Dated: June 18, 1998.

Gary Bauer,

Associate State Director, Arizona.

[FR Doc. 98–16734 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–32–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–010–07–1020–00–241A]

Northwest Colorado Resource Advisory Council Meeting

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of meeting.

SUMMARY: The next meeting of the Northwest Colorado Resource Advisory Council will be held on Thursday and Friday, July 16–17, at the Wattenberg Community Center, Walden, Colorado.

DATES: Thursday, July 16, and Friday, July 17, 1998.

ADDRESSES: For further information, contact Joann Graham, Bureau of Land Management (BLM), Grand Junction District Office, 2815 H Road, Grand Junction, Colorado 81506; Telephone (970) 244–3037.

SUPPLEMENTARY INFORMATION: The Northwest Resource Advisory Council will meet on Thursday, July 16 and Thursday July 17, 1998, at the Wattenberg Community Center in Walden, Colorado. The Wattenberg Community Center is located on State Highway 125 approximately 1 mile northeast of Walden near the airport.

The two-day meeting will begin at 1:00 p.m. on Thursday, July 16 at the Wattenberg Center. On July 17, a morning meeting at the Wattenberg Center will begin at 7:30 a.m. and will be followed by a field trip to North Sand Hills. The field trip should conclude by 1:30 p.m. on Friday at which time the Council will adjourn. Agenda items include discussions on the roadless area review, proposed statewide recreation guidelines, and subcommittee reports.

The meeting is open to the public. Interested persons may make oral statements at the meetings or submit written statements following the meeting. Per-person time limits for oral statements may be set to allow all interested persons an opportunity to speak.

Summary minutes of council meetings are maintained in both the Grand Junction and Craig District Offices. They are available for public inspection and reproduction during regular business hours within thirty (30) days following the meeting.

Dated: June 12, 1998.

Mark T. Morse,

District Manager, Craig and Grand Junction Districts.

[FR Doc. 98–16998 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–050–1040–00]

Front Range Resource Advisory Council (Colorado) Meeting

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice of meeting.

SUMMARY: In accordance with the Federal Advisory Committee Act of 1972 (FACA), 5 U.S.C. Appendix, notice is hereby given that the next meeting of the Front Range Resource Advisory Council (Colorado) will be held on July 13, 1998 in Salida, Colorado.

The meeting is scheduled to begin at 9 a.m. at the Chaffee County Fairgrounds, 10165 County Road 120, Salida, Colorado. RAC members will tour the Badger Creek Ecosystem Management Area. As part of the tour they will also review and comment on the latest Draft of the Colorado Recreation Guidelines. They will return to the Fairgrounds by 4 p.m. to adjourn.

All Resource Advisory Council meetings are open to the public, however anyone wanting to go on the tour may need to provide their own transportation.

Interested persons may make oral statements to the Council at 9:15 a.m. or written statements may be submitted for the Council's consideration. The District Manager may limit the length of oral presentations depending on the number of people wishing to speak.

DATES: The meeting is scheduled for Monday, July 13, 1998 from 9 a.m. to 4 p.m.

ADDRESS: Bureau of Land Management (BLM), Canon City District Office, 3170 East Main Street, Canon City Colorado 81212; Telephone (719) 269–8500; TDD (719) 269–8597.

FOR FURTHER INFORMATION CONTACT: Ken Smith at (719) 269-8553.

SUPPLEMENTARY INFORMATION: Summary minutes for the Council meeting will be maintained in the Canon City District Office and will be available for public

inspection and reproduction during regular business hours within thirty (30) days following the meeting.

Stuart L. Freer,

Associate District Manager.

[FR Doc. 98–17124 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[MT–922–08–1310–00–P; MTM 82796]

Notice of Proposed Reinstatement of Terminated Oil and Gas Lease

Under the provisions of Pub. L. 97–451, a petition for reinstatement of oil and gas lease MTM 82796, Richland County, Montana, was timely filed and accompanied by the required rental accruing from the date of termination.

No valid lease has been issued affecting the lands. The lessee has agreed to new lease terms for rentals and royalties at rates of $10 per acre and 16–⅔% respectively. Payment of a $500 administration fee has been made.

Having met all the requirements for reinstatement of the lease as set out in Sec. 31(d) and (e) of the Mineral Lands Leasing Act of 1920 (30 U.S.C. 188), the Bureau of Land Management is proposing to reinstate the lease, effective as of the date of termination, subject to the original terms and conditions of the lease, the increased rental and royalty rates cited above, and reimbursement for cost of publication of this Notice.

Dated: June 12, 1998.

Karen L. Johnson,

Chief, Fluids Adjudication Unit.

[FR Doc. 98–16991 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–DN–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NM–932–1310–01; OKNM 84747]

Notice of Proposed Reinstatement of Terminated Oil and Gas Lease; New Mexico

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: Under the provisions of Pub. L. 97–451, a petition for reinstatement of Oil and Gas Lease OKNM 84747, for lands in Roger Mills County, Oklahoma, was timely filed and was accompanied by all required rentals and royalties accruing from April 7, 1998, the date of termination. No valid lease has been issued affecting the lands. The lessee has agreed to new lease terms for rentals and royalties at rates of $10.00 per acre and 16⅔ percent, respectively. The lessee has paid the required $500.00 administrative fee and has reimbursed the Bureau of Land Management for the cost of this **Federal Register** notice.

The lessee has met all the requirements for reinstatement of the lease as set out in Section 31(d) and (e) of the Mineral Leasing Act of 1920, as amended (30 U.S.C. 188), and the Bureau of Land Management is proposing to reinstate the lease effective April 7, 1998, subject to the original terms and conditions of the lease and the increased rental and royalty rates cited above.

FOR FURTHER INFORMATION CONTACT: Angela Trujillo, BLM, New Mexico State Office, (505) 438–7592.

Dated: June 17, 1998.

Angela Trujillo,

Land Law Examiner, Fluids Adjudication Team.

[FR Doc. 98–17025 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–FB–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

(MT–930–1430–01; MTM 40641)

Public Land Order No. 7346; Partial Revocation of Executive Order Dated July 9, 1910; Montana

AGENCY: Bureau of Land Management, Interior.

ACTION: Public Land Order.

SUMMARY: This order partially revokes an Executive order insofar as it affects approximately 310 acres of National Forest System land withdrawn for the Bureau of Land Management's Coal Reserve Montana No. 1. The land is no longer needed for the purpose for which it was withdrawn. The revocation is needed to permit disposal of the land through a Forest Service exchange. The land has been open to metalliferous mining and mineral leasing under the withdrawal, but is temporarily closed to surface entry and mining, by the Forest Service exchange proposal.

EFFECTIVE DATE: July 13, 1998.

FOR FURTHER INFORMATION CONTACT: Sandra Ward, BLM Montana State Office, P.O. Box 36800, Billings, Montana 59107, 406–255–2949.

By virtue of the authority vested in the Secretary of the Interior by Section 204 of the Federal Land Policy and Management Act of 1976, 43 U.S.C. 1714 (1994), it is ordered as follows:

1. Executive Order dated July 9, 1910, which withdrew public lands for the Bureau of Land Management's Coal Reserve Montana No. 1, is hereby revoked insofar as it affects the following described land:

Principal Meridian, Montana

T. 6 S., R. 2 E.,
Sec. 26, W½E½NE¼NE¼,
W½NE¼NE¼NE¼, NW¼NE¼NE¼,
N½SW¼NE¼NE¼, N½S½SW¼NE¼,
W½NE¼SE¼NE¼NE¼, NW¼SE¼NE¼NE¼,
NW¼SW¼SE¼NE¼NE¼, N½NW¼NE¼,
N½S½NW¼NE¼, S½SW¼NW¼NE¼,
N½S½SE¼NW¼NE¼,
SW¼SW¼SE¼NW¼NE¼,
NE¼NE¼NW¼SW¼NE¼,
W½E½NW¼SW¼NE¼, W½NW¼SW¼NE¼,
NW¼NE¼SW¼SW¼NE¼, and
N½NW¼SW¼SW¼NE¼.

The area described contains approximately 310 acres in Madison County.

2. At 9 a.m. on July 13, 1998, the above described land will be relieved of the segregative effects of Coal Reserve Montana No. 1 and will be open to such forms of disposition as may by law be made of National Forest System lands, subject to valid existing rights, the provisions of existing withdrawals, other segregations of record, and the requirements of applicable law.

Dated: June 18, 1998.

Bob Armstrong,

Assistant Secretary of the Interior.

[FR Doc. 98–17087 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–DN–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–016–1430–00, COC61284]

Notice of Realty Action; Recreation and Public Purposes (R&PP) Act Classification and Application for Recreation Site Lease, COC61284; Colorado

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The following public land in Moffat County, Colorado have been examined and found suitable for classification for lease only under the provisions of the Recreation and Public Purposes Act, as amended (43 U.S.C. 869 *et seq.*). The purpose of the classification and application for R&PP lease is to allow recreational development on the public land by the Colorado Division of Parks and Outdoor Recreation (CDPOR) for use as

recreation sites primarily for river access for boaters.

Sixth Principal Meridian

T.5N., R. 93W., sec. 6, a metes and bounds description located in the northeast portion of Lot 8, containing approximately 3 acres; and
T.6N., R. 97W., sec. 7, a metes and bounds description located in the southeast portion of Lot 21 and the northeast portion of lot 22.

Containing approximately 2 acres.

Maps depicting the actual locations of the sites are available at this office. Leasing the land for recreation purposes is consistent with current BLM land use plans and would be in the public interest. Although the lands are withdraw for water power resources, leasing the lands for recreation purposes will not interfere with the intent of the withdrawals or future water projects.

If issued, the lease would be subject to valid existing rights and the following conditions:

1. The lease would terminate upon notice that construction of a reservoir or hydroelectric development will commence.

2. The lessee will remove, at their expense, all structures or improvements to eliminate interference with the reservoir or hydroelectric development.

FOR FURTHER INFORMATION CONTACT: Craig Haynes, Little Snake Resource Area Office, 455 Emerson Street, Craig, Colorado, 81625–1129, (970) 826–5000.

SUPPLEMENTARY INFORMATION: Upon publication of this notice in the **Federal Register,** the lands will be segregated from all other forms of appropriation under the public land laws, including the general mining laws, except for lease only under the R&PP Act. For a period of 45 days from the date of publication of this notice, interested parties may submit comments regarding the proposed lease or classification to the Little Snake Resource Area Manager, 455 Emerson Street, Craig, CO 81625–1129.

Classificaiton Comments: Interested parties may submit comments involving the suitability of the land for recreational purposes for river access sites. Comments on the classification are restricted to whether the land is physically suited for the proposal, whether the use will maximize the future use or uses of the land, whether the use is consistent with local planning and zoning, or if the use is consistent with State and Federal programs.

Application Comments: Interested parties may submit comments regarding the specific use proposed in the application and plan of development, whether the BLM followed proper administrative procedures in reaching the decision, or nay other factor not directly related to the suitability of the land for the proposed use. Any adverse comment will be reviewed by the State Director. In the absence of any adverse comments, the classification will become effective 60 days from the date of publication of this notice in the **Federal Register.**

Dated: June 17, 1998.

Robert W. Schneider,

Associate District Manager,

[FR Doc. 98–16997 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–JB–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–076–1492–00–241A]

Notice of Intent To Amend the Grand Junction Resource Management Plan

AGENCY: Bureau of Land Management, Department of Interior.

ACTION: Notice of intent to amend the Grand Junction Resource Area Resource Management Plan, 1987.

SUMMARY: Pursuant to section 102 of the National Environmental Policy Act of 1969 and section 202 of the Federal Land Policy and Management Act of 1976, the Bureau of Land Management, Grand Junction Resource Area, is proposing to amend the Grand Junction Resource Management Plan, approved in January 1987. The amendment will consider a mineral withdrawal in the Unaweep Seep/West Creek area. The effect of this change will be analyzed in an environmental assessment (EA). The amendment is being developed in concert with a revision of the Unaweep Seep Natural Area Management Plan.

FOR FURTHER INFORMATION CONTACT: Bruce Fowler, Grand Junction Resource Area, (970) 244–3036.

SUPPLEMENTARY INFORMATION: The affected area includes approximately 1440 acres of public land in Mesa County located about 6 miles northeast of Gateway, Colorado. The lands include the Unaweep Seep Research Natural Area and portions of West Creek and the North Fork of West Creek.

Mark Morse,

District Manager.

[FR Doc. 98–16992 Filed 6–26–98; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AZ–952–08–1420–00]

Arizona; Filing of Plats of Survey

June 17, 1998.

1. The plats of survey of the following described lands were officially filed in the Arizona State Office, Phoenix, Arizona, on the dates indicated:

A plat, in four sheets, representing the dependent resurvey of a portion of the west boundary and the subdivisional lines; and the subdivision of Sections 5, 8, and 18, and metes-and-bounds surveys in Sections 3, 5, 7, 8, 9, 17, and 18, Township 20 North, Range 27 East, Gila and Salt River Meridian, Arizona, was accepted April 13, 1998, and was officially filed April 24, 1998.

This plat was prepared at the request of the Navajo-Hopi Relocation Commission.

A supplemental plat showing amended lotting necessary to correct lotting shown on sheets 1 and 3, in section 7, Township 20 North, Range 27 East, Gila and Salt River Meridian, Arizona, was accepted May 6, 1998, and was officially filed May 14, 1998.

This plat was prepared at the request of the Bureau of Land Management, Arizona State Office.

A plat representing the dependent resurvey of a portion of the First Standard Parallel South through Range 1 East, and a portion of the subdivisional lines, and the metes-and-bounds survey of the South Maricopa Mountains Wilderness Area Boundary, Township 5 South, Range 1 East, Gila and Salt River Meridian, Arizona, was accepted May 11, 1998, and was officially filed May 22, 1998.

This plat was prepared at the request of the Bureau of Land Management, Phoenix Field Office.

A plat representing the dependent resurvey of a portion of the subdivisional lines, and the subdivision of section 7, Township 6 South, Range 1 East, Gila and Salt River Meridian, Arizona, was accepted May 11, 1998, and was officially filed May 22, 1998.

This plat was prepared at the request of the Bureau of Land Management, hoenix Field Office.

A plat representing the dependent resurvey of a portion of the south boundary and a portion of the subdivisional lines; and the subdivision of section 34, Township 6 South, Range 17 East, Gila and Salt River Meridian, Arizona, was accepted April 8, 1998, and was officially filed April 17, 1998.

This plat was prepared at the request of the Bureau of Land Management, Safford Field Office.

A plat representing the dependent resurvey of a portion of the north boundary and a portion of the subdivisional lines; and the subdivision of sections 3, 4, and 9, Township 24 South, Range 22 East, Gila and Salt River Meridian, Arizona, was accepted March 13, 1998, and was officially filed March 26, 1998.

This plat was prepared at the request of the Bureau of Land Management, Safford Field Office.

A plat, in 4 sheets, representing the dependent resurvey of a portion of the Principal Meridian through Township 5 South, and a portion of the subdivisional lines; and the metes-and-bounds survey of the South Maricopa Mountains Wilderness Area Boundary, Township 5 South, Range 1 West, Gila and Salt River Meridian, Arizona, was accepted March 31, 1998, and was officially filed April 10, 1998.

This plat was prepared at the request of the Bureau of Land Management, Phoenix Field Office.

A plat, in 2 sheets, representing the dependent resurvey of a portion of the Principal Meridian through Township 6 South, and a portion of the south boundary; and the metes-and-bounds survey of the South Maricopa Mountains Wilderness Area Boundary, Township 6 South, Range 1 West, Gila and Salt River Meridian, Arizona, was acceptedMay 11, 1998, and was officially filed May 22, 1998.

This plat was prepared at the request of the Bureau of Land Management, hoenix Field Office.

A plat representing the dependent resurvey of a portion of the Principal Meridian through Township 7 South, and a portion of the subdivisional lines; and the metes-and-bounds survey of the South Maricopa Mountains Wilderness Area Boundary, Township 7 South, Range 1 West, Gila and Salt River Meridian, Arizona, was accepted May 11, 1998, and was officially filed May 22, 1998.

This plat was prepared as the request of the Bureau of Land Management, Phoenix Field Office.

A plat, in 2 sheets, representing the dependent resurvey of a portion of the subdivisional lines, and the subdivision of sections 19 and 20, Township 5 South, Range 2 West, Gila and Salt River Meridian, Arizona, was accepted March 30, 1998, and was officially filed April 10, 1998.

This plat was prepared at the request of the Bureau of Land Management, Phoenix Field Office.

A plat, in 2 sheets, representing the dependent resurvey of a portion of the First Standard Parallel South through Range 2 West, and a portion of the west boundary; the survey of a portion of the east boundary, and the metes-and-bounds survey of the South Maricopa Mountains Wilderness Area Boundary, Township 6 South, Range 2 West, Gila and Salt River Meridian, Arizona, was accepted May 11, 1998, and was officially filed May 22, 1998.

This plat was prepared at the request of the Bureau of Land Management, Phoenix Field Office.

A plat representing the dependent resurvey of a portion of the east boundary, and the metes-and-bounds survey of the South Maricopa Mountains Wilderness Area Boundary, Township 5 South, Range 3 West, Gila and Salt River Meridian, Arizona, was accepted March 30, 1998, and was officially filed April 10, 1998.

This plat was prepared at the request of the Bureau of Land Management, Phoenix Field Office.

A supplemental plat showing amended tracts in sections 25, 26, and 31, necessary to correct the duplication of tract numbers in Township 8 South, Range 19 West, Gila and Salt River Meridian, Arizona, was accepted June 1, 1998, and was officially filed June 5, 1998.

This plat was prepared at the request of the Bureau of Land Management, Arizona State Office.

A supplemental plat showing an amended tract in section 6 necessary to correct the duplication of tract numbers in Township 8 South, Range 20 West, Gila and Salt River Meridian, Arizona, was accepted June 1, 1998, and was officially filed June 5, 1998.

This plat was prepared at the request of the Bureau of Land Management, Arizona State Office.

2. These plats will immediately become the basic records for describing the land for all authorized purposes. These plats have been placed in the open files and are available to the public for information only.

3. All inquiries relating to these lands should be sent to the Arizona State Office, Bureau of Land Management, 222 N. Central Avenue, P.O. Box 1552, Phoenix, Arizona 85001–1552.

Kenny D. Ravnikar,

Chief Cadastral Surveyor of Arizona

[FR Doc. 98–17009 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–32–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[CO–956–98–1420–00]

Colorado: Filing of Plats of Survey

June 17, 1998.

The plats of survey of the following described land will be officially filed in the Colorado State Office, Bureau of Land Management, Lakewood, Colorado, effective 10 am., June 17, 1998. All inquiries should be sent to the Colorado State Office, Bureau of Land Management, 2850 Youngfield Street, Lakewood, Colorado 80215–7093.

The plat representing the dependent resurvey of portions of the south boundary T. 10 S., R. 76 W., (Second Standard Parallel South), a portion of the subdivisional lines, and the subdivision of certain sections, T. 10 S., R. 76 W., Sixth Principal Meridian, Colorado, Group 1150, was accepted May 12, 1998.

The plat representing the dependent resurvey of portions of the east boundary T. 11 S., R. 76 W., a portion of the subdivisional lines, and the subdivision of certain sections, T. 11 S., R. 76 W., Sixth Principal Meridian, Colorado, Group 1150, was accepted May 12, 1998.

These surveys were requested by the State of Colorado for administrative purposes.

The plat representing the dependent resurvey of a portion of the subdivisional lines and the metes-and-bounds surveys of Tracts 37 and 38 in sections 21 and 22, T. 42 N., R. 4 E., New Mexico Principal Meridian, Colorado, Group 1178, was accepted June 9, 1998.

The plat (in two sheets) representing a dependent resurvey of portions of the subdivisional lines and certain mineral claims, the metes-and-bounds survey of public land tract 52 in section 27 and public land tract 53 in section 22, and the entire survey record of a metes-and-bounds survey in the northeast quarter of section 28, Township 42 North, Range 9 West, New Mexico Principal Meridian, Colorado, Group 1181, was accepted May 26, 1998.

These surveys were requested by the Forest Service for administrative purposes.

The plat representing the entire survey record of the dependent resurvey of the 38th mile of the boundary between the states of Colorado and Wyoming through T. 12 N., R. 66 W., Sixth Principal Meridian, Colorado, Group 1194, was accepted May 18, 1998.

The plat representing the entire survey record of the dependent resurvey of the 45th mile of the boundary between the states of Colorado and Wyoming through T. 12 N., R. 67 W., Sixth Principal Meridian, Colorado, Group 1194, was accepted May 18, 1998.

These surveys were requested by the Colorado Department of Transportation for administrative purposes.

The plat representing the dependent resurvey of portions of the First Correction Line North, (south boundary), the line between sections 35 and 36, and the restoration of a portion of the metes-and-bounds survey of School Section 36 in Township 5 North, Range 92 West, Sixth Principal Meridian, Colorado, Group 1058, was accepted June 10, 1998.

The plat (in six sheets) representing the dependent resurvey of portions of the First Standard Parallel North, east boundary, west boundary, subdivisional lines and certain tract lines, and the subdivision of certain sections in Township 5 North, Range 91 West, Sixth Principal Meridian, Colorado, Group 1058, was accepted June 10, 1998.

The plat representing the entire record of the dependent resurvey of a portion of the subdivisional lines in sections 5 and 8 and a portion of Tract 39, Township 2 South, Range 82 West, Sixth Principal Meridian, Colorado, Group 1169, was accepted May 28, 1998.

The plat representing the entire survey record of the dependent resurvey of portions of the boundaries of M.S. 2468, Kendall Mountain Placer, and M.S. 15314, The Lackawanna Placer, and the survey of Tracts 39 and 40, Township 41 North, Range 7 West, New Mexico Principal Meridian, Colorado, Group 1164, was accepted May 14, 1998.

The plat representing the dependent resurvey of a portion of the subdivisional lines and the subdivision of certain sections in Township 10 North, Range 91 West, Sixth Principal Meridian, Colorado, Group 1143, was accepted May 13, 1998.

The supplemental plat creating new lots Z and AA from original lot C by projecting line 3–4 of Mineral Survey No. 17952, Silverton Cemetery, northeasterly to an intersection with the north and south center line of Tract 38, T. 41 N., R. 7 W., New Mexico Principal Meridian, Colorado, was accepted May 14, 1998.

These plats were requested by BLM for administrative purposes.

Carl F. Nagy,

Acting Chief Cadastral Surveyor for Colorado.

[FR Doc. 98–16994 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–JB–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[OR–990–0777–68; GP8–0221; OR–54087]

Proposed Withdrawal and Opportunity for Public Meeting; Oregon

AGENCY: Bureau of Land Management, Interior.

ACTION: Notice.

SUMMARY: The Bureau of Land Management proposes to withdraw 80 acres of public land to protect the vegetative material to be planted at the Desert Springs Seed Orchard, the proposed investment of federal funds, and related facilities at the site. Jurisdiction over this parcel will be transferred from the Bureau of Land Management to the U.S. Forest Service. This notice closes the land for up to 2 years from surface entry and mining. The land has been and will remain open to mineral leasing.

EFFECTIVE DATE: Comments and requests for a public meeting must be received by September 24, 1998.

ADDRESSES: Comments and meeting requests should be sent to the Oregon/Washington State Director, BLM, P.O. Box 2965, Portland, Oregon 97208–2965.

FOR FURTHER INFORMATION CONTACT: Charles R. Roy, BLM Oregon/Washington State Office, 503–952–6189.

SUPPLEMENTARY INFORMATION: On December 12, 1997, the U.S. Forest Service filed an application to withdraw the following described public land from settlement, sale, location, or entry under the general land laws, including the United States mining laws (30 U.S.C. Ch. 2 (1994)), but not from leasing under the mineral leasing laws, subject to valid existing rights:

Willamette Meridian

T. 33 S., R. 18 E.,
Sec. 11, E½SE¼.

The area described contains 80 acres in Lake County.

Administrative jurisdiction over the land will be transferred from the Department of Interior, Bureau of Land Management, to the Department of Agriculture, Forest Service, upon approval of the withdrawal.

The purpose of the proposed withdrawal is to protect the vegetative material to be planted in the orchard, the improvements and facilities, and the future investments of federal funds for the Desert Springs Seed Orchard.

For a period of 90 days from the date of publication of this notice, all persons who wish to submit comments, suggestions, or objections in connection with the proposed withdrawal may present their views in writing to the State Director at the address indicated above.

Notice is hereby given that an opportunity for a public meeting is afforded in connection with the proposed withdrawal. All interested parties who desire a public meeting for the purpose of being heard on the proposed withdrawal must submit a written request to the State Director at the address indicated above within 90 days from the date of publication of this notice. Upon determination by the authorized officer that a public meeting will be held, a notice of the time and place will be published in the **Federal Register** at least 30 days before the scheduled date of the meeting.

The application will be processed in accordance with the regulations set forth in 43 CFR part 2300.

For a period of 2 years from the date of publication of this notice in the **Federal Register**, the land will be segregated as specified above unless the application is denied or canceled or the withdrawal is approved prior to that date. The temporary land uses which may be permitted during this segregative period include licenses, permits, rights-of-way, and disposal of vegetative resources other than under the mining laws.

Dated: June 11, 1998.

Robert D. DeViney, Jr.,

Chief, Branch of Realty and Records Services.

[FR Doc. 98–17040 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–33–P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Approval of Record of Decision; Final Environmental Impact Statement for Ala Kahakai National Trail Study, Hawaii County, Hawaii

SUMMARY: Pursuant to § 102(2)(C) of the National Environmental Policy Act of 1969 (Pub. L. 91–190, as amended), and the regulations promulgated by the Council of Environmental Quality at 40 CFR Part 1505.2, the Department of Interior, National Park Service has prepared and approved a Record of Decision for the Final Environmental Impact Statement for the Ala Kahakai

National Trail Study, Hawaii (FEIS/NTS).

The National Park Service recommends a continuous historic trail management strategy for this trail along and near the coast of Hawaii. This strategy (described as the Proposed Action, Alternative B) and three other alternatives were detailed and analyzed in the Final Environmental Impact Statement issued in April, 1998. The findings in the FEIS/NTS include: (1) the Ala Kahakai meets all three criteria for a national historic trail (as outlined in the National Trails System Act); (2) establishing a continuous trail is physically feasible; (3) local communities, landowners, and native Hawaiians must be involved in planning and implementing the trail, should it be designated by Congress.

The National Park System Advisory Committee has corroborated the national historical significance of the Ala Kahakai. The FEIS/NTS and Record of Decision (ROD) will be transmitted to Congress by the Secretary of the Interior. Copies of the ROD may be obtained from the Superintendent, Pacific Great Basin Support Office, 600 Harrison Street, Suite 600, San Francisco, CA 94107–1372, (415) 427–1438.

Dated: June 15, 1998.

John J. Reynolds,

Regional Director, Pacific West Region.

[FR Doc. 98–17086 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

National Park Servcie

Cuyahoga Valley National Recreation Area

AGENCY: National Park Service, Interior Department.

ACTION: Availability of Plan of Operations for Old Trail School Well #1.

FOR FURTHER INFORMATION CONTACT: Superintendent John P. Debo, Cuyahoga Valley National Recreation Area, 15610 Vaughn Road, Brecksville, Ohio 44141 or call (440) 546–5903.

SUPPLEMENTARY INFORMATION: Notice is hereby given in accordance with § 9.52(b) of Title 36 of the Code of Federal Regulations that the National Park Service has received from Bass Energy Company, Incorporated, a Plan of Operation to drill one oil/gas well in Cuyahoga Valley National Recreation Area, located within Summit County, Ohio.

The Plan of Operations and Environmental Assessment are available for public review and comment for a period of 30 days from the publication date of this notice. The documents can be viewed during normal business hours at the Office of the Superintendent, Cuyahoga Valley National Recreation Area, 15610 Vaughn Road, Brecksville, Ohio. Copies can be requested from the Superintendent, Cuyahoga Valley National Recreation Area, 15610 Vaughn Road, Brecksville, Ohio 44141.

Dated: June 12, 1998.

John P. Debo,

Superintendent, Cuyahoga Valley National Recreation Area.

[FR Doc. 98–16496 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

National Park Service

Final Environmental Impact Statement/ General Management Plan; National Park of American Samoa; Notice of Approval of Record of Decision

SUMMARY: Pursuant to § 102(2)(C) of the National Environmental Policy Act of 1969 (Pub. L. 91–190, as amended) and the regulations promulgated by the Council on Environmental Quality (40 CFR Part 1505.2), the Department of the Interior, National Park Service has prepared and approved a Record of Decision for the Final Environmental Impact Statement/General Management Plan, National Park of American Samoa.

The National Park Service will implement the selected plan (identified as the proposed action in the Final Environmental Impact Statement for the General Management Plan issued in February 1998) as soon as practical. This option and three other alternatives were detailed and analyzed in the Final and Draft Environmental Impact Statements (latter issued in December, 1996).

Copies of the approved Record of Decision may be obtained either from the Superintendent, National Park of American Samoa, Pago Pago, American Samoa 96799, or by phone request at (684) 633–7083; or from the Superintendent, Pacific Islands Support Office, 300 Ala Moana Boulevard, Box 50165, Honolulu, Hawaii 96850, or by phone request at (808) 541–2693.

Dated: June 15, 1998.

Patricia L. Neubacher,

Acting Regional Director, Pacific West Region.

[FR Doc. 98–17085 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

National Park Service

Notice of Availability of the Draft General Management Plan/ Environmental Impact Statement for Sitka National Historical Park

AGENCY: National Park Service, Interior.

ACTION: Notice of Availability of the Draft General Management Plan/ Environmental Impact Statement for Sitka National Historical Park.

SUMMARY: The National Park Service announces the availability of a draft General Management Plan/ Environmental Impact Statement (GMP/EIS) for Sitka National Historical Park, in the City and Borough of Sitka, Alaska. The document describes and analyzes the environmental impacts of a proposed action and two action alternatives for the future management of the park. A no action alternative also is evaluated. This notice announces that public meetings will be held to solicit comments on the draft GMP/EIS.

DATES: There will be a 60-day public review period for comments on this document. Comments on the draft GMP/EIS must be received no later than August 24, 1998. Public meetings will be held in Sitka, Alaska, on July 20, 1998, at 2:00 p.m. and 7:00 p.m. at the Shee Atika Hotel.

ADDRESSES: Comments on the draft GMP/EIS should be submitted to the Superintendent, Sitka National Historical Park, 106 Metlakatla Street, P.O. Box 738, Sitka, Alaska 99835. A limited number of copies of the draft GMP/EIS are available by request from the aforementioned address.

FOR FURTHER INFORMATION CONTACT: Ron Johnson, Job Captain, National Park Service, Denver Service Center. Telephone: (303) 969–2342 FAX: (303) 987–6679.

SUPPLEMENTARY INFORMATION: Pursuant to section 102(2)(C) of the National Environmental Policy Act of 1969 (Pub. L. 91–190, as amended), the National Park Service has prepared a GMP/EIS with proposed guidance for management of Sitka National Historical Park for the next 15–20 years. This document was developed in consultation with The Sitka Tribe of Alaska and the Southeast Alaska Indian Cultural Center.

The draft GMP/EIS describes and analyzes the environmental impacts of a proposed action, two other action alternatives, and a no action alternative. The proposed action, alternative 1, would balance resource management and visitor use. It would improve visitor

access and safety and the accuracy of information available to potential park and city visitors. It also would better protect cultural resources and enhance existing park partnerships. Alternative 2, the no-action alternative, would continue current management direction. Benefits would continue for visitors in information and interpretation, but crowding in the visitor center unit would result in adverse visitor safety conditions. In addition, the uses of adjacent lands would continue to have adverse effects on visual resources and land use. Alternative 3 would emphasize resource preservation. This alternative would increase protection of cultural and natural resources, moderately benefit visual resources and the visitor experience, and improve park administration and operation. Alternative 4 would accommodate more visitors during peak visitation times. It would lead to some improvement in visitor access and circulation in and near the park, improvements in opportunities for information about Sitka attractions, and a better visitor experience.

Dated: June 18, 1998.

Paul R. Anderson,

Regional Director, Alaska.

[FR Doc. 98–17084 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–70–P

DEPARTMENT OF THE INTERIOR

Bureau of Reclamation

Salton Sea Project, Riverside and Imperial Counties, California

AGENCY: Bureau of Reclamation, Interior.

ACTION: Notice of Intent to prepare an Environmental Impact Report (EIR)/ Environmental Impact Statement (EIS) for the improvement of the Salton Sea, California and notice of public scoping meetings.

SUMMARY: Pursuant to the National Environmental Policy Act of 1969, the Bureau of Reclamation (Reclamation) and the Salton Sea Authority (Authority), State of California, in accordance with the California Environmental Quality Act, will be preparing an EIR/EIS document to assess the impacts of alternative solutions for restoring the Salton Sea (Sea) located in Riverside and Imperial Counties, California.

DATES: Written comments on the scoping issues will be accepted until September 30, 1998. Public scoping meetings will be held at the following locations:

July 15, 1998, 5 PM—8 PM, Veterans of Foreign Wars Hall, West Shores Post 3251, 50 Desert Shores Drive, Desert Shores, California.

July 16, 1998, 5 PM—8 PM, Imperial Irrigation District Board Room, 81–600 Avenue 58, La Quinta, California.

July 17, 1998, 10 AM—1 PM, El Centro Board of Supervisors Chambers, 940 Main Street, Suite 212, El Centro, California.

ADDRESSES: Comments should be sent to Bureau of Reclamation, Lower Colorado Region, PO Box 61470, Boulder City, NV, 89006–1470, ATTN: Salton Sea Program Manager or to the Salton Sea Authority, Tom Kirk, Executive Director, 46–209 Oasis Street, 2nd Floor, Indio, CA 92201.

FOR FURTHER INFORMATION CONTACT: Mr. William Steele, Salton Sea Program Manager (Reclamation), at (702) 293–8129; or Mr. Tom Kirk, Salton Sea Authority Executive Director, at (760) 863–7942.

SUPPLEMENTARY INFORMATION: Pub. L. 102–575, 1992, directs the Secretary of the Interior to ''conduct a research project for the development of a method or combination of methods to reduce and control salinity, provide endangered species habitat, enhance fisheries, and protect human recreational values * * * in the area of the Salton Sea * * *'' In addition to this authority, Reclamation and the Authority have entered into an agreement, Salton Sea Planning and Research Program, to jointly study problems associated with the Sea.

The Authority is a public agency formed under the provisions of Articles I and II, Chapter 5, Division 7, Title 1 of the Government Code of the State of California for the purpose of ''directing and coordinating actions relating to improvement of water quality and stabilization of water elevation and to enhance recreational and economic development potential of the Sea and other beneficial uses, recognizing the importance of the Sea for the continuation of the dynamic agricultural economy of Imperial and Riverside Counties.''

The Sea is a hypersaline lake located in a closed basin of the southern California desert; it is the largest body of water within California. The Sea was initially formed in 1905–1907 by flooding on the Colorado River which breached an irrigation control structure allowing virtually the full flow of river water into the Salton Basin. The Sea's current existence is primarily due to agricultural drainage from the Imperial, Coachella, and Mexicali Valleys; smaller volumes of municipal effluent and storm water runoff also flow to the Sea.

The Sea is home to a highly eutrophic ecosystem and a productive sport fishery. The Sea, and wetlands along its shoreline, are a critical part of the Pacific flyway providing seasonal and migratory habitat to millions of birds of varying species. Several endangered species, including the desert pupfish, Yuma clapper rail, brown pelican, peregrine falcon, and bald eagle, inhabit the Sea and/or adjacent habitats.

The Sea ecosystem is under stress. Increasing salinity, currently about 43 parts per thousand, is threatening the reproductive ability of some parts of the biota. Other potential issues include high nutrient loading, heavy metals, DDT residues, and discharges of agricultural chemicals to irrigation drains leading to the Sea. At the scoping meetings, participants will be requested to identify other potentially significant issues as well as potential alternative solutions.

The purpose of the project is to identify a plan that improves the human environment and ecological conditions of the Sea. Based on past studies, various alternatives to control salinity in the Sea have been investigated. These alternatives include diked impoundments, pump-out, a combination of impoundment and pump-out alternatives, and salt removal from inflow to the Sea. Other options may surface during the scoping process. Opportunities to address other environmental issues facing the Sea, including issues related to wildlife resources, will be investigated and considered for implementation as we increase our understanding of the Sea's ecology.

The objective of this effort is to evaluate alternatives (1) capable of maintaining the Sea as a reservoir of agricultural drainage, (2) provide a safe, productive environment for resident and migratory birds and endangered species, (3) restore recreational uses, (4) maintain a viable sport fishery, and (5) identify opportunities for economic development.

The analysis will address the current issues of (1) accumulation and concentration of salts, nutrients, and organic compounds and other constituents, (2) water elevation stabilization, (3) reduced recreational use of the Sea, and (4) reduced ecological values. The environmental document will also address any Indian Trust Assets (ITA) of the Torres-Martinez Desert Cahuilla Indians and assets of any other Tribe(s).

Environmental and engineering baseline data have been collected over

the past several years and the project is now ready to move forward under the CEQA/NEPA process. The Secretary of the Interior has identified this as a high priority project and action is being expedited due to the worsening conditions at the Sea. Over 200,000 birds have died at the Sea over the past six years as a result of the current conditions. Reclamation and the Authority will be working closely with interested Congressional members and other stakeholders to develop possible solutions.

A Research Management Committee (Committee) has been established of high-level managers from the U.S. Department of the Interior, Authority, State of California, and the Torres Martinez Desert Cahuilla Indians. This Committee makes funding and other relevant decisions regarding science to be funded to support the CEQA/NEPA process. A Science Subcommittee (Subcommittee) has been established to serve as an advisory committee to provide scientific evaluations and recommendations to the Committee. The Subcommittee functions as a coordinated body to determine information gaps, identify science/information needs, and provide the Committee with recommendations for funding priorities regarding the science activities.

The draft EIR/EIS is expected to be completed by the end of December 1999.

Dated: June 16, 1998.

LeGrand Neilson,

Acting Regional Director, Lower Colorado Region.

[FR Doc. 98–17022 Filed 6–25–98; 8:45 am]

BILLING CODE 4310–94–P

INTERNATIONAL TRADE COMMISSION

[USITC SE–98–012]

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: United States International Trade Commission.

TIME AND DATE: July 14, 1998 at 11:00 a.m.

PLACE: Room 101, 500 E Street SW., Washington, DC 20436.

STATUS: Open to the public.

MATTERS TO BE CONSIDERED:

1. Agenda for future meeting: none.
2. Minutes.
3. Ratification List.
4. Inv. No. 731–TA–768 (Final) (Fresh Atlantic Salmon from Chile)—briefing and vote.
5. Outstanding action jackets: none.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carried over to the agenda of the following meeting.

Issued: June 22, 1998.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 98–17258 Filed 6–24–98; 12:57 pm]

BILLING CODE 7020–02–P

INTERNATIONAL TRADE COMMISSION

[USITC SE–98–011]

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: United States International Trade Commission.

TIME AND DATE: July 10, 1998 at 11:00 a.m.

PLACE: Room 101, 500 E Street S.W. Washington, DC 20436.

STATUS: Open to the public.

MATTERS TO BE CONSIDERED:

1. Agenda for future meeting: none.
2. Minutes.
3. Ratification List.
4. Inv. Nos. 751–TA–17–20 (Titanium Sponge from Japan, Kazakstan, Russia, and Ukraine)—briefing and vote.
5. Outstanding action jackets: none.

In accordance with Commission policy, subject matter listed above, not disposed of at the scheduled meeting, may be carried over to the agenda of the following meeting.

Issued: June 22, 1998.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 98–17259 Filed 6–24–98; 12:57 pm]

BILLING CODE 7020–02–P

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Under the Comprehensive Environmental Response, Compensation and Liability Act 42 U.S.C. 9601, et seq.

Notice is hereby given that on, June 8, 1998 a proposed Consent Decree (''Decree'') in *United States* v. *Asarco Incorporated, et al.*, Civil Action No. 2:98CVO415B was lodged with the United States District Court for the District of Utah. The United States filed this action pursuant to the Comprehensive Environmental Response, Compensation and Liability Act, as amended (''CERCLA''), 42 U.S.C. 9601, et seq., to recover the past and future response costs incurred at or in connection with the Murray Smelter Site in the City of Murray, Utah.

The proposed Consent Decree resolves claims against: Asarco Incorporated; Murray City Corporation; SALS Investors Partnership; Utah Transit Authority; Monroc Inc.; TB Warehouse L.L.C.; Timothy Buehner; Paul Buehner; Alma Utah Company, Otto Buehner and Company; Buehner Salt Lake Properties,. L.C.; Buehner Corp.; Hi–Ute Investment Company; Murray Land Trust L.C.; W.R. White Company; Ash Grove Cement; and Paragon Properties. This proposed Consent Decree recovers response costs of $109,547.37, and requires Asarco, and the other settling defendants, to implement EPA's selected remedy for the Site. The Decree also settles potential claims against the United States at the Site.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the Decree. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, Washington, D.C. 20530, and should refer to, *United States* v. *Asarco Incorporated, et al.*, Civil Action No. 2: 98CVO415B, and D.J. Ref. #90–11–3–1729.

The Decree may be examined at the United States Department of Justice, Environment and Natural Resources Division, Denver Field Office, 999 18th Street, North Tower Suite 945, Denver, Colorado, 80202 and the U.S.; EPA Region VIII, 999 18th Street, Superfund Records Center, Suite 500, Denver, Co. 80202, and at the Consent Decree Library, 1120 G Street, NW., 4th Floor, Washington, DC 20005, (202) 624–0892. A copy of the Decree may be obtained in person or by mail from the Consent Decree Library, 1120 G Street, NW., 4th Floor, Washington, DC 20005. In requesting a copy, please enclose a check in the amount of $32.00 for the Decree, without attachments (25 cents per page reproduction cost) payable to the Consent Decree Library.

Joel M. Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources, Division.

[FR Doc. 98–17011 Filed 6–25–98; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA)

In accordance with Departmental policy at 28 CFR 50.7, notice is hereby given that on May 29, 1998, a proposed consent decree in *United States* v. *Commercial Metals, Company, et al.,* Civil Action No. 3:98–CV–1265X, was lodged with the United States District Court for the Northern District of Texas, Dallas Division. The proposed Consent Decree resolves the liability of the Settling Defendants under Sections 106 and 107 of CERCLA at the RSR Superfund Site (''Site'') located in Dallas, Texas. Under the terms of the Consent Decree, the Settling Defendants have agreed to conduct a remedial action at the Site in accordance with the Operable Unit Number 4 Record of Decision (''ROD'') for the site, and to pay EPA oversight costs. The ROD estimate of performing the remedy is $11.5 million.

For a period of thirty (30) days from the date of this publication, the Department of Justice will receive written comments relating to the proposed consent decree from persons who are not parties to the action. Comments should be addressed to the Assistant Attorney General, Environment and Natural Resources Division, U.S. Department of Justice, Washington, DC 20530, and should refer to *United States* v. *Commercial Metals Company, et al.,* DOJ #90–11–3–1613.

The proposed consent decree may be examined at the offices of the United States Attorney for the Northern District of Texas, Dallas Division, 1100 Commerce St., 3rd Floor, Dallas, Texas, 75242–16996, and at the office of the United States Environmental Protection Agency, Region VI, 1445 Ross Avenue, Dallas, Texas 75202 (Attention: Mike Barra, Assistant Regional Counsel). A copy of the consent decree may also be examined at the Consent Decree Library, 1120 G Street, NW, 4th Floor, Washington, DC 20005, (202) 624–0892. Copies of the decree may be obtained in person or by mail from the Consent Decree Library. Such requests should be accompanied by a check in the amount of $18.50 (25 cents per page reproduction charge for decree, without attachments) payable to ''Consent Decree Library''. When requesting copies, please refer to *United States* v. *Commercial Metals Company, et al.,* #90–11–3–1613.

Joel Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 98–17013 Filed 6–25–98; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Notice of Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation and Liability Act

Notice is herby given that on June 5, 1998, a proposed Consent Decree in *United States* v. *Erie Coatings & Chemicals, Inc. et al.,* Civil No. 95–75842, was lodged with the United States District court for the Eastern District of Michigan. This Consent Decree resolves claims against two parties, Chem-Met Services, Inc (''Chem-Met'') and Cousins Waste Control Corporation (''Cousins''), under the Comprehensive Environmental Response, Compensation and Liability Act of 1980, as amended, 42 U.S.C. 9601 *et seq.* (''CERCLA'') relating to the Erie Coatings & Chemicals, Inc. Superfund Site (''Site'') in Erie, Michigan.

The Consent Decree requires Chem-Met to reimburse the Superfund in the amount of $25,000 and it requires Cousins to reimburse the Superfund in the amount of $40,000 for the United States' past costs incurred in conducting a removal action at the Site.

The Department of Justice will receive for a period of thirty (30) days from the date of this publication comments relating to the Consent Decree. Comments should be addressed to the Assistant Attorney General of the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and should refer in *United States* v *Erie Coatings & Chemicals, Inc. et al.,* D. J. Ref. 90–11–2–1070.

The Consent Decree may be examined at the Office of the United States Attorney, Eastern District of Michigan, 817 Federal Building, 231 West Lafayette, Detroit, Michigan 48226, and at the Consent Decree Library, 120 G Street, NW, 4th Floor, Washington, DC 20005, (202) 624–0892. A copy of the proposed Consent Decree may be obtained in person or by mail from the Consent Decree Library, 1120 G Street, NW, 4th Floor, Washington, DC 20005. In requesting a copy, please enclose a check in the amount of $5.50 (25 cents per page reproduction cost) payable to the Consent Decree Library.

Joel Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 98–17012 Filed 6–25–98; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Lodging of Consent Decree Pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act

In accordance with Departmental policy, 28 CFR § 50.7 and 42 U.S.C. § 9622(d)(2), notice is hereby given that a proposed consent decree in *United States* v. *Lewis Frame and Ruth Frame,* Civil Action No. 98–CV–2844, was lodged on June 3, 1998, with the United States District Court for the Eastern District of Pennsylvania. A complaint was filed simultaneously with the lodging of the consent decree.

The consent decree pertains to the A.I.W. Frank Superfund Site (''Site''), located in Exton, Chester County, Pennsylvania. It resolves the claims of the plaintiff, the United States of America, filed against defendants, Lewis Frame and Ruth Frame, pursuant to Sections 106 and 107 of the Comprehensive Environmental Response, Compensation and Liability Act (''CERCLA''), 42 U.S.C. § 9601 *et seq.* arising out of the defendants' past ownership of a portion of the Site. The consent decree requires the defendants to pay $1.1 million in past response costs, complete remedial work estimated to cost $1 million and provide EPA with access to the Site. The consent decree also includes covenants not to sue by the United States under Sections 106 and 107 of CERCLA, 42 U.S.C. § 9601 *et seq.,* and Section 7003 of the Resource Conservation and Recovery Act (''RCRA''), 42 U.S.C. § 6973, and provides the defendants with contribution protection.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General for the Environment and Natural Resources Division, Department of Justice, Washington, D.C. 20530, and should refer to *United States* v. *Lewis Frame and Ruth Frame,* Civil Action No. 98–CV–2844, DOJ Ref. *#90–11–3–1604.* Commentors may request an opportunity for a public meeting in the affected area, in accordance with Section 7003(d) of RCRA.

The proposed consent decree may be examined at the Office of the United States Attorney, Eastern District of Pennsylvania, 615 Chestnut Street, Suite 1250, Philadelphia, Pennsylvania 19106–4476; the Region III Office of the Environmental Protection Agency, 841 Chestnut Building, Philadelphia, Pennsylvania, 19107; and at the Consent Decree Library, 1120 G Street, N.W., 4th Floor, Washington, D.C. 20005, (202) 624–0892. A copy of the proposed consent decree may be obtained in person or by mail from the Consent Decree Library, 1120 G Street, N.W., 4th Floor, Washington, D.C. 20005. In requesting a copy of the body of the proposed consent decree, please refer to the referenced case and enclose a check in the amount of $69.75 (25 cents per page reproduction costs), for each copy. The check should be made payable to the Consent Decree Library.

Joel M. Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 98–17014 Filed 6–25–98; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Lodging of Consent Decree Under the Comprehensive, Environmental Response, Compensation and Liability Act (''CERCLA'')

In accordance with Departmental policy, 28 CFR § 50.7, notice is hereby given that a proposed consent decree in *United States* v. *General Diesel, Inc.*, (D.S.C.) Civil Action No. 2 98–1595 23 was lodged on June 2, 1998, with the United States District Court for the District of South Carolina.

In this action the United States sought injunctive relief and recovery of response costs under Sections 106(a) and 107 of CERCLA, 32 U.S.C. §§ 9606(a) and 9607, with respect to the Koppers Charleston Superfund Site Site'') in Charleston, Charleston County, South Carolina.

Under a proposed Consent Decree, General Diesel, Inc., has agreed to pay the sum of $500 in settlement of the government's claims under Sections 106 and 107 of CERCLA, 42 U.S.C. §§ 9606 and 9607, for existing contamination at the Site.

The Department of Justice will receive, for a period of thirty (30) days from the date of this publication, comments relating to the proposed consent decree. Comments should be addressed to the Assistant Attorney General for the Environment and Natural Resources Division, Department of Justice, Washington, DC 20530, and should refer to *United States* v. *General Diesel, Inc.* (D.S.C.) and DOJ #90–11–2–1012A.

The proposed consent decree may be examined at the office of the United States Attorney, 1st Union Bldg, 1441 Main Street, Suite 500, Columbia, South Carolina 29201; the Region 4 Office of the Environmental Protection Agency, 61 Forsythe Street, Atlanta, Georgia 30303, and at the Consent Decree Library, 1120 G Street, NW., 4th Floor, Washington, DC 20005, (202) 624–0892. A copy of the proposed consent decree may be obtained in person or by mail from the Consent Decree Library, 1120 G Street, NW. 4th Floor, Washington, DC 20005. In requesting a copy please refer to the referenced case and enclose a check in the amount of $6.00 (25 cents per page reproduction costs), payable to the Consent Decree Library.

Joel M. Gross,

Chief, Environmental Enforcement Section, Environment and Natural Resources Division.

[FR Doc. 98–17015 Filed 6–25–98; 8:45 am]

BILLING CODE 4410–15–M

DEPARTMENT OF JUSTICE

Membership of the 1998 Senior Executive Service Performance Review Boards

AGENCY: Department of Justice.

ACTION: Notice of Department of Justice's 1998 Senior Executive Service Performance Review Boards.

SUMMARY: Pursuant to the requirements of 5 U.S.C. 4314(c)(4), the Department of Justice announces the membership of its Senior Executive Service (SES) Performance Review Boards (PRBs). The purpose of the PRBs is to provide fair and impartial review of SES performance appraisals and bonus recommendations. The PRBs will make recommendations to the Deputy Attorney General regarding the final performance ratings to be assigned and SES bonuses to be awarded.

FOR FURTHER INFORMATION CONTACT: Joanne W. Simms, Director, Personnel Staff, Justice Management Division, Department of Justice, Washington, DC 20530; (202) 514–6788.

Department of Justice, 1998 Senior Executive Service Performance Review Board Members

Antitrust Division

Gail Kursh, Chief, Professions and Intellectual Property Section
Anthony V. Nanni, Chief, Litigation I Section
Catherine G. O'Sullivan, Chief, Appellate Section
George A. Rozanski, Chief, Economic Regulatory Section

Civil Division

Sharon Y. Eubanks, Deputy Director, Commercial Litigation Branch
Mark B. Stern, Appellate Litigation Counsel, Appellate Staff

Civil Rights Division

Irva D. Greene, Executive Officer
John L. Wodatch, Chief, Disability Rights Section

Criminal Division

Terry R. Lord, Chief, Child Exploitation and Obscenity Section
Julie E. Samuels, Chief, Office of Policy and Management Analysis

Environment and Natural Resources Division

James J. Clear, Chief, Indian Resources Section
Phyllis A. Gardner, Executive Officer
Pauline H. Milius, Chief, Policy, Legislation and Special Litigation Section
Steven P. Solow, Chief, Environmental Crimes Section

Justice Management Division

Richard B. Chapman, Director, Telecommunications Service Staff
Robert F. Diegelman, Director, Management and Planning Staff
James W. Johnston, Director, Procurement Services

Tax Division

Milan D. Karlan, Chief, Office of Review
Robert E. Lindsay, Chief, Criminal Appeals and Tax Enforcement Policy Section
Mildred L. Seidman, Chief, Court Claims Section
Joseph E. Young, Executive Officer

Bureau of Prisons

Wallace H. Cheney, General Counsel
Thomas R. Kane, Assistant Director, Information, Policy, and Public Affairs Division
Robert J. Newport, Senior Deputy Assistant Director for Administration
Steven B. Schwalf, Assistant Director, Industries, Education and Vocational Training Division
Salvador Seanez, Jr., Assistant Director, Community Corrections and Detention Division
Ronald G. Thompson, Assistant Director, Human Resource Management Division

Immigration and Naturalization Service

John P. Chase, Director of Internal Audit
Joan C. Higgins, Assistant Commissioner, Detention and Deportation

Winona H. Varnon, Director of Security
Jeffrey M. Weber, Assistant Commissioner, Budget
Jeffrey L. Weiss, Director, Asylum Division
David A. Yentzer, Assistant Commissioner, Administration

United States Marshals Service

Deborah C. Westbrook, General Counsel

Office of Justice Programs

Lawrence A. Greenfeld, Supervisory Statistician
Richard H. Ward, III, Deputy Director for Operations

Executive Office for United States Attorneys

Frank M. Kalder, Deputy Director for Resource Management and Planning Staff

Executive Office for United States Trustees

Jeffrey M. Miller, Associate Director

Valerie M. Willis,

Executive Secretary, Senior Executive Resources Board.

[FR Doc. 98–17010 Filed 6–25–98; 8:45 am]

BILLING CODE 4410–AR–M

PAROLE COMMISSION

Sunshine Act Meeting

Pursuant To The Government In the Sunshine Act (Public Law 94–409) [5 U.S.C. Section 552b].

AGENCY HOLDING MEETING: Department of Justice, United States Parole Commission.

TIME AND DATE: 1:30 p.m., Tuesday, June 30, 1998.

PLACE: 5550 Friendship Boulevard, Suite 400, Chevy Chase, Maryland 20815.

STATUS: Open.

MATTERS TO BE CONSIDERED:

The following matters have been placed on the agenda for the open Parole Commission meeting:

1. Approval of minutes of previous Commission meeting.
2. Reports from the Chairman, Commissioners, Legal, Chief of Staff, Case Operations, and Administrative Sections.
3. Consideration of Proposed Interim Regulations and Guidelines for District of Columbia prisoners to take effect August 5, 1998.

AGENCY CONTACT: Tom Kowalski, Case Operations, United States Parole Commission, (301) 492–5962.

Dated: June 23, 1998.

Michael A. Stover,

General Counsel, U.S. Parole Commission.

[FR Doc. 98–17208 Filed 6–24–98; 9:58 am]

BILLING CODE 4410–31–M

PAROLE COMMISSION

Sunshine Act Meeting

Pursuant to The Government In the Sunshine Act (Public Law 94–409) [5 U.S.C. Section 552b].

AGENCY HOLDING MEETING: Department of Justice, United States Parole Commission.

DATE AND TIME: 9:30 a.m., Tuesday, June 30, 1998.

PLACE: 5550 Friendship Boulevard, Suite 400, Chevy Chase, Maryland 20815.

STATUS: Closed—Meeting.

MATTERS CONSIDERED: The following matter will be considered during the closed portion of the Commission's Business Meeting: Appeal to the Commission involving approximately one case decided by the National Commissioners pursuant to a reference under 28 CFR 2.27. This case was originally heard by an examiner panel wherein inmates of Federal prisons have applied for parole or are contesting revocation of parole or mandatory release.

AGENCY CONTACT: Tom Kowalski, Case Operation, United States Parole Commission, (301) 492–5962.

Dated: June 23, 1998.

Michael A. Stover,

General Counsel, U.S. Parole Commission.

[FR Doc. 98–17020 Filed 6–24–98; 9:58 am]

BILLING CODE 4410–31–M

DEPARTMENT OF LABOR

Employment Standards Administration

Wage and Hour Division; Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination Decisions

General wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data made available from other sources. They specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR Part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of other Federal statutes referred to in 29 CFR Part 1, Appendix, as well as such additional statutes as may from time to time be enacted containing provisions for the payment of wages determined to be prevailing by the Secretary of Labor in accordance with the Davis-Bacon Act. The prevailing rates and fringe benefits determined in these decisions shall, in accordance with the provisions of the foregoing statutes, constitute the minimum wages payable on Federal and federally assisted construction projects to laborers and mechanics of the specified classes engaged on contract work of the character and in the localities described therein.

Good cause is hereby found for not utilizing notice and public comment procedure thereon prior to the issuance of these determinations as prescribed in 5 U.S.C. 553 and not providing for delay in the effective date as prescribed in that section, because the necessity to issue current construction industry wage determinations frequently and in large volume cause procedures to be impractical and contrary to the public interest.

General wage determination decisions, and modifications and supersedes decisions thereto, contain no expiration dates and are effective from their date of notice in the **Federal Register**, or on the date written notice is received by the agency, whichever is earlier. These decisions are to be used in accordance with the provisions of 29 CFR Parts 1 and 5. Accordingly, the applicable decision, together with any modifications issued, must be made a part of every contract for performance of the described work within the geographic area indicated as required by an applicable Federal prevailing wage law and 29 CFR Part 5. The wage rates and fringe benefits, notice of which is published herein, and which are contained in the Government Printing Office (GPO) document entitled ''General Wage Determinations Issued Under The Davis-Bacon Act and Related Acts,'' shall be the minimum paid by contractors and subcontractors to laborers and mechanics.

Any person, organization, or governmental agency having an interest in the rates determined as prevailing is encouraged to submit wage rate and fringe benefit information for consideration by the Department.

Further information and self-explanatory forms for the purpose of submitting this data may be obtained by writing to the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, Division of Wage Determinations, 200 Constitution Avenue, N.W., Room S–3014, Washington, D.C. 20210.

Modifications to General Wage Determination Decisions

The number of decisions listed in the Government Printing Office document entitled ''General Wage Determinations Issued Under the Davis-Bacon and Related Acts'' being modified are listed by Volume and State. Dates of publication in the **Federal Register** are in parentheses following the decisions being modified.

Volume I

Rhode Island
RI980001 (Feb. 13, 1998

Volume II

Pennsylvania
PA980001 (Feb. 13, 1998)
PA980004 (Feb. 13, 1998)
PA980006 (Feb. 13, 1998)
PA980014 (Feb. 13, 1998)
PA980039 (Feb. 13, 1998)

Volume III

Mississippi
MS980055 (Feb. 13, 1998)
MS980058 (Feb. 13, 1998)

Volume IV

Minnesota
MN980005 (Feb. 13, 1998)
MN980007 (Feb. 13, 1998)
MN980008 (Feb. 13, 1998)
MN980015 (Feb. 13, 1998)
MN980017 (Feb. 13, 1998)
MN980027 (Feb. 13, 1998)
MN980031 (Feb. 13, 1998)
MN980035 (Feb. 13, 1998)
MN980039 (Feb. 13, 1998)
MN980059 (Feb. 13, 1998)
MN980061 (Feb. 13, 1998)
Wisconsin
WI980010 (Feb. 13, 1998)

Volume V

Louisiana
LA980004 (Feb. 13, 1998)
LA980005 (Feb. 13, 1998)
LA980009 (Feb. 13, 1998)
LA980014 (Feb. 13, 1998)
LA980018 (Feb. 13, 1998)
Nebraska
NE980003 (Feb. 13, 1998)
NE980007 (Feb. 13, 1998)
NE980009 (Feb. 13, 1998)
NE980010 (Feb. 13, 1998)
NE980011 (Feb. 13, 1998)
Texas
TX980018 (Feb. 13, 1998)
TX980060 (Feb. 13, 1998)

Volume VI

Wyoming
WY980009 (Feb. 13, 1998)

Volume VII

None

General Wage Determination Publication

General wage determinations issued under the Davis-Bacon and related Acts, including those noted above, may be found in the Government Printing Office (GPO) document entitled ''General Wage Determinations Issued Under the Davis-Bacon and Related Acts.'' This publication is available at each of the 50 Regional Government Depository Libraries and many of the 1,400 Government Depository Libraries across the country.

The general wage determinations issued under the Davis-Bacon and related Acts are available electronically by subscription to the FedWorld Bulletin Board System of the National Technical Information Service (NTIS) of the U.S. Department of Commerce at (703) 487–4630.

Hard-copy subscriptions may be purchased from: Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402, (202) 512–1800.

When ordering hard-copy subscription(s), be sure to specify the State(s) of interest, since subscriptions may be ordered for any or all of the seven separate volumes, arranged by State. Subscriptions include an annual edition (issued in January or February) which includes all current general wage determinations for the States covered by each volume. Throughout the remainder of the year, regular weekly updates are distributed to subscribers.

Signed at Washington, D.C. this 19th day of June 1998.

Carl J. Poleskey,

Chief, Branch of Construction Wage Determinations.

[FR Doc. 98–16733 Filed 6–25–98; 8:45 am]

BILLING CODE 4510–27–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

[Docket No. ICR–98–25]

Grain Handling Facilities (29 CFR 1910.272); Information Collection Requirements

ACTION: Notice; opportunity for public comment.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA–95) (44 U.S.C. 3506(c)(2)(A)). This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and impact of collection requirements on respondents can be properly assessed. Currently, the Occupational Safety and Health Administration (OSHA) is soliciting comments concerning the proposed extension of the information collection requirements contained in the standard on Grain Handling Facilities (29 CFR 1910.272). The Agency is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;
- Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

DATES: Written comments must be submitted on or before August 25, 1998.

ADDRESSES: Comments are to be submitted to the Docket Office, Docket No. ICR–98–25, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–2625, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Telephone: (202) 219–7894. Written comments limited to 10 pages or less in length may also be transmitted by facsimile to (202) 219–5046.

FOR FURTHER INFORMATION CONTACT: Theda Kenney, Directorate of Safety Standards Programs, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–3605, 200 Constitution Avenue, N.W., Washington, D.C. 20210, telephone: (202) 219–8061. A copy of the referenced information collection request is available for inspection and

copying in the Docket Office and will be mailed to persons who request copies by telephoning Theda Kenney at (202) 219–8061, extension 100, or Barbara Bielaski at (202) 219–8076, extension 142. For electronic copies of the Information Collection Request on Grain Handling Facilities (29 CFR 1910.272), contact OSHA's WebPage on the Internet at http://www.osha-slc.gov/.

SUPPLEMENTARY INFORMATION:

I. Background

The Occupatioal Safety and Health Act of 1970 (the Act) authorizes the promulgation of such health and safety standards as are necessary or appropriate to provide safety or healthful employment and places of employment. The statute specifically authorizes information collection by employers as necessary or appropriate for the enforcement of the Act or for developing information regarding the causes and prevention of occupational injuries, illnesses, and accidents.

The standard requires employers to develop and implement a written housekeeping plan, to develop and implement an emergency action plan, to implement procedures for the use of tags and locks to prevent inadvertent operation of equipment being prepared, serviced or adjusted, and to prepare certification records after scheduled inspections of the mechanical and safety control equipment associated with dryers, grain stream processing equipment, and dust collection equipment.

The purpose of the housekeeping program is to require employers to have a planned course of action for the control and reduction of dust in grain handling facilities reducing the fuel available in a grain facility. The housekeeping program must specify in writing the frequency that housekeeping will be performed and the dust control methods that the employer believes will best reduce dust accumulations in the facility.

The written housekeeping program is used by employers in understanding their duties and responsibilities as an integral part of an overall program to control dust; and, what specific actions they are to take to reduce dust accumulations at the facility. The written housekeeping program is also used by compliance officers as a measure of compliance to compare the planned actions specified in the housekeeping program to those actually implemented to maintain an effective dust control program.

Failure to have a written housekeeping program would result in the absence of a formalized policy on the part of the employer regarding the importance of the facility dust control program, what actions are to be taken during certain circumstances, and the duties and responsibilities of employees in removing dust accumulations. The absence of these factors could adversely impact the effectiveness of the facility dust control program.

Additionally, if an incident occurs, employees must be aware of the appropriate actions in advance that need to be taken during the emergency. The standard also requires that employers issue hot work permits when hot work is performed, that employers issue permits for entry into grain storage structures and that all mechanical, electrical, hydraulic, and pneumatic equipment which represents a danger to employees entering these structures be deenergized.

The hot work permit is to assure that the employer is aware of the hot work being performed and that appropriate safety precautions have been taken prior to beginning the work. The permit for entering bins, silos, or tanks is to assure that employers and employees know if these spaces are safe to enter, and the requirement to deenergize equipment which presents a danger to employees entering these bins, silos, or tanks is to assure that employees are not injured due to accidental energization of equipment.

The procedures for the use of tags and locks while servicing equipment is meant to prevent inadvertent injury to employees servicing equipment. Finally, the requirement for certification records of maintenance inspections confirms for the employer and employees that scheduled inspections have been performed.

II. Current Actions

This notice requests public comment on OSHA's burden hour estimates prior to OSHA seeking Office of Management and Budget (OMB) approval of the information collection requirements contained in the Grain Handling Facilities standard.

Type of Review: Extension of a Currently Approved Collection.

Agency: U.S. Department of Labor, Occupational Safety and Health Administration.

Title: Grain Handling Facilities (29 CFR 1910.272).

OMB Number: 1218–0206.

Agency Number: Docket Number ICR–98–25.

Affected Public: Business or other for-profit.

Number of Respondents: 23,770.

Frequency: Varies.

Average Time per Response: Varies from two minutes to 3 hours.

Estimated Total Burden Hours: 138,921.

Total Annualized Capital/Startup Costs: $0.

Comments submitted in response to this notice will be summarized and included in the request for Office of Management and Budget (OMB) approval of the information collection request. The comments will become a matter of public record.

Signed at Washington, D.C., this 2nd day of June 1998.

Charles N. Jeffress,

Assistant Secretary of Labor.

[FR Doc. 98–17100 Filed 6–25–98; 8:45 am]

BILLING CODE 4510–26–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

[Docket No. ICR–98–29]

Storage and Handling of Anhydrous Ammonia (29 CFR 1910.111); Information Collection Requirements

ACTION: Notice; opportunity for public comment.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA–95) (44 U.S.C. 3506(c)(2)(A)). This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and impact of collection requirements on respondents can be properly assessed. Currently, the Occupational Safety and Health Administration (OSHA) is soliciting comments concerning the proposed extension of the information collection requirements contained in the standard on the Storage and Handling of Anhydrous Ammonia (29 CFR 1910.111). The Agency is particularly interested in comments which:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

• Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

DATES: Written comments must be submitted on or before August 25, 1998.

ADDRESSES: Comments are to be submitted to the Docket Office, Docket No. ICR–98–29, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–2625, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Telephone: (202) 219–7894. Written comments limited to 10 pages or less in length may also be transmitted by facsimile to (202) 219–5046.

FOR FURTHER INFORMATION CONTACT: Theda Kenney, Directorate of Safety Standards Programs, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–3605, 200 Constitution Avenue, N.W., Washington, D.C. 20210, telephone: (202) 219–8061. A copy of the referenced information collection request is available for inspection and copying in the Docket Office and will be mailed to persons who request copies by telephoning Theda Kenney at (202) 219–8061, extension 100, or Barbara Bielaski at (202) 219–8076, extension 142. For electronic copies of the Information Collection Request on the Storage and Handling of Anhydrous Ammonia (29 CFR 1910.111), contact OSHA's WebPage on the Internet at http://www.osha-slc.gov/.

SUPPLEMENTARY INFORMATION:

1. Background

The Occupational Safety and Health Act of 1970 (the Act) authorizes the promulgation of such health and safety standards as are necessary or appropriate to provide safe or healthful employment and places of employment. The statute specifically authorizes information collection by employers as necessary or appropriate for the enforcement of the Act or for developing information regarding the causes and prevention of occupational injuries, illnesses, and accidents.

The Storage and Handling of Anhydrous Ammonia standard requires the identification of anhydrous ammonia containers and systems through the use of permanent nameplates. The purpose of the information is to insure that only properly designed and tested anhydrous ammonia containers and systems are used. This will help to prevent any accidental release of (employee exposure to) anhydrous ammonia, which is a highly corrosive and toxic material.

II. Current Actions

This notice requests public comment on OSHA's burden hour estimates prior to OSHA seeking Office of Management and Budget (OMB) approval of the information collection requirements contained in the Storage and Handing of Anhydrous Ammonia standard.

Type of Review: Extension of a Currently Approved Collection.

Agency: U.S. Department of Labor, Occupational Safety and Health Administration.

Title: Storage and Handling of Anhydrous Ammonia (29 CFR 1910.111).

OMB Number: 1218–0208.

Agency Number: Docket Number ICR–98–29.

Affected Public: Business or other for-profit; Farms; State, local or tribal government.

Number of Respondents: 300.

Frequency: On occasion.

Average Time per Response: 5 minutes (.08 hr).

Estimated Total Burden Hours: 24.

Total Annualized Capital/Startup Costs: $0.

Comments submitted in response to this notice will be summarized and included in the request for Office of Management and Budget (OMB) approval of the information collection request. The comments will become a matter of public record.

Signed at Washington, D.C., this 22nd day of June 1998.

Charles N. Jeffress,

Assistant Secretary of Labor.

[FR Doc. 98–17101 Filed 6–25–98; 8:45 am]

BILLING CODE 4510–26–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration

[Docket No. ICR–98–26]

Walking-Working Surfaces; Information Collection Requirements

ACTION: Notice; Opportunity for Public Comment.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden, conducts a preclearance consultation program to provide the general public and Federal agencies with an opportunity to comment on proposed and/or continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA–95) (44 U.S.C. 3506(c)(2)(A)). This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and impact of collection requirements on respondents can be properly assessed. Currently, the Occupational Safety and Health Administration (OSHA) is soliciting comments concerning the proposed extension of the information collection requirements contained in the standard on Walking-Working Surfaces (29 CFR 1910.21–30). The Agency is particularly interested in comments which:

• Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the Agency, including whether the information will have practical utility;

• Evaluate the accuracy of the Agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;

• Enhance the quality, utility, and clarity of the information to be collected; and

• Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submissions of responses.

DATES: Written comments must be submitted on or before August 25, 1998.

ADDRESSES: Comments are to be submitted to the Docket Office, Docket No. ICR–98–26, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–2625,

200 Constitution Avenue, N.W., Washington, D.C. 20210. Telephone: (202) 219–7894. Written comments limited to 10 pages or less in length may also be transmitted by facsimile to (202) 219–5046.

FOR FURTHER INFORMATION CONTACT: Theda Kenney, Directorate of Safety Standards Programs, Occupational Safety and Health Administration, U.S. Department of Labor, Room N–3605, 200 Constitution Avenue, N.W., Washington, D.C. 20210, telephone: (202) 219–8061. A copy of the referenced information collection request is available for inspection and copying in the Docket Office and will be mailed to persons who request copies by telephoning Theda Kenney at (202) 219–8061, extension 100, or Barbara Bielaski at (202) 219–8076, extension 142. For electronic copies of the Information Collection Request on Walking-Working Surfaces (29 CFR 1910.21–30), contact OSHA's WebPage on the Internet at http://www.osha-slc.gov/.

SUPPLEMENTARY INFORMATION:

I. Background

The Occupational Safety and Health Act of 1970 (the Act) authorizes the promulgation of such health and safety standards as are necessary or appropriate to provide safe or healthful employment and places of employment. the statute specifically authorizes information collection by employers as necessary or appropriate for the enforcement of the Act or for developing information regarding the causes and prevention of occupational injuries, illnesses, and accidents.

The information collected is used by employers and employees to be aware of load limits of the floors of newly constructed buildings, the location of permanent aisles and passageways in these buildings, and defective portable metal ladders. Once the floor loading signs are posted, there is no need to change them unless structural conditions change or if the signs become lost, removed, or defaced. Once a portable metal ladder is marked as defective, it must be removed from service and either repaired or destroyed. Repaired portable metal ladders may be returned to service and the markings removed. The tags or signs used to mark the defective ladders may be used over and over again.

Further, a copy of the drawings and specifications of an outrigger scaffold not constructed and erected in accordance with table D–16 of the standard and designed by a licensed professional engineer must be maintained by the employer. The drawings and specifications are used by the employer and OSHA compliance officers to show the sizes and spacing of members.

II. Current Actions

This notice requests public comment on OSHA's burden hour estimates prior to OSHA seeking Office of Management and Budget (OMB) approval of the information collection requirements contained in the Walking-Working Surfaces standards (29 CFR 1910.21–30).

Type of Review: Extension of a Currently Approved Collection.

Agency: U.S. Department of Labor, Occupational Safety and Health Administration.

Title: Walking-Working surfaces (29 CFR 1910.21–30).

OMB Number: 1218–0199.

Agency Number: Docket Number ICR–98–26.

Affected Public: Business or other for-profit; Not-for-profit institutions; Federal government; State, local or tribal government.

Number of Respondents: 60,500.

Frequency: Initially, On Occasion.

Average Time per Response: Varies from 0.5 to 2 hours.

Estimated Total Burden Hours: 33,837.

Total Annualized Capital/Startup Costs: 0.

Comments submitted in response to this notice will be summarized and included in the request for Office of Management and Budget (OMB) approval of the information collection request. The comments will become a matter of public record.

Signed at Washington, D.C., this 22nd day of June 1998.

Charles N. Jeffress,

Assistant Secretary of Labor.

[FR Doc. 98–17102 Filed 6–25–98; 8:45 am]

BILLING CODE 4510–26–M

DEPARTMENT OF LABOR

Occupational Safety and Health Administration (OSHA)

[OSHA Docket Number H–122]

Meeting on Risk Assessment Methodology for Occupational Exposure to Environmental Tobacco Smoke

AGENCY: Occupational Safety and Health Administration, Labor.

ACTION: Notice of Meeting.

SUMMARY: The Occupational Safety and Health Administration (OSHA) is sponsoring a scientific workshop to evaluate risk assessment methodology for developing estimates of risk due to occupational exposure to environmental tobacco smoke (ETS). This workshop will be organized and hosted by the Johns Hopkins University, School of Hygiene and Public Health. The workshop proceedings will be published by a peer reviewed journal, to be selected by Johns Hopkins.

DATES: The workshop will be held on July 9 and 10, 1998, beginning at 8:30 a.m. each day and ending at approximately 5:30 p.m. Applications to attend the workshop must be submitted by July 6, 1998.

ADDRESSES: The workshop will be held at the Admiral Fell Inn, 888 South Broadway, Baltimore, Maryland 21231; phone: 410–522–7377. Send applications to attend the workshop and requests by individuals with disabilities for special accommodations to Ms. Charlotte Gerczak, Department of Epidemiology, Johns Hopkins University, School of Hygiene and Public Health, 615 North Wolfe Street, Suite W6041, Baltimore, Maryland 21205–2179; phone: 410–614–0903.

FOR FURTHER INFORMATION CONTACT: Ms. Charlotte Gerczak.

SUPPLEMENTARY INFORMATION:

Background

On April 5, 1994, OSHA published a Notice of Proposed Rulemaking on Indoor Air Quality (59 FR 15968). The ETS provisions of the proposed rule were supported by a preliminary finding of significant risk for lung cancer and heart disease due to workplace exposure to ETS.

This workshop will attempt to resolve issues raised in the public record pertaining to OSHA's ETS quantitative risk assessment (e.g., data sources, analytical methodology, dose-response risk models) and further scientific knowledge in this area. OSHA needs additional information on these issues to develop a risk assessment upon which a final rule can be based. To address OSHA's concerns, Johns Hopkins has assembled a group of experts to identify issues and discuss appropriate quantitative methodologies for estimating occupational risks from ETS exposures in the workplace. It is the intent of OSHA that the workshop results will be published in a peer reviewed journal.

Public Attendance

Interested persons are invited to attend the ETS risk assessment workshop. Because of the limited amount of seating available, interested persons are encouraged to contact Johns

Hopkins as soon as possible. If there are more requests to attend than space available, Johns Hopkins will give preference to scientists with expertise in risk assessment issues. No organization will be permitted more than one observer unless there is space available after all admissions requests are filled. Admittance to the workshop will be limited to those duly registered.

The Workshop

The workshop participants will consist of experts in the fields of risk assessment, epidemiology, and mathematical modeling. The panel discussions will be chaired by Jonathan M. Samet, M.D., Chairman, Department of Epidemiology, Johns Hopkins University, School of Hygiene and Public Health. The workshop participants have been chosen for their scientific expertise and experience in this area. This workshop is scientific in nature. The public is invited to observe the proceedings, but participation in the discussion is limited to workshop participants.

Workshop Objectives

Under the direction of Jonathan Samet, M.D., the workshop participants will address key issues related to ETS risk assessment methodology. Specifically, the participants will:

1. Consider various health end points to be included in the ETS risk assessment and make recommendations with regard to these specific health end points.

2. Consider all available studies addressing the recommended health end points and evaluate the quality of data for estimating occupational risk.

3. Review and evaluate available mathematical models for estimating occupational risk due to ETS exposure.

4. Examine properties of dose-response risk models and characterize the models with regard to validity and uncertainty and their applicability to estimating occupational risk attributable to ETS exposure in the workplace.

Authority and Signature

This document was prepared under the direction of Charles N. Jeffress, Assistant Secretary of Labor for Occupational Safety and Health, U.S. Department of Labor, 200 Constitution Avenue, NW., Washington, DC 20210. It is issued pursuant to section 6(b) of the Occupational Safety and Health Act of 1970 (84 Stat. 1594, 29 U.S.C. 655).

Signed at Washington, DC this 22nd of June 1998.

Charles N. Jeffress,

Assistant Secretary of Labor.

[FR Doc. 98–16949 Filed 6–25–98; 8:45 am]

BILLING CODE 4510–26–P

DEPARTMENT OF LABOR

Pension and Welfare Benefits Administration

Proposed Extension of Information Collection Request Submitted for Public Comment and Recommendations

ACTION: Notice.

SUMMARY: The Department of Labor, as part of its continuing effort to reduce paperwork and respondent burden conducts a preclearance consultation program to provide the general public and other federal agencies with an opportunity to comment on proposed and continuing collections of information in accordance with the Paperwork Reduction Act of 1995 (PRA 95) (44 U.S.C. 3506(c)(2)(A)). This program helps to ensure that requested data can be provided in the desired format, reporting burden (time and financial resources) is minimized, collection instruments are clearly understood, and the impact of collection requirements on respondents can be properly assessed. Currently, the Pension and Welfare Benefits Administration is soliciting comments concerning the proposed extension of the collection of information included in the procedure for applications for exemption from the prohibited transaction provisions of section 408(a) of the Employee Retirement Income Security Act of 1974 (ERISA) (29 CFR § 2570.30, *et seq.*). The Department is particularly interested in comments which evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information including the basis for any suggested alternative burden estimates. A copy of the proposed information collection request (ICR) can be obtained by contacting the office listed below in the addressee section of this notice.

DATES: Written comments must be submitted to the office listed in the addressee section below on or before August 25, 1998.

The Department of Labor is particularly interested in comments which:

- Evalute whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected;
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

ADDRESSES: Interested parties are invited to submit written comments regarding the collection of information of any or all of the Agencies. Send comments to Mr. Gerald B. Lindrew, Office of Policy and Research, U.S. Department of Labor, Pension and Welfare Benefits Administration, 200 Constitution Avenue, NW, Room N–5647, Washington, D.C. 20210. Telephone: (202) 219–4782 (this is not a toll-free number).

SUPPLEMENTARY INFORMATION:

I. Background

Section 408(a) of ERISA provides that the Secretary may grant exemptions from the prohibited transaction provisions of sections 406 and 407(a) of ERISA and directs the Secretary to establish an exemption procedure with respect to such provisions. In this regard, the Department previously issued a regulation which describes the procedures that must be followed in filing for such exemptions (29 CFR 2570.30. *et seq.*). Under section 408(a) of ERISA, in order for the Secretary to grant an exemption, it must be determined that such exemption is ''(1) administratively feasible; (2) in the interests of the plan and its participants and beneficiaries; and (3) protective of the rights of participants and beneficiaries.'' In order to make such determination, the Department requires full information regarding all aspects of the transaction, including the specific circumstances surrounding the transaction, and the parties and assets involved. Thus, sections 2570.34 and 2570.35 of the exemption procedures regulation lists the information that must be supplied by the applicant. This information includes: identifying information (name, type of plan, EIN number, etc.); an estimate of the number of plan participants; a detailed description of the transaction and the parties for which an exemption is

requested; statements regarding what section ERISA is thought to be in violation and whether the transaction(s) involved have already been entered into; a statement of whether the transaction is customary in the industry; a statement of the hardship or economic loss, if any, which would result if the exemption were denied; a statement explaining why the proposed exemption would be administratively feasible, in the interests of the plan and protective of the rights of plan participants and beneficiaries; and several other statements. In addition, the applicant must certify that the information supplied is accurate and complete.

Section 408(a) of ERISA requires that before granting an exemption from 406(a) the Secretary ''shall require that adequate notice be given to interested parties, and shall afford interested persons opportunity to present views.'' Thus, section 2570.43 of the exemption procedures regulation requires that the applicant for an exemption provide interested persons with a copy of the **Federal Register** notice containing the proposed exemption and a statement which informs them of their right to comment on the proposed exemption.

II. Current Actions

The Office of Management and Budget's approval of this ICR will expire on September 30, 1998. This existing collection of information should be continued because the requirement that an applicant for an exemption disclose information regarding their application is necessary in order for the Department to make an informed decision regarding the application. Further, the requirement of the notice to interested parties ensures that participants and beneficiaries are informed of the application for exemption and have the opportunity to respond.

Agency: Department of Labor, Pension and Welfare Benefits Administration.

Title: Procedure for Application for Prohibited Transaction Exemption Regulation pursuant to 29 CFR 2570.30, *et seq.*

Type of Review: Extension of a currently approved collection.

OMB Numbers: 1210–0060.

Affected Public: Individuals or households; Business or other for-profit; Not-for-profit institutions.

Total Respondents: 207.

Total Responses: 207.

Frequency of Response: On occasion.

Total Annual Burden: 5,708 hours.

Comments submitted in response to this comment request will be summarized and/or included in the request for Office of Management and Budget approval of the information collection request; they will also become a matter of public record.

Dated: June 22, 1998.

Gerald B. Lindrew,

Deputy Director, Pension and Welfare Benefits Administration, Office of Policy and Research.

[FR Doc. 98–17103 Filed 6–25–98; 8:45 am]

BILLING CODE 4510–29–M

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (98–081)]

Notice of Prospective Patent License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of prospective patent license.

SUMMARY: NASA hereby gives notice that Boundary Layer Research, Inc., a corporation of the State of Washington having its principal place of business at 3125 100th St. SW, Hangar C75–5, Everett, Washington 98204, has applied for an exclusive license to practice the inventions disclosed in U.S. Patent No. 5,209,430, entitled ''HELICOPTER LOW SPEED YAW CONTROL,'' and U.S. Patent No. 4,708,305 entitled ''ANTI-TORQUE SYSTEM FUSELAGE STRAKES,'' both of which are assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. Written objections to the prospective grant of a license should be sent to Langley Research Center.

DATE: Responses to this notice must be received by August 25, 1998.

FOR FURTHER INFORMATION CONTACT: Kimberly A. Chasteen, Patent Attorney, NASA Langley Research Center, Mail Stop 212, Hampton, VA 23681–0001, telephone (757) 864–3227; fax (757) 864–9190.

Dated: June 10, 1998.

Edward A. Frankle,

General Counsel.

[FR Doc. 98–17126 Filed 6–25–98; 8:45 am]

BILLING CODE 7510–01–P

NATIONAL AERONAUTICS AND SPACE ADMINISTRATION

[Notice (98–082)]

Notice of Prospective Patent License

AGENCY: National Aeronautics and Space Administration.

ACTION: Notice of prospective patent license.

SUMMARY: NASA hereby gives notice that GP:50 New York LTD of Grand Island, NY 14072, has applied for a partially exclusive license to practice the invention described and claimed in NASA Case Numbers LAR 15280–2–SB and LAR 15280–3–SB, both entitled ''CRYOGENIC HIGH PRESSURE SENSOR,'' for which U.S. Patent Applications were filed and assigned to the United States of America as represented by the Administrator of the National Aeronautics and Space Administration. Written objections to the prospective grant of a license should be sent to Langley Research Center.

DATE: Responses to this notice must be received by August 25, 1998.

FOR FURTHER INFORMATION CONTACT: Robin W. Edwards, Patent Attorney, Langley Research Center, Mail Stop 212, Hampton, VA 23681–0001, telephone (757) 864–3230; fax (757) 864–9190.

Dated: June 10, 1998.

Edward A. Frankle,

General Counsel.

[FR Doc. 98–17127 Filed 6–25–98; 8:45 am]

BILLING CODE 7510–01–P

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Establishment of the Information Security Policy Advisory Council

This notice is published to announce the establishment of the Information Security Policy Advisory Council (ISPAC). The ISPAC will advise the President, the Assistant to the President for National Security Affairs, the Archivist of the United States, and such other executive branch official as it deems appropriate, on policies established under Executive Order 12958 or its implementing directives, including recommended changes to those policies. The ISPAC shall also provide recommendations to agency heads for specific subject areas for systematic declassification review and serve as a forum to discuss policy issues in dispute.

If you have any questions regarding the establishment of the ISPAC, please contact Mary Ann Hadyka, NARA's Committee Management Officer, at (301) 713–7360 x222.

Dated: June 22, 1998.

John W. Carlin,

Archivist of the United States.

[FR Doc. 98–16979 Filed 6–25–98; 8:45 am]

BILLING CODE 7515–01–P

NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

Public Field Hearing

Establishment of the Medicare Commission is included in Chapter 3, Section 4021 of the Balanced Budget Act of 1997 Conference Report. The Medicare Commission is charged with holding public meetings and publicizing the date, time and location in the **Federal Register.**

The National Bipartisan Commission on the Future of Medicare will hold a public field hearing on Monday, July 13, 1998 at the Minneapolis Convention Center, 1301 Second Avenue South, Minneapolis, Minnesota. Please check the Commission's web site for additional information: http://Medicare.Commission.Gov

Date of hearing: Monday, July 13, 1998, 12:30 PM-3:30 PM.

Tentative Agenda: Members of the Commission to hear from witnesses testifying before the Commission.

If you have any questions, please contact the Bipartisan Medicare Commission, ph: 202–252–3380.

I hereby authorize publication of the Medicare Commission meetings in the **Federal Register.**

Julie Hasler,

Office Manager, Bipartisan Medicare Commission.

[FR Doc. 98–17152 Filed 6–25–98; 8:45 am]

BILLING CODE 1132–00–M

NATIONAL COUNCIL ON DISABILITY

Sunshine Act Meeting

TYPE: Quarterly Meeting

AGENCY: National Council on Disability

SUMMARY: This notice sets forth the schedule and proposed agenda of the forthcoming quarterly meeting of the National Council on Disability. Notice of this meeting is required under Section 522b(e)(1) of the Government in the Sunshine Act, (P.L. 94–409).

DATES: August 3–5, 1998, 8:30 a.m. to 5:00 p.m.

LOCATION: Sir Francis Drake Hotel, 450 Powell Street, San Francisco, California; 415–392–7755.

FOR INFORMATION, CONTACT: Mark S. Quigley, Public Affairs Specialist, National Council on Disability, 1331 F Street NW, Suite 1050, Washington, D.C. 20004–1107, 202–272–2004 (Voice), 202–272–2074 (TTY), 202–272–2022 (Fax).

AGENCY MISSION: The National Council on Disability is an independent federal agency composed of 15 members appointed by the President of the United States and confirmed by the U.S. Senate. Its overall purpose is to promote policies, programs, practices, and procedures that guarantee equal opportunity for all people with disabilities, regardless of the nature of severity of the disability, and to empower people with disabilities to achieve economic self-sufficiency, independent living, and inclusion and integration into all aspects of society.

ACCOMMODATIONS: Those needing interpreters or other accommodations should notify the National Council on Disability prior to this meeting.

ENVIRONMENTAL ILLNESS: People with environmental illness must reduce their exposure to volatile chemical substances in order to attend this meeting. In order to reduce such exposure, we ask that you not wear perfumes or scents at the meeting. We also ask that you smoke only in designated areas and the privacy of your room. Smoking is prohibited in the meeting room and surrounding area.

OPEN MEETING: This quarterly meeting of the National Council on Disability will be open to the public.

AGENDA: The proposed agenda includes:

Reports from the Chairperson and the Executive Director
Committee Meetings and Committee Reports
Executive Session
Youth Leadership Development Conference Update
Unfinished Business
New Business
Announcements
Adjournment
Hearing on Minority Issues

Records will be kept of all National Council on Disability proceedings and will be available after the meeting for public inspection at the National Council on Disability.

Signed in Washington, DC, on June 19, 1998.

Ethel D. Briggs,

Executive Director.

[FR Doc. 98–17214 Filed 6–24–98; 10:52 am]

BILLING CODE 6820–MA–M

NATIONAL FOUNDATION ON THE ARTS AND THE HUMANITIES

National Endowment for the Arts; Combined Arts Panel Meeting

Pursuant to Section 10(a)(2) of the Federal Advisory Committee Act (Public Law 92–463), as amended, notice is hereby given that a meeting of the Combined Arts Panel, Theater/Musical Theater, Section A (Creation & Presentation Category) to the National Council on the Arts will be held on July 27–31, 1998. The panel will meet from 9:30 a.m. to 6:30 p.m. on July 27–29, from 10:00 a.m. to 6:00 p.m. on July 30, and from 9:30 a.m. to 5:30 p.m. on July 31, in Room 714 at the Nancy Hanks Center, 1100 Pennsylvania Avenue, NW, Washington, D.C., 20506. A portion of this meeting, from 10:00 a.m. to 12:00 p.m. on July 30, will be open to the public for a policy discussion on field issues and needs, Leadership initiatives, Millennium projects, and guidelines.

The remaining portions of this meeting, from 9:30 a.m. to 6:30 p.m. on July 27–29, from 12:00 p.m. to 6:00 p.m. on July 30, and from 9:30 a.m. to 5:30 p.m. on July 31, are for the purpose of Panel review, discussion, evaluation and recommendation on applications for financial assistance under the National Foundation on the Arts and the Humanities Act of 1965, as amended, including information given in confidence to the agency by grant applicants. In accordance with the determination of the Chairman of May 14, 1998, these sessions will be closed to the public pursuant to subsection (c)(4), (6) and (9)(B) of section 552b of Title 5, United States Code.

Any person may observe meetings, or portions thereof, of advisory panels which are open to the public, and, if time allows, may be permitted to participate in the panel's discussions at the discretion of the panel chairman and with the approval of the full-time Federal employee in attendance.

If you need special accommodations due to a disability, please contact the Office of AccessAbility, National Endowment for the Arts, 1100 Pennsylvania Avenue, N.W., Washington, D.C. 20506, 202/682–5532, TDY–TDD 202/682–5496, at least seven (7) days prior to the meeting.

Further information with reference to this meeting can be obtained from Ms. Kathy Plowitz-Worden, Office of Guidelines & Panel Operations, National Endowment for the Arts, Washington, D.C., 20506, or call 202/682–5691.

Dated: June 22, 1998.

Kathy Plowitz-Worden,

Panel Coordinator, Panel Operations, National Endowment for the Arts.

[FR Doc. 98–17092 Filed 6–25–98; 8:45 am]

BILLING CODE 7537–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Elementary, Secondary and Informal Education; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub L. 92–463, as amended), the National Science Foundation announces the following meeting.

Name: Special Emphasis Panel Elementary, Secondary and Informal Education (#59).

Date and Time: Wednesday, July 15, 1998, 4:00 p.m. to 9:00 p.m. Thursday, July 16, 1998, 8:00 a.m. to 6:00 p.m., Friday, July 17, 1998, 8:00 a.m. to 5:00 p.m.

Place: National Science Foundation, 4201 Wilson Blvd., Room 375, Arlington, VA 22230.

Type of Meeting: Closed.

Contact Person: Dr. James R. Oglesby, Program Director, Division of Elementary, Secondary and Informal Education, National Science Foundation, Room 885, 4201 Wilson Boulevard, Arlington, VA 22230, Tel. (703) 306–1616.

Purpose of Meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate Informal Science Education Program proposals as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature including technical information, financial data such as salaries, and personal information concerning individuals associated with the proposals. These matters are within exemptions (4) and (6) of 5 U.S.C. 55b(c), the Government in the Sunshine Act.

Dated: June 22, 1998.

M. Rebecca Winkler,

Committee Management Officer.

[FR Doc. 98–17061 Filed 6–25––98; 8:45 am]

BILLING CODE 7555–01–M

NATIONAL SCIENCE FOUNDATION

Special Emphasis Panel in Research, Evaluation and Communication; Notice of Meeting

In accordance with the Federal Advisory Committee Act (Pub. L. 92–463, as amended), the National Science Foundation announces the following meeting.

Name and Committee Code: Special Emphasis Panel in Research, Evaluation and Communication (#1210).

Date and time: July 16–17, 1998 and 8:30 a.m.–6:00 p.m.; July 20–21, 1998 and 8:30 a.m.–6:00 p.m.

Place: National Science Foundation, 4201 Wilson Boulevard, Room 370, Arlington, VA 22230.

Type of meeting: Closed.

Contact person: Dr. Anthony E. Kelly, Program Director, Research, Evaluation and Communication, Room 855, National Science Foundation, 4201 Wilson Boulevard, Arlington, VA 22230, Telephone: (703) 306–1650.

Purpose of meeting: To provide advice and recommendations concerning proposals submitted to NSF for financial support.

Agenda: To review and evaluate formal proposals submitted to the Research on Education, Policy and Practice (REPP) Program as part of the selection process for awards.

Reason for Closing: The proposals being reviewed include information of a proprietary or confidential nature, including technical information; financial data, such as salaries; and personal information concerning individuals associated with the proposals. These matters are exempt under 5 U.S.C. 552b(c), (4) and (6) of the Government in the Sunshine Act.

Dated: June 22, 1998.

M. Rebecca Winkler,

Committee Management Officer.

[FR Doc. 98–17062 Filed 6–25–98; 8:45 am]

BILLING CODE 7555–01–M

NUCLEAR REGULATORY COMMISSION

Agency Information Collection Activities: Submission for OMB Review; Comment Request

AGENCY: U.S. Nuclear Regulatory Commission (NRC).

ACTION: Notice of the OMB review of information collection and solicitation of public comment.

SUMMARY: The NRC has recently submitted to OMB for review the following proposal for the collection of information under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. Chapter 35). The NRC hereby informs potential respondents that an agency may not conduct or sponsor, and that a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

1. Type of submission, new, revision, or extension: Extension.

2. The title of the information collection: NRC Form 474, ''Simulation Facility Certification''.

3. The form number if applicable: NRC Form 474.

4. How often the collection is required: One-time requirement for initial certification and quadrennial thereafter.

5. Who will be required or asked to report: All power reactor licensees and applicants for an operating license.

6. An estimate of the number of responses: 20.

7. The estimated number of annual respondents: 20.

8. An estimate of the total number of hours needed annually to complete the requirement or request: 2,400.

9. An indication of whether Section 3507(d), Pub. L. 104–13 applies: Not applicable.

10. Abstract: Licensed power facilities that propose the use of a simulation facility consisting solely of a plant-referenced simulator for the conduct of NRC licensing operating tests are required to submit NRC Form 474.

The information on the form consists of the results of performance testing completed on the subject simulation facility and a schedule for the conduct of performance tests for the subsequent four-year period. NRC uses this information to ascertain the acceptability of simulation facilities for use in the conduct of operating tests for nuclear power plant operator and senior operator candidates and to determine whether to initiate a simulation facility inspection at a specific site due to concerns about their suitability for use in operating tests.

A copy of the final supporting statement may be viewed free of charge at the NRC Public Document Room, 2120 L Street, NW (lower level), Washington, DC. OMB clearance requests are available at the NRC worldwide web site (http://www.nrc.gov) under the FedWorld collection link on the home page tool bar. The document will be available on the NRC home page site for 60 days after the signature date of this notice.

Comments and questions should be directed to the OMB reviewer by July 27, 1998.

Erik Godwin, Office of Information and Regulatory Affairs (3150–0138), NEOB–10202, Office of Management and Budget, Washington, DC 20503.

Comments can also be submitted by telephone at (202) 395–3084.

The NRC Clearance Officer is Brenda Jo. Shelton, 301–415–7233.

Dated at Rockville, Maryland, this 19th day of June 1998.

For the Nuclear Regulatory Commission.

Brenda Jo. Shelton,

NRC Clearance Officer, Office of the Chief Information Officer.

[FR Doc. 98–17099 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–334 and 50–412]

Duquesne Light Company; Notice of Consideration of Issuance of Amendment to Facility Operating License, Proposed no Significant Hazards Consideration Determination, and Opportunity for a Hearing

The U.S. Nuclear Regulatory Commission (the Commission) is considering issuance of an amendment to Facility Operating License Nos. DPR–66 and NPF–73 issued to Duquesne Light Company, et al. (the licensee) for operation of the Beaver Valley Power Station, Unit Nos. 1 and 2 (BVPS–1 and BVPS–2) located in Beaver County, Pennsylvania.

The proposed amendment would revise the BVPS–1 and BVPS–2 Technical Specification (TS) definition of a channel calibration to add two sentences stating that (1) the calibration of instrument channels with resistance temperature detector or thermocouple sensors may consist of an inplace qualitative assessment of sensor behavior and normal calibration of the remaining adjustable devices in the channel and (2) whenever a sensing element is replaced, the next required channel calibration shall include an inplace cross calibration that compares the other sensing elements with the recently installed sensing element. This proposed change would make the BVPS–1 and BVPS–2 TS definition of channel calibration consistent with the definition of a channel calibration contained in the NRC's improved Standard Technical Specifications for Westinghouse Plants (NUREG–1431, Revision 1).

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. As required by 10 CFR 50.91(a), the licensee has provided its analysis of the issue of no significant hazards consideration, which is presented below:

1. Does the change involve a significant increase in the probability or consequences of an accident previously evaluated?

The proposed change is administrative in nature. It does not involve any change to the configuration or method of operation of any plant equipment that is used to mitigate the consequences of an accident nor alter the conditions or assumptions in any of the Updated Final Safety Analysis Report [UFSAR] accident analyses. The revised definition would eliminate unnecessary and potentially damaging removal of resistance temperature detector (RTD) or thermocouple sensors in order to perform calibrations that are not technically possible. Therefore, it can be concluded that the proposed changes do not involve any increase in the probability or consequences of an accident previously evaluated.

2. Does the change create the possibility of a new or different kind of accident from any accident previously evaluated?

No new failure modes have been defined for any plant system or component important to safety nor has any new limiting failure been identified as a result of the proposed changes. There will be no change in the requirement to assess the entire RTD or thermocouple channel behavior including the sensor, alarm, display, and/or trip function. Therefore, it can be concluded that the proposed change does not create the possibility of a new or different kind of accident from those previously evaluated.

3. Does the change involve a significant reduction in a margin of safety?

The proposed change is administrative in nature. Assessment of channel behavior, including sensors, will continue to be required. The addition to the Channel Calibration definition will provide greater flexibility in the use of the provision for surveillance testing, and will have no adverse effect on safety. Also, the inplace qualitative assessment obviates the need to remove the RTDs or thermocouples from their installed location, thereby eliminating the possibility of damaging them during removal. Therefore, it can be concluded that the proposed changes do not involve any reduction in a margin of safety.

The NRC staff has reviewed the licensee's analysis and, based on this review, it appears that the three standards of 10 CFR 50.92(c) are satisfied. Therefore, the NRC staff proposes to determine that the amendment request 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.

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, for example, 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 in the **Federal Register** 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.

Written comments may be submitted by mail to the Chief, Rules and Directives Branch, Division of Administrative Services, Office of Administration, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, and should cite the publication date and page number of this **Federal Register** notice. Written comments may also be delivered to Room 6D59, Two White Flint North, 11545 Rockville Pike, Rockville, Maryland, from 7:30 a.m. to 4:15 p.m. Federal workdays. Copies of written comments received may be examined at the NRC Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC.

The filing of requests for hearing and petitions for leave to intervene is discussed below.

By July 27, 1998, 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 request for a hearing and a petition for leave to intervene. Requests for a hearing and a petition 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. Interested persons should consult a current copy of 10 CFR 2.714 which is available at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the B. F. Jones Memorial Library, 663 Franklin Avenue, Aliquippa, PA 15001. 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 party to the proceeding; (2) the nature 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 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 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 a list of the contentions which are sought to be litigated in the matter. Each contention must consist of a specific statement of the issue of law or fact to be raised or controverted. In addition, the petitioner shall provide a brief explanation of the bases of the contention and a concise statement of the alleged facts or expert opinion which support the contention and on which the petitioner intends to rely in proving the contention at the hearing. The petitioner must also provide references to those specific sources and documents of which the petitioner is aware and on which the petitioner intends to rely to establish those facts or expert opinion. Petitioner must provide sufficient information to show that a genuine dispute exists with the applicant on a material issue of law or fact. Contentions shall be limited to matters within the scope of the amendment under consideration. The contention must be one which, if proven, would entitle the petitioner to relief. 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 it immediately 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 request involves a significant hazards consideration, any hearing held would take place before the issuance of any amendment.

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, DC 20555–0001, Attention: Rulemakings and Adjudications Staff, or may be delivered to the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, by the above date. A copy of the petition should also be sent to the Office of the General Counsel, U.S. Nuclear Regulatory Commission, Washington, DC 20555–0001, and to Jay E. Silberg, Esquire, Shaw, Pittman, Potts & Trowbridge, 2300 N Street, NW., Washington, DC 20037, 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 presiding Atomic Safety and Licensing Board that the petition and/or request should be granted based upon a balancing of the factors specified in 10 CFR 2.714(a)(1)(i)–(v) and 2.714(d).

For further details with respect to this action, see the application for amendment dated June 19, 1998, which is available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street, NW., Washington, DC, and at the local public document room located at the B. F. Jones Memorial Library, 663 Franklin Avenue, Aliquippa, PA 15001.

Dated at Rockville, Maryland, this 22nd day of June 1998.

For the Nuclear Regulatory Commission.

Donald S. Brinkman,

Senior Project Manager, Project Directorate I–2, Division of Reactor Projects—I/II, Office of Nuclear Reactor Regulation.

[FR Doc. 98–17096 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–277 and 50–278]

PECO Energy Company, (Peach Bottom Atomic Power Station, Units 2 and 3); Exemption

I

PECO Energy Company (the licensee) is the holder of Facility Operating License Nos. DPR–44 and DPR–56, which authorize operation of Peach Bottom Atomic Power Station (PBAPS), Units 2 and 3. The licenses provide, among other things, that the licensee is subject to all rules, regulations, and orders of the Commission now or hereafter in effect.

The facility consists of two boiling-water reactors at the licensee's site located in York County, Pennsylvania.

II

Section 70.24 of Title 10 of the Code of Federal Regulations, ''Criticality Accident Requirements,'' requires that each licensee authorized to possess special nuclear material (SNM) shall maintain a criticality accident monitoring system in each area where such material is handled, used, or stored. Subsections (a)(1) and (a)(2) of 10 CFR 70.24 specify detection and sensitivity requirements that these monitors must meet. Subsection (a)(3) of 10 CFR 70.24 requires licensees to maintain emergency procedures for each area in which this licensed SNM is handled, used, or stored and provides that (1) the procedures ensure that all personnel withdraw to an area of safety upon the sounding of a criticality accident monitor alarm, (2) the procedures must include drills to familiarize personnel with the evacuation plan, and (3) the procedures designate responsible individuals for determining the cause of the alarm and placement of radiation survey instruments in accessible locations for use in such an emergency. Subsection (b)(1) of 10 CFR 70.24 requires licensees to have a means to identify quickly personnel who have received a dose of 10 rads or more. Subsection (b)(2) of 10 CFR 70.24 requires licensees to maintain personnel decontamination facilities, to maintain arrangements for a physician and other medical personnel

qualified to handle radiation emergencies, and to maintain arrangements for the transportation of contaminated individuals to treatment facilities outside the site boundary. Paragraph (c) of 10 CFR 70.24 exempts Part 50 licensees from the requirements of paragraph (b) of 10 CFR 70.24 for SNM used or to be used in the reactor. Paragraph (d) of 10 CFR 70.24 states that any licensee who believes that there is good cause why he should be granted an exemption from all or part of 10 CFR 70.24 may apply to the Commission for such an exemption and shall specify the reasons for the relief requested.

III

The SNM that could be assembled into a critical mass at PBAPS, Units 2 and 3, is in the form of nuclear fuel; the quantity of SNM other than fuel that is stored on site in any given location is small enough to preclude achieving a critical mass. The Commission's technical staff has evaluated the possibility of an inadvertent criticality of the nuclear fuel at PBAPS, Units 2 and 3, and has determined that it is extremely unlikely for such an accident to occur if the licensee meets the following seven criteria:

1. Only three new fuel assemblies are allowed out of a shipping cask or storage rack at one time.

2. The k-effective does not exceed 0.95, at a 95% probability, 95% confidence level in the event that the fresh fuel storage racks are filled with fuel of the maximum permissible U–235 enrichment and flooded with pure water.

3. If optimum moderation occurs at low moderator density, then the k-effective does not exceed 0.98, at a 95% probability, 95% confidence level in the event that the fresh fuel storage racks are filled with fuel of the maximum permissible U–235 enrichment and flooded with a moderator at the density corresponding to optimum moderation.

4. The k-effective does not exceed 0.95, at a 95% probability, 95% confidence level in the event that the spent fuel storage racks are filled with fuel of the maximum permissible U–235 enrichment and flooded with pure water.

5. The quantity of forms of special nuclear material, other than nuclear fuel, that are stored on site in any given area is less than the quantity necessary for a critical mass.

6. Radiation monitors, as required by General Design Criterion 63, are provided in fuel storage and handling areas to detect excessive radiation levels and to initiate appropriate safety actions.

7. The maximum nominal U–235 enrichment is limited to 5.0 weight percent.

By letter dated March 18, 1998, the licensee requested an exemption from 10 CFR 70.24.

In this request the licensee addressed the seven criteria given above. The Commission's technical staff has reviewed the licensee's submittal and has determined that PBAPS, Units 2 and 3, meet the applicable criteria. Criteria 2 and 3 are not applicable to PBAPS, Units 2 and 3, since Technical Specification Section 4.3.1.2 specifically states, ''The new fuel storage racks shall not be used for fuel storage. The new fuel shall be stored in the spent fuel storage racks.'' The reference to General Design Criterion (GDC) 63 was initially incorporated to ensure that licensees receiving an exemption to 10 CFR 70.24 would not erroneously view the exemption as the basis for removing from the spent fuel pool area radiation monitors that were meeting other monitoring requirements, such as those contained in GDC 63. However, Criterion 63 is not applicable to PBAPS because the units were evaluated against the draft GDCs current when PBAPS was licensed rather than the current GDCs proposed in July 1967. Thus, even though PBAPS is not required to meet GDC 63, the staff has determined that it is extremely unlikely for an inadvertent criticality to occur in SNM handling and storage areas at PBAPS, Units 2 and 3. Additionally, PBAPS, Units 2 and 3, have area radiation monitors (ARMs) that meet the requirements of 10 CFR 70.24(a)2, and function as a monitoring system capable of detecting criticality in the only area (the refuel floor) where accidental criticality is possible.

The purpose of the criticality monitors required by 10 CFR 70.24 is to ensure that if a criticality were to occur during the handling of SNM, personnel would be alerted to that fact and would take appropriate action. The staff has determined that it is extremely unlikely that such an accident could occur. The low probability of an inadvertent criticality constitutes good cause for granting an exemption from the requirements of 10 CFR 70.24(a).

IV.

The Commission has determined that, pursuant to 10 CFR 70.14, this exemption is authorized by law, will not endanger life or property or the common defense and security, and is otherwise in the public interest. Therefore, the Commission hereby grants PECO Energy Company, an exemption from the requirements of 10 CFR 70.24(a) for Peach Bottom Atomic Power Station, Units 2 and 3.

Pursuant to 10 CFR 51.32, the Commission has determined that the granting of this exemption will have no significant impact on the environment (63 FR 33735).

This exemption is effective upon issuance.

Dated at Rockville, Maryland, this 22nd day of June 1998.

For the Nuclear Regulatory Commission.

Samuel J. Collins,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 98–17095 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–346]

Toledo Edison Company, et al.; (Davis-Besse Nuclear Power Station, Unit 1); Confirmatory Order Modifying License, Effective Immediately

I

Toledo Edison Company, Centerior Service Company, and The Cleveland Electric Illuminating Company (the Licensees) are the holders of Facility Operating License No. NPF–3, which authorizes operation of the Davis-Besse Nuclear Power Station, Unit 1, located in Ottawa County, Ohio.

II

The staff of the U.S. Nuclear Regulatory Commission (NRC) has been concerned that Thermo-Lag 330–1 fire barrier systems installed by licensees may not provide the level of fire endurance intended and that licensees using Thermo-Lag 330–1 fire barriers may not be meeting regulatory requirements. During the 1992 to 1994 timeframe, the NRC staff issued Generic Letter (GL) 92–08, ''Thermo-Lag 330–1 Fire Barriers,'' and subsequent requests for additional information that asked licensees to submit plans and schedules for resolving the Thermo-Lag issue. The NRC staff has obtained and reviewed all such corrective plans and schedules. The staff is concerned that some licensees may not be making adequate progress toward resolving the plant-specific issues, and that some implementation schedules may be either too tenuous or too protracted. For example, several licensees informed the NRC staff that their completion dates had slipped by 6 months to as much as 3 years. The NRC staff has met with licensees of plants that have completion action scheduled beyond 1997 to

discuss the progress of the licensees' corrective actions and the extent of licensee management attention regarding completion of Thermo-Lag corrective actions. In addition, the NRC staff discussed with licensees the possibility of accelerating their completion schedules.

The NRC staff met with the Licensees for Davis-Besse on April 3, 1997. At this meeting, the NRC staff reviewed the schedule of Thermo-Lag corrective actions described in the Licensees' submittals to the NRC dated February 20, April 24, June 26, and November 5, 1996, as documented in the NRC meeting summary dated April 16, 1997. On the basis of the information submitted by the Licensees (including an additional letter dated September 10, 1997), the NRC staff has concluded that the schedules presented are reasonable. This conclusion is based on (1) the amount of installed Thermo-Lag; (2) the complexity of the plant-specific fire barrier configurations and issues; and (3) the need to perform certain plant modifications during outages as opposed to those that can be performed while the plant is at power. In order to remove compensatory measures such as fire watches, it has been determined that resolution of the Thermo-Lag corrective actions by the Licensees must be completed in accordance with their current schedule. By letter dated May 4, 1998, the NRC staff notified the Licensees of its plan to incorporate their schedule commitment into a requirement by issuance of an order and requested consent from the Licensees. By letter dated June 11, 1998, the Licensees provided their consent to issuance of a Confirmatory Order.

III

The Licensees' commitment as set forth in their letter of June 11, 1998, is acceptable and is necessary for the NRC to conclude that public health and safety are reasonably assured. To preclude any schedule delay and to ensure public health and safety, the NRC staff has determined that the Licensees' commitment in their June 11, 1998, letter be confirmed by this Order. The Licensees have agreed to this action. On this basis, and the Licensees' consent, this Order is immediately effective upon issuance.

IV.

Accordingly, pursuant to sections 103, 161b, 161i, 161o, 182, and 186 of the Atomic Energy Act of 1954, as amended, and the Commission's regulations in 10 CFR 2.202 and 10 CFR Part 50, *it is hereby ordered*, effective immediately, that

The Toledo Edison Company, Centerior Service Company, and The Cleveland Electric Illuminating Company (the licensees) shall complete final implementation of Thermo-Lag 330–1 fire barrier corrective actions at the Davis-Besse Nuclear Power Station, Unit No. 1, by December 31, 1998, as described in the licensees' submittals to the NRC dated February 20, 1996, April 24, 1996, June 26, 1996, November 5, 1996, and September 10, 1997, and as presented at the licensees' meeting with the NRC staff on April 3, 1997, as documented in the NRC meeting summary dated April 16, 1997.

The Director, Office of Nuclear Reactor Regulation, may relax or rescind, in writing, any provisions of this Confirmatory Order upon a showing by the Licensees of good cause.

V

Any person adversely affected by this Confirmatory Order, other than the Licensees, may request a hearing within 20 days of its issuance. Where good cause is shown, consideration will be given to extending the time to request a hearing. A request for extension of time must be made in writing to the Director, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555–0001, and must include a statement of good cause for the extension. Any request for a hearing shall be submitted to the Secretary, U.S. Nuclear Regulatory Commission, Attention: Rulemakings and Adjudications Staff, Washington, D.C. 20555–0001. Copies of the hearing request shall also be sent to the Director, Office of Nuclear Reactor Regulation, U.S. Nuclear Regulatory Commission, Washington, D.C. 20555–0001, to the Deputy Assistant General Counsel for Enforcement at the same address, to the Regional Administrator, NRC Region III, 801 Warrenville Road, Lisle, Illinois 60532–4351, and to the Licensees. If such a person requests a hearing, that person shall set forth with particularity the manner in which his/her interest is adversely affected by this Order and shall address criteria set forth in 10 CFR 2.714(d).

If a hearing is requested by a person whose interest is adversely affected, the Commission will issue an Order designating the time and place of any such hearing. If a hearing is held, the issue to be considered at such hearing shall be whether this Confirmatory Order should be sustained.

In the absence of any request for hearing, or written approval of an extension of time in which to request a hearing, the provisions specified in Section IV above shall be final 20 days from the date of this Order without further order or proceedings. If an extension of time for requesting a hearing has been approved, the provisions specified in Section IV shall be final when the extension expires if a hearing request has not been received. An answer or a request for hearing shall not stay the immediate effectiveness of this Order.

Dated at Rockville, Maryland this 22nd day of June 1998.

For the Nuclear Regulatory Commission.

Samuel J. Collins,

Director, Office of Nuclear Reactor Regulation.

[FR Doc. 98–17098 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 40–8502]

Cogema Mining, Inc.; Environmental Statements; Availability, etc

AGENCY: Nuclear Regulatory Commission.

ACTION: Final Finding of No Significant Impact and Notice of Opportunity for Hearing.

SUMMARY: The U.S. Nuclear Regulatory Commission (NRC) proposes to renew NRC Source Material License SUA–1341 to authorize the licensee, COGEMA Mining, Inc. (COGEMA), to continue the commercial operation of its in-situ leach (ISL) uranium mines and processing facilities, located in Campbell and Johnson Counties, Wyoming. This license currently authorizes COGEMA to receive, acquire, possess, and transfer uranium at its Irigaray and Christensen Ranch Facilities, which are located approximately 10 miles northeast of Sussex, Wyoming, and 30 miles north-northeast of Midwest, Wyoming, respectively. An Environmental Assessment (EA) was performed by the NRC staff in support of its review of COGEMA's license renewal request, in accordance with the requirements of 10 CFR Part 51. The conclusion of the Environmental Assessment is a Finding of No Significant Impact (FONSI) for the proposed licensing action.

FOR FURTHER INFORMATION CONTACT: Ms. Janet Lambert, Uranium Recovery Branch, Mail Stop TWFN 7-J9, Division of Waste Management, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555. Telephone 301/415–6710. E-mail: JAL@NRC.GOV

SUPPLEMENTARY INFORMATION:

Background

The Irigaray Project was licensed for commercial operation in August 1978,

under ownership of Westinghouse Electric Corporation. In 1982, operations ceased at the Irigaray plant and wellfields, and the facility was placed on standby status pending improvements in the uranium market. In June 1987, Malapai Resources Company (MRC) purchased the Irigaray site from Westinghouse and resumed operations. In 1988, MRC was granted an amendment to the SUA–1341 Irigaray license to include the Christensen Ranch satellite ion exchange (IX) plant and associated mine units (MUs). The Irigaray site was then upgraded to include facilities for processing IX resin from Christensen Ranch. In April 1993, following other ownership changes, COGEMA acquired ownership of the Irigaray and Christensen Ranch Uranium Projects. Since then operations have continued under COGEMA management.

At the Irigaray and Christensen Ranch facilities, the ISL mining method involves: (1) the injection of native groundwater, with added sodium carbonate/bicarbonate and oxygen or hydrogen peroxide, into a uranium-bearing orebody through injection wells; (2) the chemical mobilization of the uranium through oxidation and then complexation with the carbonate species; and (3) the extraction of the uranium-bearing solution from the subsurface through a pattern of pumping wells. The uranium is separated from the leach solution by conventional ion exchange (IX) methods in the processing facilities. The resulting uranium-poor solution is recharged with carbonate and oxygen and returned to the mining zone for additional uranium recovery. This cycle continues until the ore zone is depleted or recovery of the uranium is no longer economically feasible.

Once saturated with uranium, the resin in the IX columns is stripped of the uranium through an elution process. The recovered uranium solution is processed further by using ammonia or hydrogen peroxide to precipitate the uranium into a slurry. The resulting slurry is thickened by gravity settling, and then washed and de-watered in a filter press to about 50 percent solids. The filter press solids (cake) are then dried in a natural gas vacuum dryer, to produce uranium oxide, which is commonly known as ''yellowcake.'' The dried yellowcake is packaged in steel drums for storage and eventual shipment to a fuel processing facility.

The Irigaray processing plant has the capability to perform all of the previously described processing steps. However, the Christensen Ranch plant does not contain the uranium elution circuit for removing and concentrating the uranium from the IX resin. For this reason, resin from the Christensen Ranch processing plant is transferred via truck to the Irigaray facility for elution and concentration into yellowcake. The eluted resin is then returned to the Christensen Ranch plant for reuse.

All wellfields at the Irigaray site are in the restoration phase. Previous operations at Christensen Ranch have included production from Mine Units (MU) 2, 3, 4, 5, and 6, with MU 3 in the groundwater restoration phase. Remaining reserves on the entire Irigaray property controlled by COGEMA total approximately seven million pounds. Reserves remaining on the Christensen Ranch property total approximately 13 million pounds in the current, low-value uranium market.

The proposed action is to renew Source Material License SUA–1341 to authorize the continued commercial operation of the Irigaray and Christensen Ranch facilities. In its renewal application, COGEMA has proposed many changes to the operations and procedures at the facilities. One of the major changes proposed by COGEMA is to combine the mine and development plans for Irigaray and Christensen Ranch into one plan. In addition, the renewed license would authorize the facilities to be operated such that the annual average yellowcake production does not exceed 1,133,980 kg (2,500,000 pounds) of U3O8 annually. The EA discusses the environmental aspects of the COGEMA proposal. Additional information concerning the safety aspects of the proposed renewal will be contained in the safety evaluation report (SER) that will accompany the license renewal action.

The Environmental Assessment

The NRC staff performed an appraisal of the environmental impacts associated with the continued operation of the COGEMA ISL facility, in accordance with 10 CFR Part 51, Licensing and Regulatory Policy Procedures for Environmental Protection. In conducting its appraisal, the NRC staff considered the following information: (1) COGEMA's license renewal application, as amended; (2) previous environmental evaluations of the COGEMA facility; (3) COGEMA's license amendment requests submitted subsequent to its renewal application, and NRC staff approvals of these requests; (4) data contained in required semiannual environmental monitoring reports; (5) results of NRC staff site visits and inspections of the COGEMA facility; and (6) consultations with the U.S. Fish and Wildlife Service, the State of Wyoming Department of Environmental Quality, and the State Historic Preservation Officer for the State of Wyoming. The results of the staff's appraisal are documented in the EA.

Environmental Assessment Conclusions

The NRC staff has re-examined actual and potential environmental impacts associated with continued operation of the Irigaray and Christensen Ranch facilities, and has determined that renewal of Source Material License SUA–1341 will: (1) be consistent with requirements of 10 CFR Part 40; (2) not be inimical to the public health and safety; and (3) not have long-term detrimental impacts on the environment. The following statements support the FONSI and summarize the conclusions resulting from the staff's environmental assessment:

1. The proposed groundwater monitoring program is sufficient to detect excursions (vertical or horizontal) of mining solutions. Furthermore, aquifer testing and the previous history of operations indicate that the production zone is adequately confined, thereby assuring hydrologic control of mining solutions;

2. Liquid process wastes will be disposed in accordance with approved waste disposal options. Monitoring programs are in place to ensure appropriate operation of the deep disposal well and to detect potential leakage from the solar evaporation ponds;

3. An acceptable environmental and effluent monitoring program is in place to monitor effluent releases and to detect if applicable regulatory limits are exceeded. Radiological effluents from facility operations have been and are expected to continue to remain below the regulatory limits;

4. All radioactive wastes generated by facility operations will be disposed offsite at a licensed byproduct disposal site;

5. Groundwater impacted by mining operations will be restored to baseline conditions on a mine-unit average, as a primary goal. If baseline conditions cannot be reasonably achieved, the R&D operations have demonstrated that the groundwater can be restored to applicable class-of-use standards; and

6. Because the staff has determined that there will be no significant impacts associated with approval of the license renewal, there can be no disproportionally high and adverse effects or impacts on minority and low-income populations. Consequently,

further evaluation of Environmental Justice concerns, as outlined in Executive Order 12898 and NRC's Office of Nuclear Material Safety and Safeguards Policy and Procedures Letter 1–50, Revision 1, is not warranted.

Alternatives to the Proposed Action

The proposed action is to renew NRC Source Material License SUA–1341, for continued operation of the Irigaray and Christensen Ranch ISL facilities, as requested by COGEMA. Therefore, the principal alternatives available to NRC are to:

(1) Renew the license as requested by the licensee, with conditions considered necessary or appropriate to protect public health and safety and the environment; or

(2) Renew the license, with conditions considered necessary or appropriate to protect public health and safety and the environment, but not allow COGEMA to expand its operations beyond those previously approved; or

(3) Deny renewal of the license.

Based on its review, the NRC staff has concluded that the environmental impacts associated with the proposed action do not warrant either the limiting of COGEMA's future operations or the denial of the license renewal. Additionally, in the SER prepared for this action, the staff has reviewed the licensee's proposed action with respect to the criteria for license issuance specified in 10 CFR Part 40, Section 40.32, and has no basis for denial of the proposed action. Therefore, the staff considers that Alternative 1 is the appropriate alternative for selection.

Finding of No Significant Impact

The NRC staff has prepared an EA for the proposed renewal of NRC Source Material License SUA–1341. On the basis of this assessment, the NRC staff has concluded that the environmental impacts that may result from the proposed action would not be significant, and therefore, preparation of an Environmental Impact Statement is not warranted.

The Environmental Assessment and other documents related to this proposed action are available for public inspection and copying at the NRC Public Document Room, in the Gelman Building (lower level), 2120 L Street NW, Washington, DC 20555.

Notice of Opportunity for Hearing

The Commission hereby provides notice that this is a proceeding on an application for a licensing action falling within the scope of Subpart L, ''Informal Hearing Procedures for Adjudications in Materials and Operators Licensing Proceedings,'' of the Commission's Rules of Practice for Domestic Licensing Proceedings and Issuance of Orders in 10 CFR Part 2. Pursuant to § 2.1205(a), any person whose interest may be affected by this proceeding may file a request for a hearing. In accordance with § 2.1205(c), a request for a hearing must be filed within thirty (30) days from the date of publication of this **Federal Register** notice. The request for a hearing must be filed with the Office of the Secretary either:

(1) By delivery to the Rulemakings and Adjudications Staff of the Office of the Secretary at One White Flint North, 11555 Rockville Pike, Rockville, MD 20852, between 7:30 a.m. and 4:15 p.m., Federal workdays; or

(2) By mail or telegram addressed to the Secretary, U.S. Nuclear Regulatory Commission, Washington, DC 20555, Attention: Rulemakings and Adjudications Staff.

Each request for a hearing must also be served, by delivering it personally or by mail to:

(1) The applicant, COGEMA Mining, Inc., 935 Pendell Boulevard., P.O. Box 730, Mills, WY 82644;

(2) The NRC staff, by delivery to the Executive Director of Operations, One White Flint North, 11555 Rockville Pike, Rockville, MD 20852, between 7:30 a.m. and 4:15 p.m., Federal workdays; or

(3) By mail addressed to the Executive Director for Operations, U.S. Nuclear Regulatory Commission, Washington, DC 20555.

In addition to meeting other applicable requirements of 10 CFR Part 2 of the Commission's regulations, a request for a hearing filed by a person other than an applicant must describe in detail:

(1) The interest of the requestor in the proceeding;

(2) How that interest may be affected by the results of the proceeding, including the reasons why the requestor should be permitted a hearing, with particular reference to the factors set out in § 2.1205(g);

(3) The requestor's areas of concern about the licensing activity that is the subject matter of the proceeding; and

(4) The circumstances establishing that the request for a hearing is timely in accordance with § 2.1205(c).

Any hearing request that is granted will be held in accordance with the Commission's ''Informal Hearing Procedures for Adjudications in Materials and Operator Licensing Proceedings'' in 10 CFR Part 2, Subpart L.

Dated at Rockville, Maryland, this 18th day of June 1998.

For the Nuclear Regulatory Commission.

Daniel M. Gillen,

Assistant Chief, Uranium Recovery Branch, Division of Waste Management, Office of Nuclear Material Safety and Safeguards.

[FR Doc. 98–16913 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

[Docket Nos. 50–259.50–260 and 50–296]

Tennessee Valley Authority; Browns Ferry Nuclear Plant, Units 1, 2 and 3 Environmental Assessment and Finding of No Significant Impact

Introduction

The U.S. Nuclear Regulatory Commission (NRC, the Commission) is considering issuance of an amendment to Facility Operating License Nos. DPR–33, DPR–52 and DPR–68 issued to the Tennessee Valley Authority (TVA or the licensee) for operation of the Browns Ferry Nuclear Plant (BFN), Units 1, 2 and 3, located in Limestone County, Alabama.

Environmental Assessment

Identification of the Proposed Action

This Environmental Assessment has been prepared to address potential environmental issues related to the licensee's application dated September 6, 1996 as supplemented June 6 and December 11, 1996; April 11, May 1, August 14, October 15, November 5 and 14, December 3, 4, 15, 22, 23, 29, and 30, 1997; January 23, March 12 and 13, April 16, 20, and 28, May 7, 14, 19 and 27, June 5 and 10, 1998. The proposed amendments will replace the current BFN Units 1, 2 and 3 Technical Specifications (CTS) in their entirety with Improved Technical Specifications (ITS) based on Revision 1 to NUREG–1433, ''Standard Technical Specifications General Electric Plants BWR/4,'' dated April 1995.

The Need for the Proposed Action

It has been recognized that nuclear safety in all plants would benefit from improvement and standardization of TS. The Commission's ''NRC Interim Policy Statement on Technical Specification Improvements for Nuclear Power Reactors,'' (52 FR 3788, February 6, 1987), and later the Commission's ''Final Policy Statement on Technical Specification Improvements for Nuclear Power Reactors,'' (58 FR 39132, July 22, 1993), formalized this need. To facilitate the development of individual improved TS, each reactor vendor owners group (OG) and the NRC staff

developed standard TS (STS). For General Electric plants, the STS are published as NUREG–1433, and this document was the basis for the new BFN Units 1, 2 and 3 TS. The NRC Committee to Review Generic Requirements reviewed the STS and made note of the safety merits of the STS and indicated its support of conversion to the STS by operating plants.

Description of the Proposed Change

The proposed revision to the TS is based on NUREG–1433 and on guidance provided in the Final Policy Statement. Its objective is to completely rewrite, reformat, and streamline the existing TS. Emphasis is placed on human factors principles to improve clarity and understanding. The Bases section has been significantly expanded to clarify and better explain the purpose and foundation of each specification. In addition to NUREG–1433, portions of the existing TS were also used as the basis for the ITS. Plant-specific issues (unique design features, requirements, and operating practices) were discussed at length with the licensee, and generic matters with the OG.

The proposed changes from the existing TS can be grouped into four general categories, as follows:

1. Non-technical (administrative) changes, which were intended to make the ITS easier to use for plant operations personnel. They are purely editorial in nature or involve the movement or reformatting of requirements without affecting technical content. Every section of the BFN Unit Nos. 1, 2 and 3 TS has undergone these types of changes. In order to ensure consistency, the NRC staff and the licensee have used NUREG–1433 as guidance to reformat and make other administrative changes.

2. Relocation of requirements, which include items that were in the existing BFN Units 1, 2 and 3 TS. The TS that are being relocated to licensee-controlled documents are not required to be in the TS under 10 CFR 50.36 and do not meet any of the four criteria in the Commission's Final Policy Statement for inclusion in the TS. They are not needed to obviate the possibility that an abnormal situation or event will give rise to an immediate threat to the public health and safety. The NRC staff has concluded that appropriate controls have been established for all of the current specifications, information, and requirements that are being moved to licensee-controlled documents. In general, the proposed relocation of items in the BFN Units 1, 2 and 3 TS to the Final Safety Analysis Report (FSAR), appropriate plant-specific programs, procedures and ITS Bases follows the guidance of the General Electric STS (NUREG–1433). Once these items have been relocated by removing them from the TS to licensee-controlled documents, the licensee may revise them under the provisions of 10 CFR 50.59 or other NRC staff-approved control mechanisms, which provide appropriate procedural means to control changes.

3. More restrictive requirements, which consist of proposed BFN Units 1, 2 and 3 ITS items that are either more conservative than corresponding requirements in the existing BFN Units 1, 2 and 3 TS, or are additional restrictions that are not in the existing BFN Units 1, 2 and 3 TS but are contained in NUREG–1433. Examples of more restrictive requirements include: placing a Limiting Condition of Operation on plant equipment that is not required by the present TS to be operable; more restrictive requirements to restore inoperable equipment; and more restrictive surveillance requirements.

4. Less restrictive requirements, which are relaxations of corresponding requirements in the existing BFN Units 1, 2 and 3 TS that provide little or no safety benefit and place unnecessary burdens on the licensee. These relaxations were the result of generic NRC actions or other analyses. They have been justified on a case-by-case basis for BFN Units 1, 2 and 3 as will be described in the staff's Safety Evaluation (SE) to be issued with the license amendment, which will be noticed in the **Federal Register**.

In addition to the changes described above, the licensee proposed certain changes to the existing TS that deviated from the STS in NUREG–1433. These additional proposed changes are described in the licensee's application and in the staff's Notice of Consideration of Issuance of Amendment to Facility Operating License and Opportunity for a Hearing (61 FR 55026, 63 FR 29763, and 63 FR 32252). Where these changes represent a change to the current licensing basis for BFN Units 1, 2 and 3, they have been justified on a case-by-case basis and the environmental impacts of these changes will be addressed in the staff's SE to be issued with the license amendment.

Environmental Impacts of the Proposed

The Commission has completed its evaluation of the proposed action and concludes that the proposed TS conversion would not increase the probability or consequences of accidents previously analyzed and would not affect facility radiation levels or facility radiological effluents.

Changes that are administrative in nature have been found to have no effect on the technical content of the TS, and are acceptable. The increased clarity and understanding these changes bring to the TS are expected to improve the operator's control of the plant in normal and accident conditions.

Relocation of requirements to licensee-controlled documents does not change the requirements themselves. Future changes to these requirements may be made by the licensee under 10 CFR 50.59 or other NRC-approved control mechanisms, which ensures continued maintenance of adequate requirements. All such relocations have been found to be in conformance with the guidelines of NUREG–1433 and the Final Policy Statement, and, therefore, are acceptable.

Changes involving more restrictive requirements have been found to be acceptable and are likely to enhance the safety of plant operations.

Changes involving less restrictive requirements have been reviewed individually. When requirements have been shown to provide little or no safety benefit or to place unnecessary burdens on the licensee, their removal from the TS was justified. In most cases, relaxations previously granted to individual plants on a plant-specific basis were the result of a generic NRC action, or of agreements reached during discussions with the OG and found to be acceptable for BFN Units 1, 2 and 3. Generic relaxations contained in NUREG–1433 as well as proposed deviations from NUREG–1433 have also been reviewed by the NRC staff and have been found to be acceptable.

In summary, the proposed revisions to the TS were found to provide control of plant operations such that reasonable assurance will be provided so that the health and safety of the public will be adequately protected.

These TS changes will not increase the probability or consequences of accidents, no changes are being made in the types of effluents that may be released offsite, and there is no significant increase in the allowable individual or cumulative occupational radiation exposure.

With regard to potential nonradiological impacts, the proposed action does not affect nonradiological plant effluents and has no other nonradiological environmental impact. Accordingly, the Commission concludes that there are no significant nonradiological environmental impacts associated with the proposed action.

Alternatives to the Proposed Action

Since the Commission has concluded there is no significant environmental impact associated with the proposed amendments, any alternatives with equal or greater environmental impact need not be evaluated. The principal alternative to this action would be to deny the request for the amendment. Such action would not reduce the environmental impacts of plant operations.

Alternative Use of Resources

This action did not involve the use of any resources not previously considered in the Final Environmental Statement related to the operation of the BFN Units 1, 2 and 3 Electric Generating Plants.

Agencies and Persons Consulted

In accordance with its stated policy, on June 18, 1998, the staff consulted with the State official, Mr. David Walter, of the Department of Environment and Natural Resources, Division of Radiation Protection. The State official had no comments.

Finding of No Significant Impact

Based upon the environmental assessment, the Commission concludes that the proposed action will not have a significant effect on the quality of the human environment. Accordingly, the Commission has determined not to prepare an environmental impact statement for the proposed amendment.

For further details with respect to this action, see the application for amendments dated September 6, 1996 as supplemented June 6, and December 11, 1996; April 11, May 1, August 14, October 15, November 5 and 14, December 3, 4, 15, 22, 23, 29, and 30, 1997; January 23, March 12 and 13, April 16, 20, and 28, May 7, 14, 19 and 27, and June 5 and 10, 1998, which are available for public inspection at the Commission's Public Document Room, the Gelman Building, 2120 L Street NW., Washington, DC, and at the local public document room located at the Athens Public Library, 405 E. South Street, Athens, Alabama.

Dated at Rockville, Maryland, this 18th day of June 1998.

For the Nuclear Regulatory Commission.

Frederick J. Hebdon,

Director, Project Directorate II–3, Division of Reactor Projects—I/II, Office of Nuclear Reactor Regulation.

[FR Doc. 98–17097 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

NUCLEAR REGULATORY COMMISSION

The Role of Industry Stakeholder Meeting

AGENCY: Nuclear Regulatory Commission.

ACTION: Notice of meeting.

SUMMARY: The objective of the meeting is to obtain stakeholder insights into potential approaches or options the NRC could implement to more efficiently and effectively utilize consensus standards, industry initiatives that would be substitutes for regulatory action, and improvements to the regulatory framework. Plenary and breakout sessions will be held. Concurrent breakout sessions will provide a forum for discussion and feedback on (1) Consensus Codes and Standards Development and Endorsement/Use, (2) Industry Initiatives as Substitutes for Regulatory Action, and (3) Improvements to the Regulatory Framework.

DATES: Pre-registration will be August 31, 1998. The stakeholder meeting will be held on September 1, 1998.

ADDRESSES: The stakeholder meeting will be held at the Hyatt Regency O'Hare Hotel, 9300 West Bryn Mawr Avenue, Rosemont, Illinois, 60018. Telephone: (847) 696–1234, Facsimile: (847) 698–1039. (Refer to NRC Meeting for special conference rate.)

SUPPLEMENTARY INFORMATION: For additional information contact: Thomas N. Cerovski, USNRC, Telephone: (301) 415–8099; FAX: (301) 415–5151; Internet: tnc@nrc.gov.

Participation

This conference is open to the general public; however, advance registration by August 1, 1998 is recommended. To register, contact: Thomas N. Cerovski, USNRC, Telephone: (301) 415–8099; Facsimile: (301) 415–5151; Internet: tnc@nrc.gov.

Program

Following is the preliminary program for the meeting:

August 31, 1998

Pre-Registration 5:00 p.m.–8:00 p.m.

September 1, 1998

Registration—7:00 a.m.–8:00 am.
Plenary Session—Opening and Welcome—8:00 a.m.–9:00 a.m.
Morning Breakout Sessions (I, II, and III)—9:00 a.m.–11:30 a.m.
Lunch—11:30 a.m.–1:00 p.m.
Afternoon Breakout Sessions (I, II, and III)—1:00 p.m.–4:00 p.m.
Plenary Session—Closing and Summary—4:00 p.m.–5:00 p.m.

* * * * *

The agenda for each breakout session is as follows:

Breakout Session I: Codes and Standards Development and Endorsement/Use

Open discussion is invited on the following topics:

(1) Actions the NRC is taking to implement PL 104–113, ''National Technology Transfer and Advancement Act of 1995,'' March 7, 1996, (2) Options for NRC participation in the development of consensus codes and standards organizations,

(3) Whether the NRC should make greater use of available codes and standards in its regulations and regulatory guides,

(4) Options for endorsement/use of codes and standards, including potential changes regarding requirements for licensees to upgrade every 120-months to the latest ASME Code edition and addenda incorporated by reference in § 50.55a,

(5) Options for a process to interact with standards development organizations to discuss potential needs for new codes, standards, and guides and recommendations for areas of emphasis,

(6) Impediments to the adoption of updated codes and standards.

Breakout Session II: Industry Initiatives as Substitutes for Regulatory Action

Open discussion is invited on the proposed NRC review process of industry initiatives as substitutes for regulatory action:

A. Proposed process to be used by the NRC for review of industry initiatives:

(1) Industry submittal: defines parameters of issue, schedule, resources, end products,

(2) Acceptance review by NRC: resources, public access, fees, monitoring activities, enforcement policy,

(3) Detailed technical review by NRC: maintenance of desired level of safety and boundary conditions relative to agency policy.

B. Discussion of the process:

(1) Process will be used to determine whether an industry initiative can be relied on as an adequate and effective substitute for NRC regulatory activities:

a. Is the process workable from a conceptual perspective?

b. Should it be refined or more clearly defined?

(2) Are there similar processes which have been developed by public agencies or the governments of other countries from which the NRC could learn?

(3) How should NRC assure that public access is maintained in the following areas:

a. In the agency's review of the industry initiatives?

b. To information related to the bases for the agency's acceptance of the initiative?

Breakout Session III: Improvements to Regulatory Framework

Open discussion is invited on the following topics:

A. Reactor event reporting requirements. 10 CFR § 50.72, ''Immediate notification requirements for operating nuclear power reactors,'' and 10 CFR § 50.73, ''Licensee event report system'' are currently the subject of a rulemaking effort to: (a) update the current rules, including reducing the reporting burden associated with events of little or no safety significance, and (b) better align the rules with the NRC's current needs, including (i) obtaining information better related to risk and (ii) reconsidering the required reporting times in relation to the need for prompt NRC action.

(1) Other reporting requirements applicable to nuclear power plants. Are there additional areas (outside of § 50.72 and § 50.73) where event reporting requirements can be risk-informed and/or simplified?

(2) What changes should be made in those areas? For example, the time limit for reporting could be adjusted based on the safety significance of the event and the need for NRC's immediate action. The burden associated with reporting events or conditions with little or no safety or risk significance should be minimized.

(3) What would be the change in reporting burden associated with such changes?

B. Development of a systematic process and identification of candidate issues for improving the effectiveness and efficiency of rules, standards, regulatory guidance, and their application.

(1) NRC Process Development. The staff will discuss and seek comments from stakeholders on the staff process of (i) candidate issue identification utilizing a variety of readily available sources and databases; (ii) the analysis of the candidate issue for generic applicability, risk, effectiveness and efficiency; (iii) issue prioritization and disposal, and (iiii) the initiative to achieve more performance-based regulation.

(2) Candidate Issue Proposals. The staff welcomes the proposal of candidate issues for improving rules, standards, regulatory guidance, and their application. This will include consideration of issues that may improve safety, as well as issues that may reduce regulatory impact. Candidate issues will be most seriously addressed if they are provided with a discussion of (i) resource impact on the industry and the NRC, (ii) a quantitative or qualitative assessment of their impact on risk, and (iii) options of ways to address the issue.

Dated in Rockville, Maryland this 23rd day of June, 1998.

For the Nuclear Regulatory Commission.

Frank C. Cherny,

Acting Chief, Generic Safety Issues Branch, Division of Regulatory Applications, Office of Nuclear Regulatory Research.

[FR Doc. 98–17094 Filed 6–25–98; 8:45 am]

BILLING CODE 7590–01–P

SECURITIES AND EXCHANGE COMMISSION

[Investment Company Act Release No. 23263; 812–10804]

The Lipper Funds, Inc.; Notice of Application

June 22, 1998.

AGENCY: Securities and Exchange Commission (''SEC'').

ACTION: Notice of application for an order under section 6(c) of the Investment Company Act of 1940 (''Act'').

SUMMARY OF APPLICATION: Applicants request an exemption from section 15(f)(1)(A) of the Act to permit a former director (Mr. Biderman) of the Company to rejoin the Company's board of directors.

APPLICANTS: The Lipper Funds, Inc. and Prime Lipper Asset Management.

FILING DATES: The application was filed on October 1, 1997, and amended on June 2, 1998. Applicants have agreed to file an additional amendment, the substance of which is incorporated in this notice, during the notice period.

HEARING OR NOTIFICATION OF HEARING: An order granting the application will be issued unless the SEC orders a hearing. Interested persons may request a hearing by writing to the SEC's Secretary and serving applicants with a copy of the request, personally or by mail. Hearing requests should be received by the SEC by 5:30 p.m. on July 17, 1998 and should be accompanied by proof of service on applicants, in the form of an affidavit or, for lawyers, a certificate of service. Hearing requests should state the nature of the writer's interest, the reason for the request, and the issues contested. Persons may request notification of a hearing by writing to the SEC's Secretary.

ADDRESSES: Secretary, SEC, 450 Fifth Street, N.W., Washington, D.C. 20549. Applicants: The Lipper Funds, Inc. and Prime Lipper Asset Management, 101 Park Avenue, New York, N.Y. 10178.

FOR FURTHER INFORMATION CONTACT: Mary T. Geffroy, Senior Counsel, at (202) 942–0553, or Mary Kay Frech, Branch Chief at (202) 942–0564 (Division of Investment Management, Office of Investment Company Regulation).

SUPPLEMENTARY INFORMATION: The following is a summary of the application. The complete application may be obtained for a fee from the SEC's Public Reference Branch, 450 Fifth Street, N.W., Washington, D.C. 20549 (tel. (202) 8090).

Applicant's Representations

1. The Lipper Funds, Inc. (the ''Company'') is an open-end management investment company registered under the Act. The Company consists of three investment portfolios, one of which is the Prime Lipper Europe Equity Fund (the ''Europe Equity Fund''). Prime Lipper Asset Management (''PLAM''), a New York general partnership and an investment adviser registered under the Investment Advisers Act of 1940, serves as investment adviser for the Europe Equity Fund.

2. PLAM is a joint venture owned equally by its two general partners, Lipper Europe L.P. and Prime U.S.A. Inc. (''Prime USA''). Lipper Europe L.P. (''Lipper Europe'') is a Delaware limited partnership controlled by Lipper & Company, Inc. (''Lipper Inc.''). Prime USA, a Delaware corporation, is a wholly-owned subsidiary of Prime S.p.A., an asset management firm. Prime S.p.A. currently is controlled by Assicurazioni Generali (''Generali''), an Italian insurance company. Generali acquired control of Prime S.p.A. on December 20, 1996, when Fiat S.p.A. sold to Generali 95.1% of the outstanding stock of Prime S.p.A. (the ''Transaction''). The Transaction was deemed to result in an assignment of PLAM's investment advisory agreement with the Europe Equity Fund under the Act.

3. PLAM is governed by a management committee of four individuals. Each general partner appointed two members to the management committee. Mr. Biderman is an employee of Lipper Inc. and serves on the management committee on PLAM as one of the two Lipper Europe representatives.

4. Mr. Biderman previously served as a director on the board of directors of the Company (the ''Board''), including the Europe Equity Fund, but resigned effective as of the closing of the Transaction to enable the Transaction to remain subject to the safe harbor provisions of section 15(f) of the Act (described below). Applicants would like Mr. Biderman to rejoin the Board without removing the Transaction from the safe harbor.

Applicant's Legal Analysis

1. Section 15(f) of the Act is a safe habor that permits an investment adviser to a registered investment company (or an affiliated person of the investment adviser) to receive ''any amount or benefit'' in connection with a sale of securities of, or sale of any other interest in, the investment adviser that results in an ''assignment'' of the advisory contract with the investment company, if certain conditions are met. Section 15(f)(1)(A) requires that, for a period of three years after the sale, at least 75 percent of the board of directors of the investment company may not be ''interested persons'' with respect to either the predecessor or successor adviser of the investment company.

2. Section 2(a)(4) of the Act defines ''assignment'' to include: ''any direct or indirect transfer * * * of a controlling block of the assignor's outstanding voting securities by a security holder of the assignor.'' Applicants state that the Transaction was deemed to result in an assignment of PLAM's investment advisory agreement with the Europe Equity Fund. Applicants further state that the parties to the Transaction sought to rely on the safe harbor in section 15(f) in connection with that assignment. Because Mr. Biderman may be deemed an interested person of PLAM, Mr. Biderman resigned from the Company's Board as the closing of the Transaction in order for the Company's Board to meet the requirements of section 15(f)(1)(A).

3. Section 6(c) of the Act permits the SEC to exempt any person or transaction from any provision of the Act, or any rule or regulation thereunder, if the exemption is necessary or appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the Act.

4. Applicants request an order under section 6(c) to permit Mr. Biderman to rejoin the Board without causing the Transaction to fall outside the safe harbor of section 15(f) of the Act. Applicants state that Mr. Biderman was not affiliated with any party to the Transaction, except indirectly as a representative of Lipper Europe, a joint venturer with Prime USA in PLAM. Applicants further state that neither Mr. Biderman nor Lipper Inc. has any ownership interest in Prime USA, Prime S.p.A., Fiat or Generali and derived no economic interest from the Transaction. Applicants also state that the advisory fees received by Lipper Inc. and Prime S.p.A. through their respective ownership interests in PLAM are not a material portion of the revenues of either Lipper Inc. or Prime S.p.A.

5. Applicants further state that the disinterested directors of the company unanimously approved the filing of the application for exemptive relief as in the best interests of the Company's shareholders to permit Mr. Biderman to rejoin the Board. Mr. Biderman has served on the Board since its initial organization in 1995 and has been intimately involved in the operations of the Europe Equity Fund. Applicants assert that Mr. Biderman's inability to serve on the Board also deprives the Company's other portfolios of his services.

6. Applicants state that the Board could meet the requirements of section 15(f)(1)(A) if, in addition to Mr. Biderman, three disinterested directors were added to the Board. Applicants contend, however, that reconstituting the Board in this manner would result in a disproportionately large Board and would impose additional expenses on the Company. Applicants note that if Mr. Biderman rejoins the Board, the Board still will have a majority of directors who are not interested persons of PLAM.

7. Applicants assert that the conditions by which they would abide as long as they are relying on the requested order will assure that the safeguards embodied in section 15(f)(1)(A) are maintained. These conditions require, among other things, that during the period covered by the requested order, the fees paid by the Europe Equity Fund to PLAM will not increase and that applicants take all appropriate actions to ensure that the scope and quality of services provided by PLAM to the Europe Equity Fund will be at least equivalent to that which PLAM has provided since the Transaction.

8. For the reasons stated above, applicants submit that the requested relief is necessary and appropriate in the public interest and consistent with the protection of investors and the purposes fairly intended by the policy and provisions of the Act.

Applicant's Conditions

Applicants agree that the order granting the requested relief will be subject to the following conditions:

1. Applicants will take all appropriate actions to ensure that the scope and quality of investment advisory services that PLAM provides to the Europe Equity Fund will be at least equivalent to that which has been provided by PLAM since the Transaction.

2. The investment advisory fees payable by the Europe Equity Fund to PLAM under its investment advisory agreement with PLAM will not be increased.

3. If, within three years of the completion of the Transaction, it becomes necessary to replace any director of the Company, that director will be replaced by a director who is not an ''interested person'' of PLAM within the meaning of section 2(a)(19)(B) of the Act, unless at least 75% of the directors at that time are not interested persons of PLAM.

For the SEC, by the Division of Investment Management, under delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98–17081 Filed 6–25–98; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 35–26888]

Filings Under the Public Utility Holding Company Act of 1935, as Amended (''Act'')

June 19, 1998.

Notice is hereby given that the following filing(s) has/have been made with the Commission pursuant to provisions of the Act and rules promulgated under the Act. All interested persons are referred to the application(s) and/or declaration(s) for complete statements of the proposed transaction(s) summarized below. The application(s) and/or declaration(s) and any amendments is/are available for public inspection through the Commission's Office of Public Reference.

Interested persons wishing to comment or request a hearing on the application(s) and/or declaration(s) should submit their views in writing by July 14, 1998, to the Secretary, Securities and Exchange Commission, Washington, DC 20549, and serve a copy on the relevant application(s) and/or declaration(s) at the address(es) specified below. Proof of service by affidavit or, in case of an attorney at

law, by certificate) should be filed with the request. Any request for hearing should identify specifically the issues of fact or law that are disputed. A person who so requests will be notified of any hearing, if ordered, and will receive a copy of any notice or order issued in the matter. After July 14, the application(s) and/or declaration(s), as filed or as amended, may be granted and/or permitted to become effective.

Central Maine Power Company, et al.

Central Maine Power Company (''Central Maine''), a public utility holding company exempt from regulation under the Act, in accordance with rule 2 under the Act, and HoldCo, Inc. (''Holdco''), a wholly owned subsidiary of Central Maine (together, ''Applicants''), both located at 83 Edison Drive, Augusta, Maine 04336, have filed an application under sections 3(a)(1), 9(a)(2) and 10 of the Act.

Central Maine is an investor-owned public utility company primarily engaged in the business of generating, transmitting and distributing electricity to wholesale customers, principally other utilities, and to retail customers in Maine. Central Maine is the largest electric utility in Maine and serves approximately 528,000 customers in its 11,000 square mile service area. Central Maine had $954 million in consolidated electric operating revenues in 1997. Central Maine is subject to the regulatory authority of the Maine Public Utilities Commission.

Central Maine currently has three utility subsidiaries: Maine Electric Power Company, Inc. (''MEPCO''), Aroostook Valley Electric Company (''AVEC''), and NORVARCO. MEPCO owns and operates a 345-kV transmission interconnection between Wiscasset, Maine and the Maine-New Brunswick international border at Orient, Maine. AVEC owns and operates a 31 MW wood-fired generating plant in Fort Fairfield, Maine, the output of which is sold to Central Maine.[1] NORVARCO is one of two general partners in Chester SVC Partnership, a general partnership which owns certain transmission assets in Chester, Maine, adjacent to MEPCO's transmission interconnection.[2]

Central Maine's nonutility subsidiaries include: CMP International Consultants (''CMPI''), Central Securities Corporation (''Central''), Cumberland Securities Corporation (''Cumberland''), Kennebec Hydro Resources (''Hydro''), The Merimil Limited Partnership (''Merimil''), MaineCom Services, Inc. (''MainCom''), TeleSmart (''Telesmart''), The Union Water-Power Company (''Union Water''), Androscoggin Reservoir Company (''Androscoggin''), Kennebec Water Power Company (''Kennebec Water''), and the Gulf Island Pond Oxygenation Project (''GIPOP''). These subsidiaries are engaged in utility support services (such as training, research, project management and technical consulting), telecommunications, river facilities management, administrative services, and real estate activities. In 1997, they provided total revenues of $21,238,000, or approximately 2% of Central Maine's total consolidated electric operating revenues for that year.

Holdco and Central Maine seek authority for Holdco to acquire all of the outstanding common stock of Central Maine and, indirectly, of its utility subsidiaries. In addition, Holdco and Central Maine seek an order under section 3(a)(1) of the Act exempting Holdco and Central Maine from all provisions of the Act, except section 9(a)(2).

Holdco intends to form a subsidiary company, Merger Sub, for the sole purpose of consummating the acquisition of Central Maine by Holdco (''Acquisition''). In accordance with an agreement (''Merger Plan'') to be entered into by Holdco, Central Maine and Merger Sub, Merger Sub will merge with and into Central Maine. In addition each issued and outstanding share of Central Maine common stock (''CM Common Stock'') will be converted into one share of Holdco common stock (''Holdco Common Stock'').[3] The outstanding shares of Merger Sub common stock will be automatically converted into a number of shares of CM Common Stock equal to the number of shares of CM Common Stock before the Merger. The shares of Holdco Common Stock owned by Central Maine before the Merger will be canceled. All debt securities and series of Central Maine preferred stock will be unaffected by the Merger Plan and will remain securities of Central Maine.

Upon consummation of the Acquisition, each person that held shares of CM Common Stock before the Acquisition, will hold an equal number of shares of Holdco Common Stock, and Holdco will hold all of the issued and outstanding shares of CM Common Stock.

Applicants state that concurrently with the Acquisition, or shortly thereafter, Central Maine will transfer by dividend its existing equity interests in CMPI, MaineCom, Telesmart, Union Water and Androscoggin to Holdco.[4]

Applicants assert that they will each satisfy the requirements for an exemption under section 3(a)(1) upon consummation of the Merger. They state that they and their public utility subsidiaries currently are, and will continue to be, predominately intrastate in character and will continue to carry on their business substantially in Maine.

For the Commission, by the Division of Investment Management, under delegated authority.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98–17082 Filed 6–25–98; 8:45 am]

BILLING CODE 8010–01–M

[1] Central Maine has reached an agreement with a third party, FPL Group (''FPL''), to sell its interests in AVEC, as part of a sale to FPL of all of its nonnuclear generating assets.

[2] Central Maine also owns a 38% common stock interest in Maine Yankee Atomic Power Company (''Maine Yankee''), which owns the Maine Yankee nuclear electric generating plant in Wiscasset, Maine. The Maine Yankee plant is not currently operating. On August 6, 1997, the board of directors of Maine Yankee voted to shut down permanently and begin to decommission the Maine Yankee plant.

[3] Central Maine's shareholders approved the Merger Plan at their annual meeting on May 21, 1998.

[4] Central Maine expects to sell its interests in Hydro, Merimil and GIPOP as part of the planned sale of its nonnuclear generation assets. Central Maine has offered for sale its interest in Kennebec Water. If Central Maine does not receive an acceptable bid for this interest, it will retain the interest and not transfer it to Holdco. Cumberland and Central will remain subsidiaries of Central Maine.

SECURITIES AND EXCHANGE COMMISSION

Sunshine Act Meeting

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 meeting during the week of June 29, 1998.

A closed meeting will be held on Wednesday, July 1, 1998, at 2:30 p.m.

Commissioners, Counsel to the Commissioners, the Secretary to the Commission, and recording secretaries will attend the closed meeting. Certain staff members who have an interest in the matters may also be present.

The General Counsel of the Commission, or his designee, has certified that, in his opinion, 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), permit consideration of the scheduled matters at the closed meeting.

Commissioner Hunt, as duty officer, voted to consider the items listed for the closed meeting in a closed session.

The closed meeting scheduled for Wednesday, July 1, 1998, at 2:30 p.m., will be:

Institution of injunctive actions.

Institution of administrative proceedings of an enforcement nature.

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:

The Office of the Secretary at (202) 942–7070.

Dated: June 23, 1998.

Jonathan G. Katz,

Secretary.

[FR Doc. 98–17149 Filed 6–23–98; 4:11 pm]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–40105; File No. SR–NASD–98–28]

Self-Regulatory Organizations; National Association of Securities Dealers, Inc.; Order Approving Proposed Rule Change Relating to Approval of Research Reports

June 22, 1998.

I. Introduction

On April 27, 1998, NASD Regulation, Inc. (''NASD Regulation'') filed with the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend Rule 2210, ''Communications with the Public,'' of the Conduct Rules of the National Association of Securities Dealers, Inc. (''NASD'' or ''Association''). The proposed rule change will permit the approval of research reports by a supervisory analyst acceptable to the New York Stock Exchange (''NYSE'') under NYSE Rule 344, ''Supervisory Analysts,'' [3] to satisfy the requirement under NASD Rule 2210 that research reports be approved by a registered principal.

The proposed rule change was published for comment in the **Federal Register** on May 19, 1998.[4] No comments were received on the proposal. This order approves the proposal.

II. Description of the Proposal

Currently, NASD Rule 2210(b)(1) requires each item of advertising and sales literature to be approved by signature or initial of a registered principal of an NASD member prior to use or filing with NASD Regulation. Under NASD Rule 2210(a)(2), ''sales literature'' includes research reports. A joint NASD/NYSE member asked the NASD whether the approval of research reports by a supervisory analyst approved by the NYSE under NYSE Rule 344 could satisfy the requirement under NASD Rule 2210 that a registered principal approve research reports prior to use or filing with NASD Regulation.

In order to become a supervisory analyst under NYSE Rule 344, an applicant may present evidence of appropriate experience and either (i) pass an NYSE Supervisory Analyst Examination, or (ii) successfully complete a specified level of the Chartered Financial Analysts Examination prescribed by the NYSE and pass only that portion of the NYSE Supervisory Analysts Examination dealing with NYSE rules on research standards and related matters.[5] The NASD Regulation staff reviewed the NYSE content outline for the NYSE's Supervisory Analysts Examination and found that the particular categories of securities addressed in the ''securities analysis'' section of the content outline are fixed income securities and equity securities. The NASD Regulation staff concluded that the coverage of the NYSE communication rules in NYSE's Supervisory Analysts Examination is comparable to the communication materials covered in the NASD principal examination.[6] Accordingly, NASD Regulation believes that, with respect to the level of training and experience necessary for review of research reports on debt and equity securities, the level of supervisory analyst registration is comparable to the level of NASD principal registration. Given that the scope of approval authority is limited to research reports on debt and equity securities and that the material in the NYSE's Supervisory Analysts Examination and the NASD's principal examination is comparable, the NASD Regulation staff concluded that the investor protection goals that the NASD's principal review requirement are designed to serve could be satisfied by the NYSE's requirements in this area.

Accordingly, the proposed rule change amends NASD Rule 2210(b)(1) to state that the requirement that advertising and sales literature be approved by a registered principal of an NASD member firm may be met, with respect to corporate debt and equity securities that are the subject of research reports as that term is defined in NYSE Rule 472, ''Communications with the Public,'' [7] by the signature or initial of a supervisory analyst approved pursuant to NYSE Rule 344. Any other material requiring supervisory approval would continue to require approval by an NASD registered principal.

III. Discussion

After careful review, the Commission finds that the proposed rule change is consistent with the provisions of Section 15A(b)(6)[8] of the Act, which require that the rules of the Association be designed to promote just and equitable principles of trade and to protect investors and the public interest. The proposal amends NASD Rule 2210(b)(1) to state that the requirement that advertising and sales literature be approved by a registered principal of an NASD member firm may be met, with respect to corporate debt and equity securities that are the subject of research reports, as defined in NYSE Rule 472, by the signature or initial of a supervisory analyst approved pursuant to NYSE Rule 344. NASD Regulation staff states that it has reviewed the content outline for the NYSE Supervisory Analysts Examination and concluded that the coverage of the NYSE communication rules in the Supervisory Analysts Examination is comparable to the communication materials covered in the NASD principal examination. Additionally, the NASD Regulation staff has represented that any change to NYSE Rule 344 or the NYSE Supervisory Analysts Examination would be cause for the NASD to review NASD Rule 2210 to ensure that NASD and NYSE requirements for approval of research reports remain comparable.[9] Given that

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[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] NYSE Rule 344 states that supervisory analysts must be acceptable to, and approved by, the NYSE. NYSE Rule 344, Supplementary Material .10 sets forth examination and other requirements for supervisory analysts.

[4] *See* Securities Exchange Act Release No. 39985 (May 12, 1998), 63 FR 27608.

[5] *See* NYSE Rule 344, Supplementary Material .10.

[6] The NASD principal examination referred to here is the Series 24 Qualification Examination for Principals.

[7] NYSE Rule 472, Supplementary Material .10 defines ''research reports'' as ''* * * an analysis of individual companies, industries, market conditions, securities or other investment vehicles which provide information reasonably sufficient upon which to base an investment decision.''

[8] 15 U.S.C. 78*o*–e.

[9] This representation was made by Robert J. Smith of the Office of General Counsel, NASD Regulation,

the proposed rule change permits the approval of research reports by a supervisory analyst approved pursuant to NYSE Rule 344 in limited circumstances and according to standards comparable to current NASD requirements, the Commission believes that the proposed rule change preserves the investor protection goals of the NASD principal review requirement rules and eliminates duplicative regulatory requirements.

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act [10] that the proposed rule change (SR–NASD–98–28) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[11]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98–17080 Filed 6–25–98; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–40103; File No. SR–NASD–98–04]

Self-Regulatory Organizations; National Association of Securities Dealers, Inc.; Order Granting Approval to Proposed Rule Change Relating to Mandatory Arbitration of Claims Involving Exempted Securities.

June 19, 1998.

I. Introduction

On January 27, 1998, the National Association of Securities Dealers, Inc. (''NASD'' or ''Association'') submitted to the Securities and Exchange Commission (''Commission''), pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] a proposed rule change to amend the interpretation of the NASD's Code of Arbitration Procedure (''Code'') such that all claims relating to transactions in exempted securities, including government and municipal securities, may be submitted to the Office of Dispute Resolution (''Office'') for arbitration under the Code without limitation. Accordingly, when such claims arise involving public customers, Rule 10301 of the code will require member firms and associated persons to arbitrate them at the request of the customer. In addition, when such claims arise between members and other members or associated persons, Rule 10201 (which governs intra-industry disputes) will require them to be arbitrated at the request of one of the parties. Finally, when such claims arise between a member firm and a customer, customers can be required under the terms of a predispute arbitration agreement to arbitrate the claims.

Notice of the proposed rule change, together with the substance of the proposal, was published for comment in Securities Exchange Act Release No. 39880 (April 16, 1998), 63 FR 20230 (April 23, 1998). No comments were received on the proposal.

II. Description

Since at least 1989, the Office had declined to accept claims for mandatory arbitration involving transactions in government securities naming member firms that were registered solely under Section 15C of the Act as government securities broker/dealers.[3] By contrast, if a claim involves a government securities transaction by a general securities broker/dealer member firm, the Office will accept the claim for mandatory arbitration. If the claim involves a municipal securities transaction by a member firm,[4] the Office will accept the claim for arbitration.[5] In addition, the Office will accept claims where both parties agree to submit the claim to arbitration.

Rule 10101 of the Code provides that disputes ''arising out of or in connection with the business of any member'' are eligible for submission to arbitration under the Code. The definition of ''investment banking or securities business'' in Article I, paragraph (l) of the By-Laws means ''the business carried on by a broker, dealer, or municipal securities dealer * * *.'' Rule 10301(a) provides that eligible disputes ''arising in connection with the business of [a] member or in connection with the activities of [an] associated person'' must be arbitrated pursuant to any enforceable arbitration agreement or upon the demand of a customer. While these rules (and the definition) sweep in a very broad range of disputes, Rule 10301(b) permits the Office to decline to arbitrate certain matters.

In reliance on Rule 10301(b), and the NASD's limited regulatory jurisdiction over government securities-only member firms the Office has for many years declined to accept for arbitration claims that involved transactions in government securities by member firms engaged only in activities involving government securities unless both parties voluntarily agreed to submit the claim. The Office's position means that these claims cannot be compelled into arbitration under either a demand for arbitration or a presidpute arbitration agreement. The Office's decision to decline to mandate arbitration of government securities claims was based on the following rationale: (1) the NASD only regulated the exempted securities activities of member firms to the limited extent permitted in Section 15A(f)(2) of the Act; and, (2) the subject matter jurisdiction of the arbitration forum should not be significantly different from the NASD's regulatory jurisdiction over its members and associated persons.

In response to the passage of the Government Securities Act Amendments of 1993, which amended Section 15A(f)(2) of the Act and granted the NASD the authority to regulate broadly the business practices of members with respect to government securities,[6] NASD Regulation amended its rules to consolidate the Government Securities Rules it had adopted pursuant to Section 15A(f)(2) of the Act with its more generally applicable

to Heidi Pilpel, Special Counsel, Division of Market Regulation, on May 12, 1998.

[10] 15 U.S.C. 78s(b)(2).

[11] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] Section 15C of the Act, 15 U.S.C. 78*o*–5, governs the registration of government securities broker/dealers. Since 1986, when Section 15C was adopted as part of the Government Securities Act, government securities broker/dealers have been required to become members of an exchange or the NASD.

[4] Section 15B of the Act, 15 U.S.C. 78*o*–4, governs the registration of municipal securities dealers. Municipal securities dealers are not required to become members of an exchange or the NASD. Nevertheless, some NASD members which are engaged in a general securities business are registered as municipal securities dealers, and some firms which are exclusively municipal securities dealers have become members of the NASD.

[5] The NASD previously asked claimants in these cases if they wanted the claim referred to the Municipal Securities Rulemaking Board (''MSRB'') for arbitration. However, the Commission recently approved an MSRB proposed rule change terminating the MSRB's arbitration program and requiring the financial institutions that are subject to its rules to submit to arbitration in the NASD's forum as if they were NASD members. *See* Securities Exchange Act Release No. 39378 (December 1, 1997), 62 FR 64417 (December 5, 1997). The Commission believes that compelling NASD members to arbitrate municipal securities claims would be consistent with the intent of the MSRB's rule filing eliminating its arbitration program and sending its arbitration cases to the NASD. The Commission notes that NASD members engaged in municipal securities transactions already are required to arbitrate their claims because they are either general securities broker/dealers that are otherwise required to arbitrate all of their other claims, or because they voluntarily became NASD members. The Commission notes that this filing does not affect the arbitration of municipal securities.

[6] The NASD is still barred from establishing regulations covering the municipal securities activities of broker/dealers; that authority is reserved to the MSRB.

Conduct Rules. NASD Regulation now regulates the activities of members engaged in government securities activities that are both general securities broker/dealers and limited purpose government securities broker/dealers.

Under the new policy, a member that is registered solely as a government securities broker/dealer and that has a dispute with a customer over a transaction in exempted securities shall be required to submit the dispute to arbitration upon the demand of the customer.[7] Such disputes also may be compelled to arbitration pursuant to a valid predispute arbitration agreement. Intra-industry disputes involving exempted securities also will be subject to mandatory arbitration upon the request of one of the parties.

NASD Regulation also believes the policy should permit any claim involving exempted securities to be submitted for arbitration without regard to when the transaction occurred; however, if more than six years have elapsed from the transaction, occurrence, or event giving rise to the claim, under Rule 10304 of the Code, the claim will not be eligible for submission to arbitration.[8] All claims involving general securities broker/dealers will continue to be accepted for arbitration consistent with past practice. Claims previously submitted that the Office has already declined to arbitrate under the old policy cannot be resubmitted under the new policy.

III. Discussion

The Commission believes that the proposed rule change is consistent with the provisions of Section 15A(b)(6) of the Act[9] in that eliminating a barrier to the arbitration of disputes involving exempted securities will allow public customers and members access to the arbitration forum for the resolution of such disputes. The Commission believes it is reasonable, given the broadening of NASD Regulation's regulatory jurisdiction over government securities and the recent adoption of amendments to the NASD's rules in recognition of the broader jurisdiction,[10] for NASD Regulation to amend its arbitration policy to include claims involving government securities by members engaged exclusively in exempted securities activities[11] within the scope of those claims that are subject to mandatory arbitration under the Code.[12]

IV. Conclusion

It is therefore ordered, pursuant to Section 19(b)(2) of the Act,[13] that the proposed rule change (SR–NASD–98–04) is approved.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98–17083 Filed 6–25–98; 8:45 am]

BILLING CODE 8010–01–M

[7] NASD Regulation notes that few government securities claims involving public customers have been filed or attempted to be filed with the Office. Most of the claims involving government securities have involved member-to-member claims.

[8] NASD Regulation proposed an amendment to Rule 10304, rule filing SR–NASD–97–44, pending approval with the SEC. Under the proposed rule change all claims are presumed to be eligible; however, the presumption could be overcome if the respondent challenges the claim on the basis that more than six years have elapsed since the act or occurrence giving rise to the claim.

[9] 15 U.S.C. 78*o*–3.

[10] In Notice to Members 96–66, published in October 1996, the NASD announced the consolidation of its Government Securities Rules into the Conduct Rules, ending the regulatory distinction between the activities of general securities broker/dealers and government securities broker/dealers. *See* Securities Exchange Act Release No. 37588 (August 20, 1996) 61 FR 44100 (August 27, 1996).

[11] As noted above, general securities broker/dealers are already required to arbitrate all their claims, including those involving government securities.

[12] As required by Section 19(b)(5) of the Act, the Commission has consulted with the Treasury Department on this proposal.

[13] 15 U.S.C. 78s(b)(2).

[14] 17 CFR 200.30–3(a)(12).

DEPARTMENT OF STATE

[Public Notice #2843]

Determination on Export-Import Bank Support for the Sale to Venezuela of Defense Articles or Services To Be Used Primarily for Counter-Narcotics Purposes

Pursuant to section 2(b)(6) of the Export-Import Bank Act of 1945, as amended, and Executive Order 11958 of January 18, 1977, as amended by Executive Order 12680 of July 5, 1989, I hereby determine that:

(1) The defense articles and services for which the Government of Venezuela has requested Export-Import Bank financial guarantees, parts and services for the refurbishment of seventeen (17) OV–10 aircraft, are being sold primarily for anti-narcotics purposes;

(2) the sale of such defense articles and services would be in the national interest of the United States;

(3) The requirement for a determination that the Government of Venezuela has complied with all restrictions imposed by the United States on the end-use of defense articles or services for which the Export-Import Bank has provided guarantees or insurance under section 2(b)(6) of the Export-Import Bank Act is inapplicable because the pending financing will be the first Ex-Im Bank transaction with Venezuela made under section 2(b)(6) of the Act;

(4) the requirement for a determination that the Government of Venezuela has not used defense articles or services for which the Export-Import Bank has provided guarantees or insurance under section 2(b)(6) of the Export-Import Bank Act to engage in a consistent pattern of gross violations of internationally recognized human rights is inapplicable because the pending transaction will be the first Ex-Im Bank transaction with Venezuela made under section 2(b)(6) of the Act.

The determination shall be reported to Congress and shall be published in the **Federal Register**.

Dated: June 12, 1998.

Strobe Talbott,

Acting Secretary of State.

[FR Doc. 98–17021 Filed 6–25–98; 8:45 am]

BILLING CODE 4710–19–M

DEPARTMENT OF STATE

[Public Notice No. 2842]

United States International Telecommunications Advisory Committee (ITAC) Development Sector (ITAC–D); Notice of Meeting

The Department of State announces a meeting, under the International Telecommunications Advisory Committee (ITAC), of Study Groups 1 and 2 of the Telecommunications Development Sector (ITAC–D). The meeting will be held on Wednesday, July 8, 1998, 10:00 a.m.–12:00 noon, in Room 1207 of the Department of State, 2201 ''C'' Street, NW., Washington, DC.

The purpose of ITAC is to advise the Department on policy, technical and operational matters and to provide strategic planning recommendations, with respect to international telecommunications and information issues. The purpose of this meeting is to develop U.S. positions for the upcoming ITU–D meetings. The meeting agenda will include preparation for planned ITU–D meetings of Study Group 1 (Telecommunications & Development Strategies and Policies) and Study Group 2 (Development, Harmonization, Management and Maintenance of Telecommunication Networks and Services, including Spectrum Management). Questions regarding the agenda or ITAC–D Sector activities in general may be directed to Doreen

McGirr, Department of State (202–647–0201), fax number (202–647–7407).

Members of the General Public may attend these meetings and join in the discussions, subject to the instructions of the Chair. Admittance of public members will be limited to the seating available. In this regard, entrance to the Department of State is controlled.

Persons intending to attend the meeting should send a fax to (202) 647–7407 not later than 24 hours before the meeting. On this fax, please include the name of the meeting, your name, social security number, date of birth and organization. One of the following photo IDs will be required for admittance: U.S. driver's license with your picture on it, U.S. passport, or a U.S. Government identification (company ID's are no longer accepted by Diplomatic Security). Enter from the ''C'' Street Main Lobby.

Dated: June 15, 1998.

Doreen F. McGirr,

Chair, U.S. ITAC for Telecommunications Sector.

[FR Doc. 98–17028 Filed 6–25–98; 8:45 am]

BILLING CODE 4710–45–M

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Reports, Forms and Recordkeeping Requirements; Agency Information Collection Activity Under OMB Review

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describes the nature of the information collection and its expected burden. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on March 30, 1998 [63 FR 15257].

DATES: Comments must be submitted on or before July 27, 1998.

FOR FURTHER INFORMATION CONTACT: Mr. Paul Scott, Office Engineering, Federal Highway Administration, U.S. Department of Transportation, HNG–10, Room 3134, 400 7th St., SW. Washington, DC 20590–0001, telephone (202) 366–4104. Office hours are from 7:45 a.m. to 4:15 p.m., E.T., Monday thru Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Federal Highway Administration (FHWA)

Title: Eligibility Statement for Utility Adjustments.

OMB Number: 2125–0515.

Type of Request: Extension of a currently approved collection.

Affected Public: State highway agencies and local highway agencies.

Abstract: The FHWA requires State (and in some cases local) highway agencies to submit to the FHWA a statement which establishes the highway agency's legal authority or obligation to pay for utility adjustments. The FHWA reviews this statement for acceptability. If the statement is found to be suitable, it then forms a basis for Federal-aid participation in utility relocation costs under the provisions of 23 U.S.C. 123. The State highway agencies have previously submitted statements covering the extent to which utility adjustments may be legally reimbursed under State law. These statements have previously been reviewed by the FHWA and a determination of suitability has been made. Hence, the only submissions required now would be for those instances where circumstances have modified (for example, a change in State statute) the extent to which utility adjustments are eligible for reimbursement by the State or those instances where a local highway agency's legal basis for payment of utility adjustments differs from that of the State.

Estimated Total Annual Burden: 180 hours.

ADDRESSES: Send comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725–17th Street, NW., Washington, DC 20503, Attention FHWA Desk Officer. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication.

Issued in Washington, DC, on June 22, 1998.

Phillip A. Leach,

Clearance Officer, United States Department of Transportation.

[FR Doc. 98–17066 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Reports, Forms and Recordkeeping Requirements; Agency Information Collection Activity Under OMB Review

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), this notice announces that the Information Collection Requests (ICRs) abstracted below have been forwarded to the Office of Management and Budget (OMB) for review and approval. The ICRs describe the nature of the information collections and their expected burden. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following information collection was published on April 6, 1998 [63 FR 16854–16856].

DATES: Comments must be submitted on or before July 27, 1998.

FOR FURTHER INFORMATION CONTACT: Michael Robinson, NHTSA Information Collection Clearance Officer at (202) 366–9456.

SUPPLEMENTARY INFORMATION:

National Highway Traffic Safety Administration (NHTSA)

(1) Title: Procedures for Selecting Lines to be Covered by the Theft Prevention Standard (49 CFR 542).

OMB Control Number: 2127–0539.

Type Request: Extension of a currently approved collection.

Affected Public: Business or other for-profit.

Abstract: The Anti Car Theft Act of 1992 (amended the Motor Vehicle Theft Law Enforcement Act of 1984 (P.L.98–547) requires this collection of information. One component of the theft prevention package requires the Secretary of Transportation (delegated to the National Highway Traffic Safety Administration (NHTSA) to promulgate a theft prevention standard for the designation of high-theft vehicle lines. Provisions delineating the information collection requirements include section 33104, which requires NHTSA to promulgate a rule for the identification of major component parts for vehicles

having or expected to have a theft rate above the median rate for all new passenger motor vehicles (cars, MPVs, and light-duty trucks—6000 lbs GVWR and below) sold in the United States, as well as with major component parts that are interchangeable with those having high-theft rate.

The specific lines and parts to be identified are to be selected by agreement between the manufacturer and the agency. If there is a disagreement of the selection, the statute states that the agency shall select such lines and parts, after notice to the manufacturer and an opportunity for written comment. The procedures, contained in Part 542 (1) and (2) will be applied to those lines introduced before or after the 1997 model year (MY).

Estimated Annual Burden: 1,600 hours.

(2) Title: Petitions for Exemption from the Vehicle Theft Prevention Standard, 49 CFR Part 543.

OMB Control Number: 2127–0542.

Type Request: Extension of a currently approved collection.

Affected Public: Business or other for-profit.

Abstract: 49 U.S.C. Chapter 331 requires the Secretary of Transportation to promulgate a theft prevention standard to provide for the identification of certain motor vehicles and their major replacement parts to impede motor vehicle theft. 49 U.S.C. section 33106 provides for an exemption to this identification process by petitions from manufactures who equip covered vehicles with standard original equipment anti theft devices, which the Secretary determines are likely to be as effective in reducing or deterring theft as the identification system.

Estimated Annual Burden: 192 hours.

ADDRESSES: Send comments, within 30 days, to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725–17th Street, NW., Washington, DC 20503, Attention NHTSA Desk Officer. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication.

Issued in Washington, DC, on June 22, 1998.

Phillip A. Leach,

Clearance Officer, United States Department of Transportation

[FR Doc. 98–17067 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Reports, Forms and Recordkeeping Requirements; Agency Information Collection Activity Under OMB Review

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act 1995 (44 USC Chapter 35), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget (OMB) for review and comment. The ICR describes the nature of the information collection and its expected burden. The **Federal Register** Notice with a 60-day comment period soliciting comments on the following collection of information was published on February 17, 1998 [63 FR 7849–7850].

DATES: Comments must be submitted on or before July 27, 1998.

FOR FURTHER INFORMATION CONTACT: Ms. Arlene Kennedy, Office of Information Services, (202) 366–9458, Department of Transportation, Federal Highway Administration, 400 Seventh Street, SW., Washington, DC 20590. Office hours are from 7:45 a.m. to 4:15 p.m., e.t., Monday through Friday, except Federal holidays.

SUPPLEMENTARY INFORMATION:

Federal Highway Administration (FHWA)

Title: Certification of Enforcement of the Heavy Vehicle Use Tax.

OMB Number: 2125–0541.

Type of Request: Extension of a currently approved collection.

Form(s): N/A

Affected Public: State highway agencies.

Abstract: Title 23, United States Code, Section 141(d), provides that a State's apportionment of funds under 23 U.S.C. 104(b)(5) shall be reduced in an amount up to 25 percent of the amount to be apportioned during any fiscal year beginning after September 30, 1984, if vehicles subject to the Federal heavy vehicle use tax are lawfully registered in the State without having presented proof of payment of the tax. The annual certification of collection of the heavy vehicle use tax submitted by each State serves as the primary means of determining State compliance with 23 U.S.C. 141(d) by the FHWA. Under the rulemaking authority granted to the Secretary of Transportation by 23 U.S.C. 315, the FHWA has determined that an annual certification of compliance by each State is the least obtrusive means of administering the provisions of the legislative mandate.

Evidence of compliance with 23 U.S.C. 141(d) is comprised of two elements: reporting and recordkeeping. The reporting element consists of a simple certification submitted to FHWA on an annual basis by the State's Governor or designated official. The recordkeeping element consists of a one-year retention of Schedule 1, Form 2290, by the States (or other suitable alternative provided by regulation).

Compliance reviews are periodically conducted by FHWA to determine if the certification is adequate to ensure effective administration of 23 U.S.C.141(d).

The certification requirement is the critical factor in establishing a manageable and reasonable procedure for determining State compliance with the statute. Without annual certification and supporting records, determinations of compliance would involve frequent reviews of State registration procedures and practices and would clearly be an obtrusive Federal presence in State programs.

Estimated Annual Burden Hours: 612.

ADDRESSES: Send comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725–17th Street, NW., Washington, DC 20503, Attention FHWA Desk Officer. Comments are invited on: whether the proposed collection of information is necessary for the proper performance of the functions of the Department, including whether the information will have practical utility; the accuracy of the Department's estimate of the burden of the proposed information collection; ways to enhance the quality, utility and clarity of the information to be collected; and ways to minimize the burden of the collection of information on respondents, including the use of automated collection techniques or other forms of information technology.

A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication.

Issued in Washington, DC, on June 22,1998.

Vanester M. Williams,

Clearance Officer, United States Department of Transportation

[FR Doc. 98–17068 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Broad Agency Announcement: Funds Availability for Research Projects and Technology Advancements Under the Next Generation High-Speed Rail Program

AGENCY: Federal Railroad Administration (FRA), Department of Transportation (DOT).

ACTION: Notice of funds availability: Broad Agency Announcement (BAA) for research projects and technology advancements under the next generation high-speed rail program.

Introduction

The Federal Railroad Administration (FRA) is soliciting pre-proposal concept papers for various research projects, technology advancements and/or demonstrations directed at enhancing the deployment of high-speed rail service in the United States. Technologies most likely to enhance the deployment of high-speed rail service in the U.S. are those which will—(a) enhance the revenue-generating capability of high-speed operations; (b) bring about capital cost reductions and economy in producing equipment and facilities; (c) reduce operating costs of high-speed rail service; (d) improve the reliability of equipment and infrastructure components; (e) improve safety; and/or (f) enhance the social benefits and/or environmental aspects of high speed rail.

Eligible Participants

This is an unrestricted solicitation. Any responsible source may submit a pre-proposal concept paper for consideration including, but not limited to, states or local governments, or organizations of state or local governments, institutions of higher education, hospitals or other non-profit organizations, private individuals, corporations, businesses or commercial organizations, except that any business owned in whole or in part by the Federal Government is not eligible. Although businesses owned in whole or in part by the Federal Government are not eligible for funding under the Program, they may contract with eligible participants. Cooperative arrangements (e.g., joint ventures, limited partnerships, teaming arrangements, or collaboration and consortium arrangements) are permitted and encouraged. Small, Small Disadvantaged (SD), and Women-Owned (WO) Business Concerns, and Historically Black Colleges and Universities (HBCU) and Minority Institutions (MIs) are encouraged to submit pre-proposal concept papers on their own and/or in collaboration with others. However, no portion of this BAA will be set aside exclusively for Small, SD, or WO Business Concerns, or for HBCU and MIs. Attention: Minority, Women-Owned and Disadvantaged Business Enterprises (DBEs)! The Department of Transportation (DOT), Short-Term Lending Program (STLP) offers working capital financing in the form of lines of credit to finance accounts receivable for transportation related contracts. Maximum line of credit is $500,000 with interest at the prime rate. For further information call (800) 532–1169. Internet address: *http://osdbuweb.dot.gov*.

Exchanges and Points of Contact

Exchanges of information between interested parties and the Government, prior to submission of pre-proposal concept papers, are strongly encouraged. Such informal exchanges may provide would-be offerors with preliminary information on the Government's level of interest in prospective works or projects or on the availability of funds. Any exchanges of information must be consistent with procurement integrity requirements of section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423, as amended) (see Federal Acquisition Regulation (FAR) 3.104). For technical inquires, interested parties may contact the BAA primary technical point of contact, Mr. Robert McCown (Tel: 202/632–3250, Fax: 202/632–3854), or one of the other, secondary technical points of contact identified in Appendix A of the BAA 98–01 Pre-Proposal Preparation Package (BAA 98–01 Package), available from the FRA. All non-technical inquiries should be directed to the Grants/Contracting Officer, Mr. Thomas Riddle (Tel: 202/632–3391, Fax: 202/632–3846). Please note that FRA anticipates changing its telephone service on or about July 10, 1998. New telephone numbers will be assigned during this change over. For the first 30 days after the change over, there will be a automatic bridge/link in which the service provider will furnish callers with the new number of the party they are trying to reach when an old [replaced] number is dialed. After 30 days, a caller who dials an old number will be routed to the DOT operator for assistance/new number, or the caller may dial the DOT information line direct at 202/366–4000. As of the date this announcement/notice was submitted for publication, the following numbers have been tentatively assigned for the points of contact identified above, for *usage on or after July 10, 1998:* Mr. McCown—Tel: 202/493–6350, RDV–30 Fax: 202/493–6333. Mr. Riddle—Tel: 202/493–6149.

BAA Time Line

BAA 98–01 is being published in both the Commerce Business Daily (CBD) and the **Federal Register** (FR) in June 1998. (Note: BAA 98–01 is a single broad agency announcement of the FRA, that is being advertised and published in these two different media to reach a broad base of prospective applicants. The description of BAA 98–01 may different slightly in form between the two publications, but each will be substantially the same as the other in all material respects.) FRA will accept pre-proposal concept paper submissions, inquiries and requests for the BAA 98–01 Package under BAA 98–01, immediately upon its announcement and appearance in either the CBD, or FR, or June 22, 1998, whichever single date/event occurs first. However, to allow interested parties adequate time to prepare pre-proposal concept papers, FRA will not begin its technical evaluations before July 22, 1998. Unless BAA 98–01 is superceded or canceled, FRA will continue to accept concept submissions, inquiries and package requests, through April 30, 1999; however, fiscal year 1999 (FY 99) awards are subject to the availability of FY 99 appropriations or the continued availability of unobligated prior no-year funds. Although the BAA is open for an extended period, interested parties would be well advised to submit proposals as early as possible.

Funding Authority and Related Information

Funds for this program are authorized in the Department of Transportation and Related Agencies Appropriations Act 1998, Public Law 105–66 (October 27, 1997). FRA will make available up to $4.3 million for awards under the BAA during fiscal year 1998 for research project and technology advancements in areas of research interest to the FRA, that are evaluated favorably and determined by the FRA to be consistent with the objectives of this BAA and of interest to the Government, and for which adequate funding exist. Awards

may be of any dollar value within the maximum amounts allowed for each area of interest (so long as those amounts do not exceed the total amount available under the BAA), but it is anticipated that most, if not all, individual awards (or that part of the Government's portion in a cost sharing arrangement) will have dollar values ranging between $25,000 and $500,000 each. Prospective offerors are advised that awards greater than $500,000 will generally require the awardee (except a small business concern) to already have in place or prepare, at or before the time of award, an acceptable plan to maximize the participation of minority, women-owned and disadvantaged business enterprises. Because the range and diversity of activities that may be proposed under the BAA does not permit a common work statement, no single Standard Industrial Classification (SIC) code will be issued for the BAA. SIC codes will be specific to each individual contract award as determined by the type of activity in which the actual offeror will be engaged, and as a function of the ownership characteristics of the prospective offeror. Cost sharing by awardees is not mandatory under this BAA, however because of the potential for long-term benefits to those firms or institutions involved in these research and development activities, offerors are strongly encouraged to consider sharing the cost of their proposed projects.

Awards

Research projects, technology advancements, and/or demonstrations proposed under this BAA will be considered for award through a two-step process. In the first step, interested parties must submit a pre-proposal concept paper for each research project, technology advancement or demonstration (by area of interest) the applicant wishes the FRA to consider. The purpose of the pre-proposal concept paper is to preclude unwarranted and possibly costly effort on the part of interested parties whose proposed work may not be of interest to the FRA under this BAA. Pre-proposal concept papers submitted under this BAA will be subject to technical review in accordance with the established evaluation criteria. Based upon its evaluations, the FRA will subsequently notify each respondent who submits a pre-proposal concept paper as to whether the Government encourages or does not encourage the submission of a full proposal. In the second step, respondents whose pre-proposal concept papers are evaluated favorably and determined by the FRA to be consistent with the objectives of the BAA and of interest to the Government, may be requested to submit a full technical and cost proposal or other information relative to the initial submission for further consideration. Such a request will NOT guarantee the applicant that an award will be forthcoming for the offered work or project, nor otherwise create an obligation on the part of the Government. Awards may take the form of contracts, grants or cooperative agreements. Contracts will be used when the principal purpose is the acquisition of supplies or services (including research and development) for the direct benefit or use of the Federal Government. Grants or cooperative agreements will be used when the principal purpose of the transaction is to stimulate or support research and development for another public purpose.

Areas of Technology Interest

Technologies which are high-priority research candidates for evaluation pursuant to this announcement include: (1) Grade crossing hazard mitigation systems. (2) Innovative, low cost technologies to improve track and structures. (3) Advance train control systems. (4) Non-electric locomotives and passenger equipment systems. (5) Other scientific study, technology adaptation, or demonstration directed toward advancing the state-of-the-art or increasing the knowledge or understanding of high-speed passenger rail service in the U.S.

Pre-Proposal Concept Papers and Preparation Instructions

Pre-proposal concept papers should be ten (10) pages or less (except as otherwise noted). Pre-proposal concept paper submissions must contain a Technical Concept Section and a Cost or Pricing Section, and when applicable, should contain a Phased or Follow-on Research Project Section. Specific content and format requirements and additional instructions for preparing submissions, as well as further information on the areas of interest themselves and the evaluation/selection process, are provided in the BAA 98–01 Package. Interested parties may obtain a copy of the BAA 98–01 Package by submitting a written request to U.S. Department of Transportation, Federal Railroad Administration, Office of Acquisition and Grants Services, RAD–30, 400 7th Street, SW, Mail Stop 50, Washington, DC 20590, or via tele-facsimile request (Fax No. 202/632–3846), to the attention of the Grants/Contracting Officer, Mr. Riddle. The request should also reference the Solicitation No. BAA 98–01. The BAA 98–01 Package should also be available on the Internet in July 1998,

Evaluation Criteria

Pre-proposal concept papers (and later full proposals or other submissions, if and when requested) will be evaluated using the following criteria, which are listed in descending order of relative importance: (1) The overall scientific merit and/or technical merits of the proposal. (2) The degree to which the overall proposed technical effort will advance U.S. high-speed rail technology, and the extent to which its application to railroad operations would improve intercity passenger operations through improved railroad capital equipment or infrastructure, traffic control centers, interfaces among these, or operating methods, and/or its potential for performance improvement in one or more qualities such as, cost effectiveness, reliability, safety, availability, or maintainability. (3) The technical qualifications and demonstrated experience of key personnel proposed to perform the technical efforts. (4) The administrative qualifications and demonstrated experience of the proposing organization to support projects such as those proposed. (5) The reasonableness and realism of the proposed costs and fee (if any). (6) The degree to which Federal funds are leveraged by private, non-Federal, and/or Federal funds available from sources other than FRA programs. (7) The availability of funds. THIS ANNOUNCEMENT CONSTITUTES THE ONLY SOLICITATION. NO OTHER REQUEST FOR PROPOSALS OR ANNOUNCEMENT WILL BE ISSUED.

Dated: June 18, 1998.

James T. McQueen,

Associate Administrator for Railroad Development.

[FR Doc. 98–16762 Filed 6–25–98; 8:45 am]

BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 33556]

Canadian National Railway Company, Grand Trunk Corporation, and Grand Trunk Western Railroad Incorporated—Control—Illinois Central Corporation, Illinois Central Railroad Company, Chicago, Central and Pacific Railroad Company, and Cedar River Railroad Company

AGENCY: Surface Transportation Board.

ACTION: Decision No. 5 in STB Finance Docket No. 33556; Request for Comments on Procedural Schedule.

SUMMARY: The Surface Transportation Board (Board) is inviting comments from interested persons on a proposed procedural schedule for this proceeding. On February 12, 1998, Canadian National Railway Company (CNR), Grand Trunk Corporation (GTC), and Grand Trunk Western Railroad Incorporated (GTW),[1] and Illinois Central Corporation (IC Corp.), Illinois Central Railroad Company (ICR), Chicago, Central and Pacific Railroad Company (CCP), and Cedar River Railroad Company (CRRC),[2] filed a notice of intent (CN/IC–1)[3] to file a joint application seeking Surface Transportation Board (Board) authority under 49 U.S.C. 11321–26 for the acquisition of control, by CNR, through its indirect wholly owned subsidiary Blackhawk Merger Sub, Inc., of control of IC Corp. and through it of ICR and its railroad affiliates, and for the resulting common control by CNR of GTW and its railroad affiliates and ICR and its railroad affiliates.[4]

DATES: Written comments on the Board's proposed schedule must be filed with the Board no later than July 16, 1998. Applicants' reply is due by July 27, 1998.

ADDRESSES: Send an original and 25 copies of all pleadings referring to STB Finance Docket No. 33556 to: Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, N.W., Washington, DC 20423–0001. In addition, one copy of all documents in this proceeding must be sent to Administrative Law Judge David Harfeld, Federal Energy Regulatory Commission, Office of Administrative Law Judges, 888 First Street, N.E., Suite 11F, Washington, DC 20426 [(202) 219–2514; FAX: (202) 219–3289] and to each of Applicants' representatives: (1) Paul A. Cunningham, Esq., Harkins Cunningham, 1300 19th Street, N.W., Suite 600, Washington, DC 20036–1609; and (2) William C. Sippel, Esq., Oppenheimer Wolff & Donnelly, Two Prudential Plaza, 45th Floor, 180 North Stetson Avenue, Chicago, IL 60601–6710. Comments should contain the name and address of the commenting party, any recommendations for changes to the attached proposed procedural schedule and support for any such changes.

In addition to submitting an original and 25 copies of all paper documents filed with the Board, the parties shall also submit, on disks or CDs, copies of all textual materials, electronic workpapers, data bases and spreadsheets used to develop quantitative evidence. Data must be submitted on 3.5 inch IBM-compatible floppy disks or CDs. Textual materials must be in, or convertible by and into, WordPerfect 7.0. Electronic spreadsheets must be in, or convertible by and into, Lotus 1–2–3 97 Edition, Excel Version 7.0, or Quattro Pro Version 7.0. A copy of each disk or CD submitted to the Board should be provided to any other party upon request.[5]

FOR FURTHER INFORMATION CONTACT: Julia M. Farr, (202) 565–1613. [TDD for the hearing impaired: (202) 565–1695.]

SUPPLEMENTARY INFORMATION: On May 20, 1998, Applicants filed a petition (CN/IC–5) to establish a proposed procedural schedule[6] as follows:

Applicants' Proposed Procedural Schedule[7]

F Primary Application and any related applications filed.

F + 30 Board notice of acceptance of primary application (and any related applications) published in the **Federal Register**.

F + 30 Environmental Report and Safety Integration Plan due.

F + 45 Notification of intent to participate in proceeding due. Description of anticipated inconsistent and responsive applications due; petitions for waiver or clarification due with respect to such applications.

F + 60 Inconsistent and responsive applications due. All comments, protests, requests for conditions, and any other evidence and argument in opposition to the Primary Application due. Comments by U.S. Department of Justice (''DOJ'') and U.S. Department of Transportation (''DOT'') due.

F + 75 Notice of acceptance (if required) of inconsistent and responsive applications published in the **Federal Register**.

F + 90 Response to inconsistent and responsive applications due. Response to comments, protests, requested conditions, and other opposition due. Rebuttal in support of primary application and related applications due.

F + 105 Rebuttal in support of inconsistent and responsive applications due.

F + 125 Briefs due, all parties (not to exceed 50 pages).

F + 145 Oral argument.

F + 150 Voting conference (at Board's discretion).

F + 180 Date of service of final decision.

The proposed schedule contains substantially shorter time periods than those provided for in the statute at 49 U.S.C. 11325. For instance, pursuant to 49 U.S.C. 11325(b)(1), written comments about an application may be filed with the Board within 45 days after Board notice of acceptance of the primary application (and any related applications) is published in the **Federal Register**. Applicants propose that comments be filed within 30 days of publication in the **Federal Register**. The proposed schedule also suggests that inconsistent and responsive applications be filed 30 days following acceptance of the primary application rather than the 90 days noted in the statute.

Comments in opposition to the Applicants' proposed procedural schedule were filed by the Brotherhood of Maintenance of Way Employees (BMWE), on June 2, 1998, and the United Transportation Union (UTU), on June 8, 1998. Both BMWE and UTU state that the proposed schedule is too short and urge the Board to adopt the statutory procedural schedule set forth at 49 U.S.C. 11325(b). Alternatively, UTU urges the Board to adopt a 350-day schedule modeled upon the procedural

[1] CNR, GTC, and GTW, and their affiliates, are referred to collectively as CN.

[2] IC Corp., ICR, CCP, and CRRC, and their affiliates, are referred to collectively as IC. CN and IC are referred to collectively as Applicants.

[3] CN/IC–1 reflected Applicants' expectation that they would file the Primary Application on or before June 12, 1998. In view of the need to take account of subsequent developments, Applicants state that they now expect to file in July.

[4] In Decision No. 2 (served March 13, 1998, and published that day in the **Federal Register** at 63 FR 12574), we found that the transaction contemplated by Applicants is a major transaction, as that term is defined at 49 CFR 1180.2(a); we assigned the proceeding to Administrative Law Judge David Harfeld for handling of all discovery matters and the initial resolution of discovery disputes; and we advised the parties that they will be required to submit all pleadings both in the required paper form and also as computer data contained on diskettes (disks) or compact discs (CDs).

In Decision No. 4 (simultaneously being served with this decision today), we address Applicants' petition (CN/IC–4) for waiver or clarification of certain filing requirements.

[5] In Decision No. 3 (served May 19, 1998, and published on May 22, 1998, in the **Federal Register** at 63 FR 28442–44), we denied a petition for reconsideration of Decision No. 2, concerning the requirement that parties submit copies of all textual materials on disks or CDs, and stated that parties may individually seek a waiver from the disk-CD requirement.

[6] Applicants' proposed schedule is similar to the 180-day schedule proposed to the Interstate Commerce Commission by applicants in Finance Docket No. 32549, *Burlington Northern Inc. and Burlington Northern Railroad Company—Control and Merger—Santa Fe Pacific Corporation and The Atchison, Topeka and Santa Fe Railway Company (BN/SF).*

[7] The term ''F'' designates the date of filing of the application and ''F + n'' means ''n'' days following that date.

schedule issued by the Board in *CSX Corporation and CSX Transportation, Inc., Norfolk Southern Corporation and Norfolk Southern Railway Company—Control and Operating Leases/Agreements— Conrail Inc., and Consolidated Rail Corporation*, STB Finance Docket No. 33388, Decision No. 6 (STB served May 30, 1997).

We do not at this time see any compelling reason to adopt a 6-month procedural schedule for this proceeding. The statute allows 16 months for the processing of major consolidation proceedings. Under 49 U.S.C. 11325(b)(3), the Board must conclude the evidentiary stage of the proceeding within 13 months of the application's filing date,[8] and must issue the final decision by the 90th day after the conclusion of the evidentiary stage. We believe that a 10-month procedural schedule would be sufficiently expeditious so as not to delay unnecessarily any benefits that would flow from the proposed integration of the CN and IC systems, while at the same time allowing sufficient time to develop the record upon which the Board's decision would be based. We propose to modify Applicants' proposed procedural schedule so as to conclude the evidentiary stage of this proceeding approximately 8 months after the application is filed, and to issue the final decision approximately 2 months thereafter.

Given the importance of the safe implementation of major rail consolidations, we propose to require Applicants to file Safety Integration Plans on Day (F + 30) as they have proposed. Also, we propose to require inconsistent and responsive applicants to file their Responsive Environmental Reports and Environmental Verified Statements on Day (F + 100), which is 20 days in advance of when inconsistent and responsive applications would be due.

Specifically, as for the remainder of the procedural schedule, we propose to modify Applicants' proposed schedule to allow 30 more days for parties intending to file comments, protests, requests for conditions, and any other opposition evidence and argument, so that these filings would not be due until 90 days after the application is filed [Day (F + 90)]. Comments from the U.S. Department of Justice (DOJ) and the U.S. Department of Transportation (DOT) would be due 120 days after the application is filed. Responses to comments, protests, requested conditions, and other opposition (except DOJ and DOT), and also rebuttal in support of the primary application and related applications would be due on Day (F + 120). We propose to keep inconsistent and responsive applications due 120 days after the application is filed [Day (F + 120)] as provided for under 49 U.S.C. 11325(b)(2). Response to comments of DOJ and DOT would be due on Day (F + 150). Descriptions of anticipated inconsistent and responsive applications and petitions for waiver or clarification due with respect to such applications would be due on Day (F + 60) (rather than Day (F + 45)).

In addition, we propose adding 5 days for responses to inconsistent and responsive applications (which would be due Day (F + 155)), and adding 15 days for rebuttals for inconsistent and responsive applications (which would be due Day (F + 185)). Briefs would be due on Day (F + 205), and we are proposing page limitations for briefs for all parties to promote useful, focused filings, with Applicants permitted to file somewhat longer briefs, as they would have more points to address at that time than would other parties. We propose, however, adding 10 days to Applicants' proposed period of time for parties to prepare for oral argument, so that oral argument would occur on Day (F + 235). The oral argument would close the record. We propose (as did the Applicants) a 5-day interval between the oral argument and the voting conference, so that a voting conference would occur on Day (F + 240). We also propose allowing 60 days after the voting conference for the service of the Board's final decision on Day (F + 300).

Proposed Procedural Schedule as Modified by The Board

F Primary application and any related applications filed.

F + 30 Board notice of acceptance of primary application (and any related applications) published in the **Federal Register**.

F + 30 Safety Integration Plan due.

F + 45 Notification of intent to participate in proceeding due.

F + 60 Description of anticipated inconsistent and responsive applications due; petitions for waiver or clarification due with respect to such applications.

F + 90 All comments, protests, requests for conditions, and any other evidence and argument in opposition to the Primary Application due (except filings by U.S. Department of Justice (DOJ) and U.S. Department of Transportation (DOT)).

F + 100 Responsive Environmental Report and Environmental Verified Statements for inconsistent and responsive applicants due.

F + 120 Inconsistent and responsive applications due. Comments by DOJ and DOT due. Response to comments, protests, requested conditions, and other opposition (except DOJ and DOT) due. Rebuttal in support of primary application and related applications due.

F + 140 Notice of acceptance (if required) of inconsistent and responsive applications published in the **Federal Register**.

F + 150 Response to comments of DOJ and DOT due.

F + 155 Response to inconsistent and responsive applications due.

F + 185 Rebuttal in support of inconsistent and responsive applications due.

F + 205 Briefs due, all parties (not to exceed 50 pages for Applicants and not to exceed 25 pages for all other parties).

F + 235 Oral argument (close of record).

F + 240 Voting conference (at Board's discretion).

F + 300 Date of service of final decision.

Immediately upon each evidentiary filing, the filing party will place all documents relevant to the filing (other than documents that are privileged or otherwise protected from discovery) in a depository open to all parties, and will make its witnesses available for depositions. Access to documents subject to protective order will be appropriately restricted.[9] Discovery relating to applications and other filings (including responsive and inconsistent applications), where permitted, will begin immediately upon their filing. The Administrative Law Judge (ALJ) assigned to this proceeding will have the authority initially to resolve any discovery disputes.

Environmental Review Process

Based on consultations with Applicants, the Board's Section of Environmental Analysis (SEA) has determined that preparation of an Environmental Assessment (EA) is appropriate in this proceeding. This approach is consistent with the Board's environmental rules at 49 CFR 1105.6 (b)(4), which call for an EA in a merger or acquisition such as this proceeding. Also, in making its determination to prepare an EA, SEA considered the nature of the transaction, including the projected changes in train traffic, the

[8] Specifically, the statute requires the completion of the evidentiary stage within 12 months after publication of the **Federal Register** notice accepting the application. That publication is due no later than 30 days after the application is filed.

[9] In Decision No. 1 (served February 26, 1998), a protective order was issued in this proceeding.

anticipated changes at rail yards and intermodal facilities, and the number, type, and location of proposed construction projects. However, if SEA determines that this proceeding has the potential for significant environmental impacts, then SEA may prepare an Environmental Impact Statement, as required by the National Environmental Policy Act (NEPA).

Applicants originally proposed to file an environmental report 30 days after they filed their application. In a letter dated June 18, 1998, however, Applicants requested that SEA conduct a modified environmental review process in this proceeding. SEA concurs with this approach. Under this approach, Applicants will provide, with their application and operating plan, an environmental overview rather than an environmental report. This is consistent with the Board's environmental rules at 49 CFR 1105.10 (d), which waive the requirement for an environmental report for applicants that retain an independent third-party contractor to work under SEA's direction to prepare the necessary environmental documentation. For this proceeding, Applicants have retained the requisite independent third-party contractor.

With direction and guidance from SEA, Applicants will prepare and submit to SEA a Preliminary Draft Environmental Assessment (PDEA). Preparation of a PDEA is consistent with the Council on Environmental Quality regulations at 40 CFR 1506.5(b) that permit preparation of an environmental assessment by an applicant. Upon receipt of Applicants' PDEA, SEA will review and verify the environmental information provided by Applicants in this document. SEA will then prepare a Draft Environmental Assessment (Draft EA) for public review and comment. The Draft EA will include SEA's independent preliminary recommendations for mitigation to address potentially adverse environmental impacts.

As part of the environmental review process, Applicants also propose to submit a safety integration plan, which will fully describe the extensive plans they have for maximizing the safe operation of the combined system.

After reviewing all of the public comments on the Draft EA and conducting additional analyses, SEA will prepare a Final Environmental Assessment (Final EA). The Final EA will include SEA's final recommendations for environmental mitigation. The Board will consider all public comments, the Draft EA and Final EA, and SEA's environmental recommendations in making its final decision in this proceeding.

Other Matters

Applicants recommend that, in addition to noting that new evidence may not be filed with briefs, the Board should further clarify that cross-examination depositions of rebuttal witnesses cannot be used as a vehicle for adding to the evidentiary record any documents not filed with the Board as part of the application or one of the rounds of evidentiary filings specifically provided for by the Board's schedule.

Applicants suggest that the Board include in its procedural schedule language which reminds parties that, in discovery and in submissions to the Board, they focus strictly on relevant issues.

Applicants request that the Board direct that parties wishing to engage in discovery consult with the ALJ designated to handle all discovery matters and to resolve initially all discovery disputes, and that the Board give the ALJ authority to adopt discovery guidelines and rule on discovery matters but not to modify the procedural schedule.

Applicants also suggest that the Board require appeals of ALJ decisions to be filed within 3 working days of the date of a bench ruling, or in its absence the date of a written ruling, with replies to appeals or to any motion filed with the Board to be filed within 3 working days.

We invite all interested persons to submit written comments on the procedural schedule we are proposing here. Comments must be filed by July 16, 1998. Applicants may reply by July 27, 1998.[10]

This action will not significantly affect either the quality of the human environment or the conservation of energy resources.

Decided: June 22, 1998.

By the Board, Chairman Morgan and Vice Chairman Owen.

Vernon A. Williams,

Secretary.

[FR Doc. 98–17132 Filed 6–25–98; 8:45 am]

BILLING CODE 4915–00–P

[10] The comments of BMWE and UTU will be considered along with any other comments received in response to this notice.

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 33585]

RailTex, Inc.—Control Exemption—Central Properties, Inc., The Central Railroad Company of Indianapolis, and The Central Railroad Company of Indiana

AGENCY: Surface Transportation Board.

ACTION: Notice of exemption.

SUMMARY: Under 49 U.S.C. 10502, the Board exempts from the prior approval requirements of 49 U.S.C. 11323–25 the acquisition of control by RailTex, Inc., of The Central Railroad Company of Indianapolis and The Central Railroad Company of Indiana, Class III rail carriers, through the purchase of all of the stock of their noncarrier parent holding company, Central Properties, Inc.

DATES: The exemption will be effective July 26, 1998. Petitions to stay must be filed by July 13, 1998, and petitions to reopen must be filed by July 21, 1998.

ADDRESSES: Send an original and 10 copies of all pleadings referring to STB Finance Docket No. 33585 to: Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, NW, Washington, DC 20423–0001. In addition, send one copy of pleadings to petitioner's representative: Karl Morell, Ball Janik LLP, Suite 225, 1455 F Street, NW, Washington, DC 20005.

FOR FURTHER INFORMATION CONTACT: Joseph H. Dettmar (202) 565–1600. [TDD for the hearing impaired (202) 565–1695.]

SUPPLEMENTARY INFORMATION: Additional information is contained in the Board's decision. To purchase a copy of the full decision, write to, call, or pick up in person from: DC News & Data, Inc., 1925 K Street, NW, Suite 210, Washington, DC 20006. Telephone: (202) 289–4357. [Assistance for the hearing impaired is available through TDD services (202) 565–1695.] Board decisions and notices are available on our website at WWW.STB.DOT.GOV.

Decided: June 22, 1998.

By the Board, Chairman Morgan and Vice Chairman Owen.

Vernon A. Williams,

Secretary.

[FR Doc. 98–17133 Filed 6–25–98; 8:45 am]

BILLING CODE 4915–00–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Docket No. AB–55 (Sub–No. 563X)]

CSX Transportation, Inc.—Abandonment Exemption—In Harrison County, WV

On June 8, 1998, CSX Transportation, Inc. (CSXT) filed with the Surface Transportation Board (Board) a petition under 49 U.S.C. 10502 for exemption from the provisions of 49 U.S.C. 10903 to abandon a 0.87-mile portion of its line of railroad known as the WVA&P Subdivision, extending between milepost 1.23 and milepost 2.1, in Clarksburg, Harrison County, WV. The line traverses U.S. Postal Service Zip Code 2630l and includes no stations.

The line does not contain federally granted rights-of-way. Any documentation in CSXT's possession will be made available promptly to those requesting it.

The interest of railroad employees will be protected by the conditions set forth in *Oregon Short Line R. Co.—Abandonment—Goshen*, 360 I.C.C. 91 (1979).

By issuance of this notice, the Board is instituting an exemption proceeding pursuant to 49 U.S.C. 10502(b). A final decision will be issued by September 25, 1998.

Any offer of financial assistance (OFA) under 49 CFR 1152.27(b)(2) will be due no later than 10 days after service of a decision granting the petition for exemption. Each offer must be accompanied by a $1,000 filing fee. *See* 49 CFR 1002.2(f)(25).

All interested persons should be aware that, following abandonment of rail service and salvage of the line, the line may be suitable for other public use, including interim trail use. Any request for a public use condition under 49 CFR 1152.28 or for trail use/rail banking under 49 CFR 1152.29 will be due no later than July 16, 1998. Each trail use request must be accompanied by a $150 filing fee. *See* 49 CFR 1002.2(f)(27).

All filings in response to this notice must refer to STB Docket No. AB–55 (Sub-No. 563X) and must be sent to: (1) Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, N.W., Washington, DC 20423–0001, and (2) Charles M. Rosenberger, 500 Water Street, Jacksonville, FL 32202. Replies to the CSXT petition are due on or before July 16, 1998.

Persons seeking further information concerning abandonment procedures may contact the Board's Office of Public Services at (202) 565–1592 or refer to the full abandonment or discontinuance regulations at 49 CFR part 1152. Questions concerning environmental issues may be directed to the Board's Section of Environmental Analysis (SEA) at (202) 565–1545. [TDD for the hearing impaired is available at (202) 565–1695.]

An environmental assessment (EA) (or environmental impact statement (EIS), if necessary) prepared by SEA will be served upon all parties of record and upon any agencies or other persons who commented during its preparation. Other interested persons may contact SEA to obtain a copy of the EA (or EIS). EAs in these abandonment proceedings normally will be made available within 60 days of the filing of the petition. The deadline for submission of comments on the EA will generally be within 30 days of its service.

Board decisions and notices are available on our website at ''WWW.STB.DOT.GOV.''

Decided: June 18, 1998.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 98–16929 Filed 6–25–98; 8:45 am]

BILLING CODE 4915–00–P

DEPARTMENT OF THE TREASURY

Customs Service

Determination of Origin of Goods Processed in a Qualifying Industrial Zone or in Israel and the West Bank or Gaza Strip

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

ACTION: General policy statement.

SUMMARY: This document expands upon T.D. 96–58 by notifying the public that in determining the country of origin of textile and apparel products processed in a designated qualifying industrial zone Customs will exclusively apply the rules of origin for textile and apparel products set forth in section 102.21, Customs Regulations (19 CFR 102.21), which were promulgated pursuant to the authority of section 334, Uruguay Round Agreements Act (19 U.S.C. 3592). A qualifying industrial zone is defined in General Note 3(a)(v)(G), Harmonized Tariff Schedule of the United States (HTSUS), in part, as an area that encompasses portions of the territory of Israel and Jordan or Israel and Egypt.

In addition, this document advises the public that, in accordance with the principles and policy set forth in T.D. 96–58, Customs determines the origin of a textile or apparel product processed both in Israel (outside of a qualifying industrial zone) and in the West Bank or Gaza Strip by first applying the Customs rulings and administrative practices in effect prior to December 8, 1994. If the application of those rulings and practices results in Israel not being the origin of the good, Customs applies the rules in section 102.21 to determine the country of origin, with no further consideration being given to the processing performed in Israel.

Finally, this document reminds the public that section 102.21 is not used to determine whether foreign materials have undergone a ''double substantial transformation'' for purposes of determining whether their cost or value may be counted toward the value-content requirement of various special tariff treatment programs, such as the U.S.-Israel Free Trade Implementation Act.

EFFECTIVE DATE: The portion of this policy statement concerning the origin of textile and apparel products processed in a qualifying industrial zone shall apply to goods entered or withdrawn from warehouse for consumption on or after March 13, 1998. The remainder of this policy statement shall apply to goods entered or withdrawn from warehouse for consumption on or after July 1, 1996.

FOR FURTHER INFORMATION CONTACT: Craig Walker, Special Classification and Marking Branch, Office of Regulations and Rulings, (202) 927–1116.

SUPPLEMENTARY INFORMATION:

Background

Section 334 of the Uruguay Round Agreements Act (''URAA'') (19 U.S.C. 3592) established rules of origin for textiles and textile products. Section 102.21, Customs Regulations (19 CFR 102.21), implemented the provisions of section 334, which became effective July 1, 1996.

T.D. 96–58

T.D. 96–58, published in the **Federal Register** on July 31, 1996 (61 FR 40076), gave notice of Customs interpretation and application of section 334(b)(5) of the URAA. That subsection excepts from the rules of origin governing textiles and textile products set forth in section 334, goods which under rulings and administrative practices in effect immediately before the enactment of section 334 (December 8, 1994) would have originated in, or been the growth, product, or manufacture of, Israel. Section 334(b)(5) further provides that those rulings and administrative practices in effect prior to December 8,

1994, will continue to be applied in determining whether goods originate in Israel, ''unless such rulings and practices are modified by the mutual consent of the parties to the [the U.S.-Israel Free Trade Agreement].''

After analyzing the wording in section 334(b)(5) and the implementing Customs Regulations (19 CFR 102.21), Customs concluded in T.D. 96–58 that in determining whether goods originate in, or are the growth, product, or manufacture of Israel, Customs will first apply the rulings and administrative practices in effect prior to December 8, 1994. If that determination results in Israel not being the country of origin of the goods, then Customs will apply the rules in 19 CFR 102.21 to determine the country of origin, with no consideration being given to assembly or manufacturing processes performed in Israel. In other words, if a good is determined not to be a product of Israel under the rulings and administrative practices in effect prior to December 8, 1994, the application of the rules in section 102.21 cannot result in Israel being the country of origin of the good. The statement of policy in T.D. 96–58 was effective July 1, 1996.

Qualifying Industrial Zones

On October 2, 1996, the U.S.-Israel Free Trade Area Implementation Act of 1985 (19 U.S.C. 2112 note), was amended, creating a new section 9, to authorize the President to proclaim the elimination of duties for articles produced in the West Bank, Gaza Strip, and a ''qualifying industrial zone.'' Pursuant to that authority, the President issued Proclamation No. 6955 dated November 13, 1996 (published in the **Federal Register** on November 18, 1996 (61 FR 58761)), which modified General Note 3(a), Harmonized Tariff Schedule of the United States (HTSUS), to provide duty-free treatment to articles which are the product of the West Bank, Gaza Strip or a qualifying industrial zone (''QIZ''), provided certain requirements are met. Such treatment was effective for products of the West Bank, Gaza Strip or a QIZ entered or withdrawn from warehouse for consumption on or after November 21, 1996. In Proclamation 6955, the President delegated to the U.S. Trade Representative the authority to designate QIZs.

Under General Note 3(a)(v)(A), HTSUS, articles the product of the West Bank, Gaza Strip or a QIZ which are imported directly to the U.S. from the West Bank, Gaza Strip, a QIZ or Israel qualify for duty-free treatment, provided the sum of (1) the cost or value of materials produced in the West Bank, Gaza Strip, a QIZ or Israel, plus (2) the direct costs of processing operations performed in the West Bank, Gaza Strip, a QIZ or Israel, is not less than 35% of the appraised value of such articles when imported into the U.S. An article is considered to be a product of the West Bank, Gaza Strip or a QIZ if it is either wholly the growth, product or manufacture of one of those areas or a new or different article of commerce that has been grown, produced or manufactured in one of those areas. General Note 3(a)(v)(C), HTSUS, states that ''[t]he term ''new or different article of commerce'' means that articles must have been substantially transformed in the West Bank, the Gaza Strip or a qualifying industrial zone into articles with a new name, character or use.''

General Note 3(a)(v)(G), HTSUS, defines a *qualifying industrial zone* as any area that: ''(1) Encompasses portions of the territory of Israel and Jordan or Israel and Egypt; (2) has been designated by local authorities as an enclave where merchandise may enter without payment of duty or excise taxes; and (3) has been designated by the U.S. Trade Representative in a notice published in the **Federal Register** as a qualifying industrial zone.''

By letters dated June 30, 1997, and July 1, 1997, to the U.S. Trade Representative, the Governments of Jordan and Israel, respectively, requested the designation of the industrial zone in Irbid, Jordan, as a QIZ. Pursuant to subsequent consultations among the three Governments, the Governments of Israel and Jordan entered into a written agreement dated November 16, 1997, relating to the establishment of the Irbid QIZ, which included the following provision, entitled ''Rules of Origin':

> The [Governments of Israel and Jordan] agree that the origin of any textile or apparel product that is processed in the Irbid Qualifying Industrial Zone, regardless of the origin or place of processing of any of its imputs or materials prior to entry into, or subsequent to withdrawal from, the zone, will be determined solely pursuant to the rules of origin for textile and apparel products set out in Section 334 of Uruguay Round Agreements Act, 19 U.S.C. 3592.

By notice published in the **Federal Register** on March 13, 1988 (63 FR 12572), the Office of the U.S. Trade Representative formally designated the Israeli-Jordanian Irbid Qualifying Industrial Zone as a QIZ, effective upon publication of the notice in the **Federal Register**. To date, this is the only QIZ designated by the U.S. Trade Representative.

Thus, pursuant to the agreement between the Governments of Israel and Jordan, and by the mutual consent of the U.S. and Israel, Customs will exclusively apply the textile and apparel rules of origin set forth in 19 CFR 102.21 in determining the country of origin of a textile or apparel product processed in the Irbid QIZ. This means that the section 102.21 rules will be used not only with regard to processing performed with respect to a textile or apparel article in the Jordanian and/or Israeli portion of the Irbid Zone, but also with regard to processing, if any, performed outside of the Zone in Israel or in any other country either prior to the article's entry into the Zone for processing or subsequent to its withdrawal from the Zone after processing.

Example

The following example is set forth to illustrate the application of the 19 CFR 102.21 rules of origin to determine the origin of articles processed in the Irbid QIZ from imputs processed in Israel:

> Fabric woven in China is cut in Israel (outside of the Irbid QIZ) into components for a simple shirt. Those components are assembled into the completed shirt in the Jordanian portion of the Irbid QIZ by sewing.
>
> Pursuant to section 334(b)(5) of the URAA, the U.S. and Israel have determined by mutual consent that the section 102.21 rules of origin rather than the rulings and administrative practices in effect prior to December 8, 1994, shall be used to determine the country of origin of textile and apparel products processed in the Irbid QIZ. Therefore, Customs must apply section 102.21 to determine the origin of the shirt.
>
> (a) Section 102.21 requires that the General Rules, found in section 102.21(c), be applied in sequential order. Section 102.21(c)(1) states that the country of origin of a good is the single country, territory, or insular possession in which the good was wholly obtained or produced. Since the shirt in the above example was not wholly obtained or produced in a single country, that section is not applicable.
>
> (b) Section 102.21(c)(2) requires that the good comply with the applicable tariff shift rule in section 102.21(e). The applicable tariff shift rule for the shirt in the above example is a change to the heading in which that garment is classified from any other heading, provided that the change is the result of the garment being wholly assembled in a single country, territory, or insular possession. The shirt in the above example meets this requirement because it was wholly assembled in the Jordanian portion of the Irbid QIZ. Therefore, the shirt is considered to be the ''growth, product or manufacture'' of the QIZ for purposes of obtaining duty-free treatment under General Note 3(a)(v), HTSUS. It should also be noted that, because the country of origin marking statute (19 U.S.C. 1304) provides that, unless excepted, every imported foreign article (or its container) shall be marked with the ''name of the country of origin of the article'' (emphasis

added), merely marking the shirt to indicate that it is a product of the Irbid QIZ would not satisfy the requirements of 19 U.S.C. 1304. Therefore, since the processing which determines the origin of the shirt under 19 CFR 102.21 takes place in the Jordanian portion of the QIZ, the country of origin of the shirt for marking purposes is Jordan, and it must be so marked.

West Bank and Gaza Strip

As previously stated, articles produced in the West Bank or Gaza Strip which meet the requirements set forth in General Note 3(a)(v), HTSUS, are entitled to duty-free treatment when imported into the U.S., effective for articles entered on or after November 21, 1996.

Example

The following example illustrates how a determination is made as to the country of origin of a textile or apparel product which is processed in the West Bank or Gaza Strip from imputs processed in Israel (outside of the Irbid QIZ):

Fabric woven in country A is cut in Israel (outside the Irbid QIZ) into components for men's boxer shorts of the underwear type. The components are assembled into the completed boxer shorts in the West Bank or Gaza Strip.

In this example, no processing is performed in the Irbid QIZ. Therefore, pursuant to section 334(b)(5) of the URAA and the statement of policy set forth in T.D. 96–58, Customs must first apply the rulings and administrative practices in effect prior to December 8, 1994, to determine whether Israel is the country of origin of the good. It is only when the first determination results in Israel not being the country of origin of the good that resort is made to the section 102.21 rules of origin to determine the good's country of origin, with no further consideration being given to the processing performed in Israel.

With regard to the example, Customs has a long line of administrative rulings predating December 8, 1994, holding that the cutting of fabric into garment components results in a substantial transformation of the fabric, while the assembly of those components into a simple garment does not. Thus, in this example, since the cutting of the garment parts is performed in Israel, Israel is the country of origin of the boxer shorts, and there is no application of the section 102.21 rules.

Double Substantial Transformation

In addition to the North American Free Trade Agreement (''NAFTA'') (General Note 12, HTSUS), there are a number of special tariff preference programs which Congress has implemented to promote economic development in certain parts of the world by permitting duty-free entry of certain products from designated countries, provided certain requirements are met. These include the Generalized System of Preferences (''GSP'') (19 U.S.C. 2461 *et seq.*), the Caribbean Basin Economic Recovery Act (''CBERA'') (19 U.S.C. 2701 *et seq.*), the Andean Trade Preference Act (''ATPA'') (19 U.S.C. 3201 *et seq.*), the U.S.-Israel Free Trade Area Implementation Act (''IFTA'') (19 U.S.C. 2112 note), General Note 3(a)(iv), HTSUS (relating to products from U.S. insular possessions), and General Note 3(a)(v), HTSUS (relating to products from the West Bank, Gaza Strip or a QIZ).

To receive duty-free treatment under these programs, an eligible article must be a ''product of'' the beneficiary country, it must be imported directly to the U.S., and it must satisfy a value-content requirement. The value content requirements in the GSP, CBERA, ATPA, IFTA, and General Note 3(a)(v), HTSUS, are nearly identical and provide that the sum of (1) the cost or value of the materials produced in the beneficiary country (or countries), plus (2) the direct costs of processing operations performed in the beneficiary country (or countries), must represent at least 35% of the appraised value of the article at the time it is entered into the U.S.

The value-content requirement set forth in General Note 3(a)(iv), HTSUS, is somewhat different. It provides that products of a U.S. insular possession must not contain foreign materials which represent more than 70% of the goods' total value, or in the case of goods ineligible for duty-free treatment under the CBERA, more than 50% of their total value.

In determining whether products meet the value-content requirements in the above programs, a concept known as ''double substantial transformation'' is used. According to this concept, the value of foreign material (that is, material that does not originate in the applicable country, territory or possession) may be considered as part of the value of materials produced in that country, territory or possession for purposes of the value-content requirement only if it undergoes two substantial transformations in the country, territory or possession. That is, the foreign material must be substantially transformed in the beneficiary country, territory or possession into a new and different intermediate article of commerce, which is then transformed a second time during production of the final article which is exported to the U.S.

Customs application of the double substantial transformation requirement in the context of the GSP received judicial approval in *The Torrington Company* v. *United States,* 596 F.Supp. 1083 (CIT 1984), aff'd. 764 F.2d 1563 (Fed.Cir. 1985). See also *Azteca Milling Co.* v. *United States,* 703 F.Supp. 949 (CIT 1988), aff'd 890 F.2d 1150 (Fed. Cir. 1989), and *F.F. Zuniga,* a/c *Refractarios Monterrey, S.A.* v. *United States,* 16 CIT 459 (1992), aff'd 996 F.2d 1203 (Fed.Cir. 1993). T.D. 88–17, published in the **Federal Register** on April 13, 1988 (53 FR 12143), applied the double substantial transformation concept to products of U.S. insular possessions for purposes of determining whether the products meet the foreign value limitation under General Note 3(a)(iv), HTSUS.

The GSP, CBERA, and ATPA statutes specifically exclude most textile and apparel articles from eligibility for duty-free treatment under those programs. However, all textile and apparel articles are eligible for duty-free treatment under the IFTA, General Note 3(a)(iv), HTSUS, and General Note 3(a)(v), HTSUS, provided that they meet the applicable requirements of those programs.

In T.D. 95–69 (the Final Rule document promulgating 19 CFR 102.21), which was published in the **Federal Register** on September 5, 1995 (60 FR 46189), Customs responded to certain comments received in response to the Notice of Proposed Rulemaking concerning the effect of the section 102.21 rules of origin on existing Customs rulings holding that the cutting of garment parts and the assembly of those parts into garments constitute a double substantial transformation for purposes of the foreign value limitation in General Note 3(a)(iv), HTSUS. Customs stated that:

[s]ince section 334 deals with the country of origin of textile and apparel products and not with value requirements for purposes of duty preferences, section 334 will not affect either foreign material value determinations required under General Note 3(a)(iv) or value-added requirements contained in other statutory provisions. Accordingly, Customs intends to continue its current tariff treatment of garments which are cut and assembled in insular possessions.

Consistent with the above response, Customs wishes to remind the public that the section 102.21 rules of origin are not used to determine whether foreign materials have undergone a double substantial transformation for purposes of determining whether their cost or value may be considered as part of the value of materials produced in the beneficiary country, territory or possession under the tariff preference programs referenced above.

Conclusion

In determining the country of origin of textile and apparel products processed in a designated QIZ, Customs will exclusively apply the rules of origin for textile and apparel products set forth in 19 CFR 102.21. However, pursuant to the principles and policy set forth T.D. 96–58, Customs determines the origin of a textile or apparel product processed both in Israel (outside of a QIZ) and in the West Bank or Gaza Strip by first applying the rulings and administrative practices in effect prior to December 8, 1994. If that determination results in Israel not being the origin of the good, Customs applies the rules in section 102.21 to determine the country of origin, with no further consideration being given to the processing performed in Israel.

Finally, section 102.21 is not used to determine whether foreign materials have undergone a double substantial transformation so that their cost or value may be considered as part of the value of materials produced in the beneficiary country, territory or possession for purposes of the value-content requirements set forth in the above-specified tariff preference programs.

Dated: June 22, 1998.

Stuart P. Seidel,

Assistant Commissioner, Office of Regulations and Rulings.

[FR Doc. 98–17059 Filed 6–25–98; 8:45 am]

BILLING CODE 4820–02–P

DEPARTMENT OF THE TREASURY

Internal Revenue Service

Proposed Collection; Comment Request for Form 8824

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning Form 8824, Like-Kind Exchanges.

DATES: Written comments should be received on or before August 25, 1998 to be assured of consideration.

ADDRESSES: Direct all written comments to Garrick R. Shear, Internal Revenue Service, room 5571, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the form and instructions should be directed to Martha R. Brinson, (202) 622–3869, Internal Revenue Service, room 5571, 1111 Constitution Avenue NW., Washington, DC 20224.

SUPPLEMENTARY INFORMATION:

Title: Like-Kind Exchanges

OMB Number: 1545–1190

Form Number: 8824

Abstract: Form 8824 is used by individuals, corporations, partnerships, and other entities to report the exchange of business or investment property, and the deferral of gains from such transactions under Internal Revenue Code section 1031. It is also used to report the deferral of gain under Code section 1043 from conflict-of-interest sales by certain members of the executive branch of the Federal government.

Current Actions: There are no changes being made to the form at this time.

Type of Review: Extension of a currently approved collection.

Affected Public: Individuals or households and business or other for-profit organizations.

Estimated Number of Respondents: 200,000

Estimated Time Per Respondent: 1 hr., 46 min.

Estimated Total Annual Burden Hours: 353,884

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record.

Comments are invited on: (a) Whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 16, 1998.

Garrick R. Shear,

IRS Reports Clearance Officer.

[FR Doc. 98–16843 Filed 6–25–98; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Internal Revenue Service

[INTL–939–86]

Proposed Collection; Comment Request for Regulation Project

AGENCY: Internal Revenue Service (IRS), Treasury.

ACTION: Notice and request for comments.

SUMMARY: The Department of the Treasury, as part of its continuing effort to reduce paperwork and respondent burden, invites the general public and other Federal agencies to take this opportunity to comment on proposed and/or continuing information collections, as required by the Paperwork Reduction Act of 1995, Public Law 104–13 (44 U.S.C. 3506(c)(2)(A)). Currently, the IRS is soliciting comments concerning an existing notice of proposed rulemaking, INTL–939–86, Insurance Income of a Controlled Foreign Corporation for Taxable Years Beginning After December 31, 1986 (§§ 1.953–2(e)(3)(iii), 1.953–4(b), 1.953–5(a), 1.953–6(a), 1.953–7(c)(8), and 1.6046–1).

DATES: Written comments should be received on or before August 25, 1998 to be assured of consideration.

ADDRESSES: Direct all written comments to Garrick R. Shear, Internal Revenue Service, room 5571, 1111 Constitution Avenue NW., Washington, DC 20224.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the regulation should be directed to Carol Savage, (202) 622–3945, Internal Revenue Service, room 5569, 1111 Constitution Avenue NW., Washington, DC 20224.

SUPPLEMENTARY INFORMATION:

Title: Insurance Income of a Controlled Foreign Corporation for Taxable Years Beginning After December 31, 1986.

OMB Number: 1545–1142.

Regulation Project Number: INTL–939–86.

Abstract: This regulation relates to the definition and computation of the insurance income of a controlled foreign corporation, and it also contains rules applicable to certain captive insurance companies. The information collection is required by the IRS in order for taxpayers to elect to locate risks with respect to moveable property by reference to the location of the property in a prior period; to allocate investment income to a particular category of insurance income; to allocate deductions to a particular category of insurance income; to determine the amount of those items, such as reserves, which are computed with reference to an insurance company's annual statement; to elect to have related person insurance income treated as income effectively connected with the conduct of a United States trade or business; and to collect the information required by Code section 6046 relating to controlled foreign corporations as defined in Code section 953(c).

Current Actions: There is no change to this existing regulation.

Type of Review: Extension of a currently approved collection.

Affected Public: Business or other for-profit organizations.

Estimated Number of Respondents/ Recordkeepers: 500.

Estimated Time Per Respondent/ Recordkeeper: 28 hr., 12 min.

Estimated Total Annual Burden Hours: 14,100.

The following paragraph applies to all of the collections of information covered by this notice:

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection of information displays a valid OMB control number. Books or records relating to a collection of information must be retained as long as their contents may become material in the administration of any internal revenue law. Generally, tax returns and tax return information are confidential, as required by 26 U.S.C. 6103.

Request for Comments: Comments submitted in response to this notice will be summarized and/or included in the request for OMB approval. All comments will become a matter of public record. Comments are invited on: (a) whether the collection of information is necessary for the proper performance of the functions of the agency, including whether the information shall have practical utility; (b) the accuracy of the agency's estimate of the burden of the collection of information; (c) ways to enhance the quality, utility, and clarity of the information to be collected; (d) ways to minimize the burden of the collection of information on respondents, including through the use of automated collection techniques or other forms of information technology; and (e) estimates of capital or start-up costs and costs of operation, maintenance, and purchase of services to provide information.

Approved: June 16, 1998.

Garrick R. Shear,

IRS Reports Clearance Officer.

[FR Doc. 98–16845 Filed 6–25–98; 8:45 am]

BILLING CODE 4830–01–P

DEPARTMENT OF VETERANS AFFAIRS

Wage Committee, Meetings

The Department of Veterans Affairs (VA), in accordance with Pub. L. 92–463, gives notice that meetings of the VA Wage Committee will be held on:

Wednesday, July 15, 1998, at 2 p.m.

Wednesday, August 12, 1998, at 2 p.m.

Wednesday, August 26, 1998, at 2 p.m.

Wednesday, September 9, 1998, at 2 p.m.

The meetings will be held in Room 246, Department of Veterans Affairs Central Office, 810 Vermont Avenue NW, Washington, DC 20420.

The Committee's purpose is to advise the Under Secretary for Health on the development and authorization of wage schedules for Federal Wage System (blue-collar) employees.

At these meetings the Committee will consider wage survey specifications, wage survey data, local committee reports and recommendations, statistical analyses, and proposed wage schedules.

All portions of the meetings will be closed to the public because the matters considered are related solely to the internal personnel rules and practices of the Department of Veterans Affairs and because the wage survey data considered by the Committee have been obtained from officials of private business establishments with a guarantee that the data will be held in confidence. Closure of the meetings is in accordance with subsection 10(d) of Pub. L. 92–463, as amended by Pub. L. 94–409, and as cited in 5 U.S.C. 552b(c)(2) and (4).

However, members of the public are invited to submit material in writing to the Chairperson for the Committee's attention.

Additional information concerning these meetings may be obtained from the Chairperson, VA Wage Committee (05), 810 Vermont Avenue NW, Washington, DC 20420.

Dated: June 16, 1998.

By direction of the Secretary.

Heyward Bannister,

Committee Management Officer.

[FR Doc. 98–17008 Filed 6–25–98; 8:45 am]

BILLING CODE 8320–01–M

Corrections

Federal Register

Vol. 63, No. 123

Friday, June 26, 1998

This section of the FEDERAL REGISTER contains editorial corrections of previously published Presidential, Rule, Proposed Rule, and Notice documents. These corrections are prepared by the Office of the Federal Register. Agency prepared corrections are issued as signed documents and appear in the appropriate document categories elsewhere in the issue.

DEPARTMENT OF COMMERCE

National Institute of Standards and Technology

15 CFR Part 280

[Docket Number: 970724177–8057–02]

RIN 0693–AB43

Procedures for Implementation of the Fastener Quality Act

Correction

In rule document 98–9397 beginning on page 18260 in the issue of Tuesday, April 14, 1998, make the following corrections:

§ 280.2 [Corrected]

1. On page 18272, in the second column, in § 280.2, in the definition of *Fastener Quality Assurance System (QAS)*, paragraph (2)(iii), in the ninth line, ''of'' should read ''or''.

§ 280.6 [Corrected]

2. On page 18274, in the first column, in § 280.6(c)(5)(vi), in the second line, ''conform'' and ''do not conform'' should read ''*conform*'' and ''*do not conform*''.

§ 280.602 [Corrected]

3. On page 18275, in the second column, in § 280.602(o), in the second line, ''*FOA*'' should read ''*FQA*''.

§ 280.1010 [Corrected]

4. On page 18278, in the second column, in § 280.1010(b)(3)(vi), in the first line, ''authority of'' should read ''authority to''.

§ 280.1011 [Corrected]

5. On page 18280, in the third column, § 280.1011(c)(2)(v) should be added above § 280.1011(c)(2)(vi) read as follows:

''(v) Be able to communicate effectively, both in writing and orally, in the required languages;''

BILLING CODE 1505–01–D

DEPARTMENT OF JUSTICE

28 CFR Part 16

[Attorney General Order No. 2156–98]

RIN 1105–AA20

Revision of Freedom of Information Act and Privacy Act Regulations and Implementation of Electronic Freedom of Information Act Amendments of 1996

Correction

In rule document 98–14341 beginning on page 29591, in the issue of Monday, June 1, 1998, make the following corrections:

1. On page 29593, in the first column, under the heading *Regulatory Flexibility Act*, in the third line, ''U.S.C. 605 ()),'' should read ''U.S.C. 605 (b)), ''.

2. On page 29593, in the first column, under the heading *Regulatory Flexibility Act*, in the third line from the bottom, '' indiidual'' should read ''individual''.

§ 16.11 [Corrected]

3. On page 29598, in the first column, in § 16.11(b)(7), in the fourth line from the bottom, after time remove ''include'' and insert ''includes time spent considering any formal objection to disclosure made by a business submitter under § 16.8, but does not''.

4. On page 29599, in the third column, in § 16.11(k)(3)(i), in the fourth line, ''*furthred*''should read ''*furthered*''.

§ 16.41 [Corrected]

5. On page 29600, in the third column, in § 16.41(a), in the 29th line, ''make'' should read ''mark''.

§ 16.42 [Corrected]

6. On page 29601, in the second column, in § 16.42(e), in the fourth line from the bottom, ''regrading'' should read ''regarding''.

§ 16.51 [Corrected]

7. On page 29603, in the second column, in § 16.51(a), in the last line, '' that.'' should read ''that:''.

§ 16.54 [Corrected]

8. On page 29603, in the third column, in §16.54(c), ''individuals'' should read ''individual''.

Appendix to Part 16 [Corrected]

9. On page 29604, in the first column, in the 10th line, ''2053'' should read ''20530''.

10. On page 29604, in the second column, under the heading **C**, in the 12th line, ''20503'' should read ''20530''.

11. On page 29604, in the second column, under the heading **C**, in the 19th line, ''20503'' should read ''20530''.

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Friday
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Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Part 400, et al.
Medicare Program; Establishment of the Medicare+Choice Program; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 400, 403, 410, 411, 417, and 422

[HCFA–1030–IFC]

RIN 0938–AI29

Medicare Program; Establishment of the Medicare+Choice Program

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

ACTION: Interim final rule with comment period.

SUMMARY: The Balanced Budget Act of 1997 (BBA) establishes a new Medicare+Choice (M+C) program that significantly expands the health care options available to Medicare beneficiaries. Under this program, eligible individuals may elect to receive Medicare benefits through enrollment in one of an array of private health plan choices beyond the original Medicare program or the plans now available through managed care organizations under section 1876 of the Social Security Act. Among the alternatives that will be available to Medicare beneficiaries are M+C coordinated care plans (including plans offered by health maintenance organizations, preferred provider organizations, and provider-sponsored organizations), M+C ''MSA'' plans, that is, a combination of a high deductible M+C health insurance plan and a contribution to an M+C medical savings account (MSA), and M+C private fee-for-service plans.

The introduction of the M+C program will have a profound effect on Medicare beneficiaries and on the health plans and providers that furnish care. The new provisions of the Medicare statute, set forth as Part C of title XVIII of the Social Security Act, address a wide range of areas, including eligibility and enrollment, benefits and beneficiary protections, quality assurance, participating providers, payments to M+C organizations, premiums, appeals and grievances, and contracting rules. This interim final rule explains and implements these provisions.

In addition, we are soliciting letters of intent from organizations that intend to offer M+C MSA plans to Medicare beneficiaries and/or to serve as M+C MSA trustees.

DATES: *Effective date:* This interim final rule is effective July 27, 1998.

Comment period: Comments will be considered if received at the appropriate address, as provided below, no later than September 24, 1998.

ADDRESSES: Mail written comments (1 original and 3 copies) to the following address: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1030–IFC, P.O. Box 26688, Baltimore, MD 21207.

If you prefer, you may deliver your written comments (1 original and 3 copies) to one of the following addresses:

Room 309–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

Room C5–09–26, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1027–IFC Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 309–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (phone: (202) 690–7890).

FOR FURTHER INFORMATION CONTACT:

Provider Sponsored Organizations, Aaron Brown, 410–786–1033.

M+C Private Fee-For Service Plans, Anita Heygster, 410–786–4486.

M+C MSA Plans, Cindy Mason, 410–786–6680.

Applications, Robert King, 410–786–7623.

Quality Assurance, Brian Agnew, 410–786–5964.

Payment/ACRs, Al D'Alberto, 410–786–1100.

Encounter Data, Cynthia Tudor, 410–786–6499.

Federal/State, Rebecca Cardozo, 410–786–0300.

Beneficiary Appeals, Valerie Hart, 410–786–6690.

Enrollment, Debe McKeldin, 410–786–9159.

Information Campaign, Jan Drass, 410–786–1354.

Contracts, Chris Eisenberg, 410–786–5509.

General Issues, Tony Hausner, 410–786–8290.

General Issues, Dorothea Musgrave, 410–786–8290.

SUPPLEMENTARY INFORMATION:

I. Background

A. Balanced Budget Act of 1997

Health care benefits covered under the Medicare program are divided into two parts: hospital insurance, also known as ''Part A,'' and supplementary medical insurance, also known as ''Part B.'' Health care services covered under Part A include: inpatient hospital care, skilled nursing facility care, home health agency care, and hospice care. Part B coverage is optional and requires payment of a monthly premium. Part B covers physician services (in both hospital and nonhospital settings) and services furnished by certain nonphysician practitioners. It also covers certain other services, including: clinical laboratory tests, durable medical equipment, medical supplies, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

Section 4001 of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33), enacted August 5, 1997, added sections 1851 through 1859 to the Social Security Act (the Act) to establish a new Part C of the Medicare program, known as the ''Medicare+Choice Program.'' Note that hereinafter, unless otherwise indicated references to the statute are references to the Act. (The existing Part C of the statute, which included provisions in section 1876 governing existing Medicare health maintenance organization (HMO) contracts, has been redesignated as Part D.) Under section 1851(a)(1), every individual entitled to Medicare Part A and enrolled under Part B, except for individuals with end-stage renal disease, may elect to receive benefits through either the existing Medicare fee-for-service program or a Part C M+C plan.

The introduction of the M+C program represents what is arguably the most significant change in the Medicare program since its inception in 1965. As its name implies, the primary goal of the M+C program is to provide Medicare beneficiaries with a wider range of health plan choices to complement the Original Medicare option. Alternatives available to beneficiaries under the M+C program include both the traditional managed care plans (such as HMOs) that have participated in Medicare on a capitated payment basis under section 1876 , as well as a broader range of plans comparable to those now available through private insurance. Specifically, effective January 1, 1999, section 1851(a)(2) provides for three types of M+C plans:

- M+C coordinated care plans, including HMO plans (with or without point of service options), provider-sponsored organization (PSO) plans, and preferred provider organization (PPO) plans.

- M+C medical savings account (MSA) plans (that is, combinations of a high deductible M+C health insurance plan and a contribution to an M+C MSA).
- M+C private fee-for-service plans.

In addition to expanding the types of available health plans, the M+C program introduces several other fundamental changes to the private health plan sector of the Medicare program. These changes include:

- Establishment of an expanded array of quality assurance standards and other consumer protection requirements.
- Introduction of an annual coordinated election period. This election period, to be conducted in November for a January effective date, will feature a phased in lock-in of enrollees to the plan they have elected during this coordinated election period. In addition, the annual coordinated election period will include the distribution by HCFA of uniform, comprehensive information about participating plans that is needed to promote informed choices by beneficiaries.
- Revisions in the way we calculate payment rates to the plans that will narrow the amount of payment variation across the country and increase incentives for plans to operate in diverse geographic areas.
- Establishment of requirements concerning participation procedures for physicians and other health care professionals in M+C plans, including prohibitions on interference with advice to enrollees.

These requirements will bring about changes for beneficiaries, for physicians and other health care providers, for managed care organizations that now contract with Medicare as well as those that will be able to contract with Medicare for the first time, and for HCFA and the States. The specific areas addressed by the different sections of the statute are as follows:

- Section 1851—Eligibility, election and enrollment
- Section 1852—Benefits and beneficiary protections
- Section 1853—Payments to M+C organizations
- Section 1854—Premiums
- Section 1855—Organizational and financial requirements for M+C organizations
- Section 1856—Establishment of standards
- Section 1857—Contracts with M+C organizations
- Section 1859—Definitions and miscellaneous provisions

As provided for in section 1856(b)(1), this interim final rule (1) incorporates the new M+C provisions into the Medicare regulations, (2) interprets the new statutory provisions in Part C, and (3) establishes by regulation new standards under the M+C program. Other provisions of the BBA addressed in this interim final rule include:

- Section 4002—Transitional rules for current HMO Medicare program.
- Section 4003—Conforming changes in the Medigap program.
- Section 4006—M+C MSAs.

We note that in February, 1998, the President issued an Executive Order directing the Secretary to comply to the extent possible through administrative activities with the standards contained in the Consumer Bill of Rights and Responsibilities. Therefore, as discussed in several sections of this preamble, we have taken these standards into consideration in developing the regulations contained in this interim final rule. We have also incorporated conforming provisions consistent with other parts of the Medicare statute, such as exempting services under M+C coordinated care plans from the anti-referral provisions in section 1877.

In several places in this preamble, we indicate that HCFA intends to develop additional policy guidance or instructions. In doing so, we will use a formal rulemaking process and allow for review by the Office of Management and Budget pursuant to the requirements of the Paperwork Reduction Act of 1995, wherever it is appropriate to do so.

B. Codification of Regulations

The regulations text set forth in this interim final rule is codified in 42 CFR Part 422—Medicare+Choice Program. (Note that new part 422 was established in our April 14, 1998 interim final rule on PSOs (63 FR 18124).) The current Medicare regulations for managed care organizations that contract with HCFA under section 1876, or for health care prepayment plans (HCPPs) that are paid under section 1833(a)(1)(A), will continue to be located in 42 CFR part 417, Health Maintenance Organizations, Competitive Medical Plans, and Health Care Prepayment Plans. Although the part 422 provisions will eventually supersede the regulations in part 417 for contracts with risk-bearing HMOs and competitive medical plans (CMPs), there are some purposes for which the part 417 provisions will continue in effect for a transitional period. Also, various provisions of section 4002 of the BBA provide for the continuation of cost-based contracts under section 1876 and of agreements with HCPPs under section 1833(a). Thus, the part 422 regulations cannot entirely replace the part 417 regulations at this time. (Both transitional provisions and those relating to cost-based contracts and HMOs are discussed in detail below in the appropriate sections of this interim final rule.)

For the convenience of organizations that contract with HCFA only under the M+C program, we are including in part 422 both new requirements that implement newly enacted provisions in Part C and existing requirements from part 417 that also will be imposed under Part C. For transitional requirements, which could logically appear in both parts, we are setting forth the full requirements in part 422 and referencing them in part 417. Requirements that apply to organizations that contract with HCFA, or are paid by HCFA, only under section 1876 or 1833(a) will remain in part 417. Regulations implementing the provisions of section 1310 of the Public Health Service Act concerning Federally-qualified HMOs also remain in part 417.

C. Organizational Overview of Part 422

The major subjects covered in each subpart of part 422 are as follows:

- Subpart A—Definitions, including definition of types of plans, application process, and user fees.
- Subpart B—Requirements concerning beneficiary eligibility, election, enrollment and disenrollment procedures, and plan information and marketing materials.
- Subpart C—Requirements concerning benefits, point of service options, disclosure of information, access to services, confidentiality of enrollee records, advance directives, and beneficiary protection against liability.
- Subpart D—Quality assurance standards, external review, and deeming of accredited organizations.
- Subpart E—Organizational relationships with participating entities including the prohibition against interference with health care professionals' advice to enrollees, physician incentive requirements, and special rules for M+C private fee-for-service plans and private contracts with health care professionals.
- Subpart F—Payment methodology for M+C organizations, coverage that begins or ends during inpatient hospital stays, hospice care, and encounter data requirements.
- Subpart G—Requirements concerning terms and conditions for receiving capitated payments, limits on premiums and cost sharing, determination of adjusted community rate, and prohibition of State-imposed premium taxes.

- Subpart H—Requirements concerning provider-sponsored organizations (PSOs).
- Subpart I—Organization compliance with State law and preemption by Federal law.
- Subpart K—General contract and enrollment requirements, administration and management, and procedures for nonrenewal or termination of contracts.
- Subpart L—Effect of change of ownership or leasing of facilities during term of contract.
- Subpart M—Requirements concerning beneficiary grievances and organization determinations and appeals.
- Subpart N—Requirements and procedures for contractor appeals of nonrenewals or terminations of contracts.
- Subpart O—Procedures for imposing intermediate sanctions.

Each of these subparts is discussed below in section II of this preamble. Sections III and IV consist of separate discussions of provisions of the part 422 regulations that specifically concern M+C MSA plans and M+C private fee-for-service plans, respectively.

II. Provisions of the Interim Final Rule

A. General Provisions—Subpart A

1. Overview

Subpart A begins with a brief section (§ 422.1) that specifies the general statutory authority for the ensuing regulations and indicates that the scope of part 422 is to establish standards applicable to the M+C program. Under § 422.2, we then set forth definitions for terms used in part 422 that we believe need clarification. These definitions provide the generally applied meaning for terms that are used throughout part 422. Where necessary, we have included in specific subparts of part 422 definitions for terms used primarily in those subparts. In § 422.4, we define the three different types of M+C plans, consistent with section 1851(a)(2)—M+C coordinated care plans, M+C MSA plans and M+C private fee-for-service plans.

Sections 422.6 and 422.8 then detail the application process for an entity seeking an M+C contract and HCFA's application evaluation procedures.

Section 422.10 adopts, for purposes of the M+C program, the user fee provisions now set forth at § 417.472(h).

2. Definitions (§ 422.2)

For the most part, the definitions presented here are taken directly from the statute or are essentially self-explanatory. Below, we discuss some notable exceptions to this, including cases where we have clarified the exact meaning and context of certain terms. Please keep in mind that the definitions set forth in subpart A reflect general meanings for the terms as they are used in part 422 unless otherwise indicated; the definitions apply strictly for purposes of part 422. For example, the term ''provider'' has a more inclusive meaning under part 422 than it does for other Medicare purposes, as discussed below. Similarly, when we define a term anywhere in part 422 other than in subpart A, it can be assumed that the definition of the term is limited to a specified purpose in the relevant subpart or section. Thus, as specified in the relevant sections of the regulations, the term ''substantial financial risk'' has a different meaning for purposes of the physician incentive provisions under § 422.208 than it does in the PSO provisions under § 422.356.

Benefits and Benefit Categories

In § 422.2, we have defined both the term ''benefits'' as well the different categories under which benefits are provided: basic benefits, additional benefits, mandatory supplemental benefits, and optional supplemental benefits. ''Benefits'' consist of the health care services delivered or covered by an M+C organization. (Note that ''services,'' under the long-standing Medicare definition at § 400.202, encompass medical care, services, and items.) The definition of benefits is relevant both for purposes of the process of determining adjusted community rates (ACRs) for M+C plans and for purposes of a new provision in Part C that ''pre-empts'' State laws relating to ''benefits.''

When we refer to one of the categories under which benefits are provided, however, we generally are referring not only to the actual health services that a beneficiary receives or is eligible to receive, but also to the pricing structure applied to these benefits. For example, the definition of ''additional benefits'' includes both the health care services covered under a plan that are in addition to regularly covered Medicare services, as well as any reductions in premiums or cost-sharing for Medicare covered services. Thus, the amount of deductibles or copayments that an M+C plan enrollee must expend to receive services would fall within the scope of the term ''additional benefits.''

We wish to note that we have defined ''basic benefits'' in this regulation to include *both* the Medicare-covered benefits required under section 1852(a)(1)(A) *and* required ''additional benefits'' under section 1852(a)(1)(B). Both Medicare benefits and required additional benefits are: (1) Coupled together in section 1852(a)(1), in the first paragraph under subsection (a), titled ''Basic Benefits''; (2) benefits that an M+C has an obligation to provide (in contrast to supplemental benefits, which may be provided totally at the M+C organization's discretion); (3) benefits paid for with Medicare trust fund money; and (4) benefits that are covered by the basic premium, if any, that counts towards the limit based on the actuarial value of original Medicare coinsurance and deductible amounts.

For all of these reasons, we have decided to divide benefits into the two categories of the ''basic benefits'' including all required benefits, and ''supplemental benefits,'' including both mandatory and optional supplemental benefits provided at the discretion of the M+C organization. We note that while Congress did not include a ''definition'' of ''basic benefits'' in Part C, it appears to use the term ''basic'' to refer only to the Medicare-covered service package. (See, for example, section 1851(b)(1)(B) or section 1854(e)(1).) Although Congress did not actually include additional benefits in the term ''basic benefits,'' in almost all cases, it coupled these benefits together, and treated them the same. (See sections 1852(a)(1), and 1854(a)(2)(A), (3)(A), (4)(A), and (e)(1).) We accordingly believe that it is appropriate in this regulation to include these two categories together in the definition of ''basic benefits'' that applies for purposes of part 422. We note, however, that where a statutory provision refers only to the Medicare benefit component of our part 422 definition of ''basic benefits,'' we will similarly limit the regulation implementing that provision.

M+C Organization and M+C Plan

The definitions of ''M+C organization'' and ''M+C plan'' set forth in § 422.2 are based on the BBA's use of these terms, which is not always compatible with the way the terms ''organization'' and ''plan'' have been used in the past. In previous HCFA documents, the term ''managed care organization'' frequently has been used interchangeably with the term ''managed care plan'' or ''health plan.'' Section 422.2 addresses this area of potential confusion by clarifying the distinction between an M+C organization and an M+C plan. Succinctly stated, an M+C ''organization'' is an entity that contracts with HCFA to offer an M+C plan; the ''plan'' consists of the specific health benefits, terms of coverage, and pricing structure.

Section 1857(a) specifically states that HCFA contracts with an M+C organization. Thus, for requirements that we would normally think of as contractual requirements, we use the term ''M+C organization.'' In § 422.2 then, an M+C organization is defined as a public or private entity organized and licensed under State law as a risk-bearing entity (with the exceptions of PSOs receiving waivers) that is certified by HCFA as meeting the M+C contract requirements. Under various BBA provisions, the requirements M+C organizations are responsible for meeting include: processing the enrollment and disenrollment of beneficiaries within a plan; transmitting information such as enrollment information and encounter data to HCFA; submitting marketing materials; providing all Medicare-covered benefits and other benefits covered under the contract in a manner consistent with specified access standards; performing quality assurance; creating and carrying out all plan procedures for grievances, organization determinations, and appeals; maintaining necessary records; providing advance directives; establishing procedures related to provider participation; setting medical policies; notifying beneficiaries of any ''Conscience Protection'' exceptions; disclosing physician incentive plans; receiving payment; reporting financial information; paying user fees; making prompt payments to providers; receiving any sanctions invoked by HCFA on any of the organization's plans; and fulfilling other contract requirements as specified in regulation.

Again, in contrast, an M+C plan is merely the health benefits coverage and pricing structure that the organization offers to beneficiaries. An M+C plan may include the basic benefits only (basic benefits include Medicare-covered benefits and additional benefits) or basic benefits combined with mandatory and/or optional supplemental benefits.

An M+C organization may select which providers furnish services under the plan, as long as the benefit package meets all the requirements for access within the area, and outside of the area for specific services. As discussed in detail below, service areas and benefit packages generally are associated with individual plans; uniform premium requirements and the need for an ACR proposal also apply at the plan level.

Service Area

The service area designation of an M+C plan is an important element of the structure and design of a particular plan. A plan's service area—

- Determines the payment rate to the organization for enrollees of the plan, based on the counties included in the service area;
- Affects what benefits will be provided, since benefits and premiums must be uniform under an M+C plan, throughout that plan's defined service area;
- Determines which beneficiaries are able to elect the plan, because organizations are obligated to enroll any eligible resident of the service area who elects the plan; and
- For network plans, is the area in which the plan is required to make covered services available and accessible; and determines the boundaries beyond which the plan assumes liability for urgently needed care and may offer enrollment continuation options.

As explained below, we will exercise discretion in reviewing and approving service areas requested by M+C plans. For network plans, we will use our knowledge of how service areas have been designated in the past in the Medicare managed care program and in the Federally-qualified HMO program, which we have administered since 1986, to ensure availability and accessibility of services. We will attempt to ensure that service areas of M+C network plans are consistent with community patterns of care and/or rating practices—that is, service area designations are not artificially delineated in such a way that usual sources of care, in terms of geographic location, are not available to beneficiaries; or in such a way that the service area designation allows ''gaming'' of the community rate that forms the basis of M+C premiums and benefits, to the disadvantage of Medicare beneficiaries. A nondiscrimination standard will also apply to both network and non-network plans. To the extent possible, we will attempt to ensure a ''level playing field'' among plans operating in the same geographic area (for example, if one plan in an area is subject to the county integrity rule discussed below, a new plan may also be subject to the same standard in determining a new service area). These standards will also be applied in evaluating requests for M+C service area expansions and service area reductions. Consistent with the goals of the new M+C program, we will attempt to maximize the number of choices available to Medicare beneficiaries and maximize the availability of low-cost plans offering additional benefits.

The regulations at § 422.2 provide that an M+C organization may propose a specified service area for each M+C plan, and HCFA will determine whether the proposed area can be approved. The regulatory definition of service area is slightly different from the current service area definition at § 417.401. The latter regulation defines the term geographic area (which we used interchangeably with service area with respect to section 1876 contracts) as ''the area found by the Secretary to be the area in which an HMO is able to deliver the full range of services,'' a definition that was essentially common to both the Medicare program and the Federally qualified HMO program (§ 417.1, ''service area''). The earlier definition emphasizes the role of the Secretary (HCFA) in the designation of service areas, and incorporates one of the standards applicable to network plans (which continue to apply to such plans in these regulations). Statutory references to a service area or geographic area under Medicare, including references in the BBA, do not offer a definition of the term or an indication of how the area is to be determined.

We have modified the wording of the earlier regulatory definition of ''service area'' to recognize that organizations will propose specific areas for M+C plans. Pursuant to section 1856(b)(1), which provides for establishing M+C standards by regulation, and section 1856(b)(2), which provides for basing the standards on standards under section 1876, we have retained our authority to approve or deny service area configurations that organizations propose. This reflects what has been the actual past practice of the agency in administering the Medicare HMO/CMP program and the Federally-qualified HMO program. The new definition also recognizes that service areas designated by organizations for non-network plans are designated for the purpose of determining who is eligible to enroll in the plan.

Consistent with current and past regulatory and statutory standards, we will evaluate proposed service areas of network plans to determine whether covered services are available and accessible, under the standards of § 422.112, to any resident of the area eligible to elect enrollment in the plan. We will also examine the proposed service area of any plan, including non-network plans, to ensure that the delineation of the area does not result in discrimination against beneficiaries through ''gerrymandering'' or ''red-lining'' to deliberately avoid particular areas (e.g., to prevent the enrollment of poorer Medicare beneficiaries, or those known to be in poorer health). An example of such a practice would be an

urban area network plan's exclusion of poorer inner-city areas, leaving obvious ''holes'' in the service area where residents would not have any problem gaining access to care through the plan's providers had the area been included in the proposed service area. Although we would not ordinarily dictate the inclusion of particular areas in the service area of a plan—for example, a multi-county commercial plan could include only some of its counties in a Medicare contract—we would seek to prevent clear cases of discrimination against, or disadvantaging of, particular groups or populations.

Prior to the BBA, contracting HMOs and CMPs (virtually without exception) all had existing, defined service areas prior to entering into a Medicare contract. These were areas in which the entities offered comprehensive health care services to non-Medicare enrollees of the specified geographic area. As noted above, Medicare's statutory language did not clearly define the terms service area or geographic area, but it was assumed that each organization would have a specific service area in which it operated and provided coverage to any enrollee from the community (including any Medicare enrollee). The Medicare premiums and benefits are a function of the community rate of the plan, the rate applicable to any covered group within the community covered by the plan. Hence, until the mid-1980s, we required that the service area for Medicare be the same as the service area for the non-Medicare population. Subsequently, we changed our policy to permit HMOs and CMPs to limit the Medicare service area to a subset of the non-Medicare (commercial) area, breaking the link between commercial service areas and Medicare service areas (though the Medicare premiums and benefits continue to be based on the community rate for the entire non-Medicare community). We applied a ''county integrity'' standard in determining how HMOs could reduce their service areas for Medicare; whole counties could be excluded, but partial counties could only be excluded if the organization operated (for commercial purposes) only in a portion of the county.

Because the BBA provisions on waiver of minimum enrollment and composition of enrollment requirements permit organizations to have M+C plans with no prior enrollment, there will be plans that do not have designated service areas and do not have a commercial service area that can be used as a reference point for the designation of a Medicare service area. In the case of network plans, we would work with such organizations to determine an appropriate service area for the plan's provider network, taking into consideration the patterns of medical care in the community (e.g., where people obtain care, the types of providers available in the community, reasonable travel times to obtain care). We would also use our knowledge of how plan service areas generally have been determined and approved in the past, as well as how other organizations in the same area, or a similar area, have established their service areas. There could be concerns both with a proposed area that is too wide, offering limited availability of services for outlying areas, and with a proposed area that is too small, which would limit choices available to beneficiaries or might raise the concerns discussed above regarding discrimination.

We believe that basing our decisions on community patterns of care and the practices of other organizations in the same area, or in similar areas, is consistent with our past approach to the issue of service area designations, and consistent with the BBA. The BBA requires a similar approach in developing elements of the adjusted community rate for new plans (e.g., 1854(f)(4), referring to ''enrollment experience of other contracts entered into under this part and * * * data in the general commercial marketplace'').

With respect to another issue related to service areas, our policy that permitted HMOs and CMPs under 1876 to vary premium and benefit offerings by county within a service area (the ''flexible benefits'' policy) will no longer apply under M+C. The flexible benefits policy permitted organizations to use non-Medicare revenue to offer extra benefits or reduced premiums (''free benefits'') to residents of a particular county or counties rather than in the entire service area, as long as all Medicare beneficiaries in the entire service received at least the level of benefits required under the statute as determined through the adjusted community rate process. With the requirement that premiums and benefits be uniform throughout an M+C service area, it is not possible to continue the flexible benefits policy. However, an organization may be able to offer multiple plans and propose different service areas for the plans in order to achieve a similar result as the flexible benefits policy. This presents us with an issue of how to deal with the proposals for service areas, or the carving up of existing non-Medicare service areas, when it is done in order to have different premiums and benefits in different counties. In the case of network plans, a carving up of an existing service area, and the offering of multiple plans across what may be a single service area for the non-Medicare population, is only possible if each of the plans with different service areas is able to ''stand alone'' in terms of meeting all the requirements applicable to plans. The designation of multiple service areas in such cases should also be consistent with community practices in patterns of care, and/or consistent with rating practices, and service are designations, for other purchasers.

Except in the case of non-network MSA plans, as discussed below, the fact that Medicare pays different capitation rates by county is not a sufficient reason to establish service areas consisting of individual counties. For example, a staff-model HMO operating in a multi-county area, that has a service delivery network consisting of only one hospital and a group of physicians employed by the organization, cannot designate each county as a separate service area. Although services are accessible and available in each county, we do not believe there is a valid reason to charge different premiums by county, for example, when all Medicare beneficiaries enrolled in the organization will be using the same providers.

On the other hand, some organizations that operate with very large service areas may be justified in breaking up larger service areas for Medicare contracting purposes. This would be similar to what Federally-qualified HMOs do in designating distinct service areas as ''regional components,'' which are sub-areas with an autonomous provider network and with different community rating for the regional component. Some HMOs, although they do not identify distinct service areas, require enrollees to obtain services from a particular subset of providers within the broader network (as Federally-qualified HMOs are permitted to do (see 45 FR 28655 (April 29, 1980)). Some HMOs offer large employers a statewide service area consisting of different provider networks in geographically distinct areas in which there is no crossing of boundaries, or very little crossing of boundaries, to receive services. The large employer may be offered one rate for all areas, but the same HMO may have smaller designated service areas for smaller regional employers, in which different rates apply.

In evaluating proposals requesting approval of multiple service areas in a contiguous geographic area, we would consider the patterns of care in the community; and the rating and service

area practices of the individual organization, of other organizations in the area, and of other organizations in similar areas. The commercial service area will continue to be a reference point in that we would be likely to approve a proposal if what is proposed for Medicare contracting is similar to what is done in the commercial marketplace. Similarly, we would take into consideration any determination, or approval, of service areas by State regulatory bodies.

At a minimum, each proposed M+C service area must be an area in which the full range of covered services are available and accessible to all Medicare enrollees primarily through providers located in the service area. We would also evaluate proposals on the basis of the criteria we discuss above relating to discrimination against, or disadvantaging of, particular beneficiaries in the community. These criteria would also be used in evaluating the proposed service areas of non-network plans. Using the inner-city example, an entity could request an area consisting only of the poorer inner-city area, where residents would be required to pay a relatively high premium, while other areas were charged a much lower premium. We would view this practice as discouraging enrollment within a particular area. Although the statute does not expressly provide for evaluation of service area designations to determine whether they are discriminatory, we believe that it is consistent with statutory requirements relating to discrimination and discouraging enrollment (at 1852(a)(3), with respect to the pricing of mandatory supplemental premiums, and 1852(b), with respect to limiting enrollment based on a health status factor, including claims experience or insurability). We have included the above criteria for service area approval in the definition of ''service area'' in § 422.2.

As noted above, we are providing for a special exception for service areas for non-network MSA plans. In the case of M+C MSA plans, differences in payment rates for a given county affect not just the amount the M+C organization offering the MSA plan is paid, but the amount that is deposited in MSA accounts. (See section III of this preamble.) We have decided that in the case of M+C non-network MSA plans, under which enrollees are not limited to receiving services in a defined area, we will permit M+C organizations to offer a different M+C plan in each county in which they wish to enroll beneficiaries. This would mean that a uniform amount would be deposited in the M+C MSA account of every enrollee in the M+C MSA plan, and the M+C organization could file a separate premium amount for each county to ensure that the proper amount is deposited in accounts in that county.

Emergency and Urgently Needed Services

The definitions of emergency services and urgently needed services in § 422.2 are based on section 1852(d) and thus differ from those in existing § 417.401. In accordance with section 1852(d)(3) of the statute, we are codifying the concept that an ''emergency medical condition'' exists if a ''prudent layperson'' could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual. In addition, the new definition of ''emergency services'' includes emergency services provided both within and outside of the plan, while the definition of ''urgently needed services'' continues to encompass only services provided outside of the plan's service area (or continuation area, if applicable), except in extraordinary circumstances such as those discussed below.

Under section 1852(d)(1)(C)(i), M+C organizations are required to pay for nonemergency services provided other than through the organization where the services are immediately required because of unforseen illness, injury or condition, and it is not reasonable given the circumstances to obtain the services through the organization. We believe that except in the rarest and most extraordinary of circumstances, the only situation in which it would not be reasonable to receive nonemergency services through the organization would be when the enrollee is absent from the service area of the M+C plan in which he or she is enrolled. It is possible, however, albeit extremely unlikely, that there might be other situations in which this standard would be met by an enrollee who is in the plan service area.

For example, there could be some temporary disruption of access to the M+C plan's provider network, such as a strike, or possibly some temporary physical impediment to traveling to M+C plan providers that are otherwise readily accessible. Under such circumstances, an individual might not need emergency services, but still may warrant immediate attention. Because we do not believe that we can say that the statutory standard could *never* be met by an individual who is in the plan service area, we believe it is appropriate to provide for an exception in the definition of urgently needed services to the rule that the enrollee be out of area. We are thus providing for such an exception in extraordinary cases in which the network is unavailable or inaccessible due to an unusual event.

Other Definitions

In our April 14, 1998 interim final rule setting forth the definition of a PSO and related requirements, we established under § 422.350(b) a definition for ''health care provider'' that is based on the PSO requirements in section 1855(d)(5). In this interim final rule, we are adopting the identical definition for general purposes of the M+C program. Under this definition, as discussed in greater detail in our April 14 interim final rule (63 FR 18126), the term ''provider'' applies both to individuals licensed or certified by a State to engage in the delivery health care services (such as physicians, nurse practitioners, clinical social workers), as well as to entities engaged in the delivery of health care services (such as hospitals, nursing homes, home health agencies).

Another clarification contained in this subpart involves the definition of ''copayment.'' We have defined copayment as a fixed amount that can be charged for a service. This is to distinguish copayment from ''coinsurance,'' which is a fixed percentage of the total cost of a service that can be charged. Copayments, coinsurance, and deductibles represent the three forms of cost-sharing under a plan.

Finally, we have included a general definition of the term ''balance billing,'' indicating that balance billing refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer (for example, the original Medicare program) will pay for the service plus any cost sharing by the individual. We note that there is significant variation within both original Medicare and the M+C program regarding the extent to which balance billing is permissible. For example, under original Medicare, no balance billing is permitted for providers of services (such as hospitals and home health agencies), while for nonparticipating physicians, balance billing is permissible only up to the difference between the Medicare allowed amount and the Medicare limiting charge. Different rules apply under original Medicare for other nonparticipating suppliers (such as ambulance or durable medical equipment suppliers, for which there are currently no limits on balance

billing). Similarly, under the M+C program, different balance billing restrictions apply depending on the type of M+C plan and the contracting status of the provider. These restrictions are discussed in detail in the appropriate sections of this preamble, particularly in section IV regarding M+C private fee-for-service plans.

3. Types of M+C Plans (§ 422.4)

The creation of the M+C program allows beneficiaries access to a much wider array of private health plan choices than the existing alternatives to the original Medicare program. Moreover, this new program will enable Medicare to use innovations from the commercial sector that have helped the private market contain costs and expand health care delivery options.

The BBA provides for several different types of M+C plans to be available for beneficiaries. As noted above, these various M+C plans can be classified into three general categories: M+C coordinated care plans, M+C MSA plans (that is, a combination of a high deductible M+C health insurance plan and a contribution to an M+C MSA), and M+C private fee-for-service plans. Within each of these three categories, M+C organizations may offer a variety of plans to Medicare beneficiaries.

Since these are the only legally significant categories of plans under the M+C program, we do not believe it is necessary to define all of the different entities that accept prepaid, capitated payment for delivering health services. Thus, examples of these entities, such as PPOs, HMOs, or health insurance organizations, are not defined for purposes of this regulation. Essentially, all entities that apply to offer an M+C plan must conform to the requirements for either an M+C coordinated care plan, an M+C MSA plan, or an M+C private fee-for-service plan.

M+C Coordinated Care Plans (§ 422.4(a)(1))

Under the M+C program, beneficiaries may choose from among a variety of coordinated care plans. Coordinated care plans include, but are not limited to, HMO plans (with or without point of service options) (HMOs), plans offered by PSOs (as defined in section 1855(d) and in our April 14, 1998 interim final rule), and PPO plans. In addition, certain beneficiaries may be able to choose another type of coordinated care plan, the Religious Fraternal Benefit Society plan, which is defined in section 1859(e).

Except in the case of a PSO granted a waiver under subpart H of part 422, all organizations offering M+C coordinated care plans must meet the State licensure requirements in section 1855 (and § 422.400). Thus, an M+C coordinated care plan must be offered by an entity that is (1) appropriately licensed by the State to bear risk and (2) eligible to offer health insurance or health benefits coverage in each State in which it offers an M+C plan.

In addition, an M+C coordinated care plan must meet the definition of a coordinated care plan set forth in § 422.4. That is, an M+C coordinated care plan is a type of plan offered by an M+C organization that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by HCFA. The network must be approved by HCFA to ensure that all applicable requirements are met including access and availability standards, service area requirements, and quality standards. A coordinated care plan may include mechanisms to control utilization, such as referrals from a gatekeeper to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care.

Except for PSOs that have obtained a waiver of the State licensure requirement, and thus are subject to the additional requirements set forth in subpart H of part 422, distinctions among HMOs, PSOs, PPOs, and other coordinated care plans are not relevant for the purpose of applying to offer an M+C plan. The distinctions among the various types of coordinated care plans may be relevant for purposes of State licensure. However, for the purpose of an M+C application, we are not concerned with what type of coordinated care plan an applicant intends to offer. In fact, an entity may offer an M+C coordinated care plan even though it is not specifically licensed as an HMO, PSO, or PPO. As long as the entity is licensed as a risk-bearing entity in accordance with section 1855 of the statute and the plan being offered meets the definition of a coordinated care plan under § 422.4, the entity does not need to be licensed specifically as an HMO, PSO, or PPO to offer an M+C coordinated care plan.

For example, like an HMO or a PSO, a PPO may offer an M+C plan. Any organization that is licensed as a risk-bearing entity in a State may offer an M+C plan that is structured in the form of a PPO. We are not requiring that an organization applying to offer an M+C PPO plan be operating as a PPO in the non-Medicare marketplace. In that sense, the BBA imposes a distinct change from prior law, because it does not require that organizations with Medicare prepaid health plan contracts meet certain conditions imposed on their structure and their commercial business. Under section 1876, a PPO generally could not obtain a Medicare risk contract because most PPOs have members that are enrollees of an indemnity insurance product, and would not meet the requirements under section 1876 to be an ''eligible organization'' entitled to contract under that section. The BBA only requires that an organization be providing health benefits and insurance to enrollees (regardless of whether on an indemnity or prepaid, capitated status) and that it be licensed by the State as a risk-bearing entity.

The majority of the PPOs that are currently operating are plans being offered by State-licensed indemnity carriers or State-licensed HMOs. However, where the State does license the PPO as a risk-bearing entity, the PPO may be eligible to become an M+C organization in and of itself. Conversely, where the State does not allow the PPO to bear risk, the PPOs in those States would not be eligible to become an M+C organization on their own. These PPOs that are not allowed to bear risk may partner with a licensed risk-bearing entity or contract with a licensed risk-bearing entity to ''rent out'' their PPO network of providers. Consistent with our policy of deferring to the State as to which entities constitute licensed risk-bearing entities eligible for the M+C program, HCFA will defer to the State in terms of whether the PPOs can accept partial capitation from the licensed indemnity carrier or licensed HMO.

An entity offering a PPO plan must still comply with the requirements in 1854(e), which limit enrollee financial liability under a PPO plan in the same manner that liability is limited under an HMO plan or any other type of M+C coordinated care plan. That is, the sum of the premium for basic benefits and the actuarial value of all out-of-pocket expenses for such benefits (including the actuarial value of all cost-sharing for non-participating providers in a PPO) cannot exceed the actuarial value of the deductibles and coinsurance in original fee-for-service Medicare. Therefore, if a PPO expects a high level of utilization of non-participating providers, it must have a very low premium or it must have a significantly reduced level of cost-sharing for such services.

Religious Fraternal Benefit Society Plans

One specific type of coordinated care plan authorized by the BBA is a religious fraternal benefit society plan

(RFB plan), which is defined in section 1859(e). An RFB plan is an entirely new type of plan that may be offered under the M+C program.

As with the other types of coordinated care plans, an entity offering an RFB plan must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers an M+C plan. Essentially, an RFB society must meet the state licensing requirements outlined in section 1855. As discussed above, the States define the criteria for licensure, including any fiscal solvency standards that apply.

Also, an organization offering an RFB plan under the M+C program must do more than merely pay health care claims on behalf of their beneficiaries. Rather, RFB plans that constitute M+C coordinated care plans must meet the definition of a coordinated care plan included in this regulation. That is, they must have a network of health professionals and meet the applicable access, availability, service area, and quality assurance requirements.

Section 1859(e) defines and describes the requirements for RFB plans. Section 1859(e)(2) describes an M+C RFB plan as a coordinated care plan that: (A) Is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group; and (B) permits all members to enroll without regard to health status-related factors. Section 1859(e)(3) states that the RFB plan must be offered by a religious fraternal benefit society that: (A) is described under section 501(c)(8) of the Internal Revenue Code and is exempt from taxation under section 501(a) of that Act; (B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (C) offers, in addition to an M+C religious fraternal benefit society plan, at least the same level of health coverage to individuals not entitled to Medicare benefits who are members of such church, convention, or group; and (D) does not impose any limitation on membership in the society based on any health status-related factor.

Section 501(c) of the Internal Revenue Code generally describes the rules applicable to those organizations which are not subject to Federal income tax under section 501(a) of the code. Section 501(c)(8) describes one type—fraternal beneficiary societies, orders or associations that (a) operate under the lodge system for the exclusive benefit of a Fraternity itself operating under the lodge system; (b) provide for the payment of life, sick or accident or other benefits for the members of such society or association or their dependents.

RFB Plans have two distinguishing factors from other types of M+C coordinated care plans. The first is that RFB plans are allowed to limit their enrollment to members of the church. Section 1859(e)(1) indicates that a religious fraternal benefit society offering an M+C plan may restrict the enrollment of individuals in the plan to individuals who are members of the church, convention, or group with which the society is affiliated.

In addition to this ability to limit enrollment strictly to members of the church, RFB plans are distinct from other M+C coordinated care plans in that RFB plans may be subject to possible payment adjustments to ensure an ''appropriate payment level.'' Specifically, section 1859(e)(4) indicates that the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

M+C MSA Plans (§ 422.4(a)(2))

The definition of an M+C MSA plan, as well as other requirements that apply solely or in a different manner to M+C MSA plans, are discussed in full in section III. of this preamble. Note that in section III.K. of this preamble, we solicit letters of intent from organizations that intend to offer M+C MSA plans to Medicare beneficiaries and/or to serve as M+C MSA trustees.

M+C Private Fee-For-Service Plans (§ 422.4(a)(3))

The definition of an M+C private fee-for-service plan, as well as other requirements that apply solely or in a different manner to M+C private fee-for-service plans, are discussed in full in section IV of this preamble.

Multiple Plans (§ 422.4(b))

Section 422.4(b) establishes that an M+C organization may offer multiple plans, including plans of different types, under a single contract with HCFA, provided that the organization is licensed or approved under State law to offer the applicable types of plans. We believe that this policy should prove to be less administratively burdensome for both prospective M+C organizations and for HCFA than other alternatives, such as requiring separate contracts between HCFA and an M+C organization for each plan, or type of plan, being offered by the organization. We also specify under this section that if an M+C organization has received a waiver of the licensing requirement to offer a PSO plan, the waiver does not apply to the licensing requirement for other types of plans. Other issues associated with the ability of an M+C organization to offer multiple plans under a single contract with HCFA are discussed below, in the section of the preamble that deals with the contract requirements contained in subpart K of part 422.

4. Applications (§§ 422.6 and 422.8)

Sections 422.6 and 422.8 set forth the application requirements for entities seeking to contract with HCFA to offer M+C plans, as well as HCFA's application evaluation procedures. For the most part we have retained the contracting requirements from §§ 417.143 and 417.144 as authorized by section 1856(b)(2). This section of the law allows HCFA to use past contracting standards applied to contracts under section 1876 or to create new standards as needed to implement the M+C program. The application requirements and evaluation procedures are almost identical to the current application procedures.

The primary change to our previous process is the additional requirement that organizations wishing to contract with HCFA must submit documentation of their appropriate State licensure, or submit documentation of State certification that the entity is, in fact, able to offer health insurance or health benefits coverage meeting State fiscal solvency standards and authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health care services. (Entities meeting the definition of a PSO can be exempted from this requirement if they meet conditions for a waiver, which can be granted by HCFA—see subpart H of part 422.) This requirement is necessitated by the fact that HCFA will no longer have primary responsibility for determining the fiscal solvency of new contractors. We intend to rely for the most part on State certification to insure that the entities that we contract with are indeed fiscally solvent and have the ability to handle and afford risk payments for health care coverage, although we will if necessary ''look behind'' State certifications for validation purposes.

In one addition to existing rules, § 422.8(b) specifies that HCFA may deny an entity's application to offer an M+C plan if the entity has failed to complete a corrective action plan during the term of its previous contract with HCFA, regardless of whether the contract was under the section 1833, 1876, or the new Part C provisions of the law. We

believe that this provision explicitly ensures that the proven performance problems of entities that apply to contract with HCFA under the M+C program are taken into consideration in the application evaluation process.

5. User Fees (§ 422.10)

The last section of subpart A contains regulations implementing the user fees provided for in section 1857(e)(2). Section 1857(e)(2) directs the Secretary to collect user fees from M+C organizations, with each paying its pro rata share, for the purpose of paying for costs associated with enrollment and information activities under section 1851 and subpart B, and counseling and assistance programs under section 4360 of the Omnibus Budget Reconciliation Act of 1990 (Public Law 103–66).

Under section 1876(k)(4)(D), the user fees provided for in section 1857(e)(2) apply in 1998 to HMOs and CMPs with risk contracts under section 1876. On December 2, 1997, we published regulations in § 417.472(h) implementing the user fee authority in section 1857(e)(2), and setting forth a methodology for determining an organization's ''pro rata share'' of these fees. (62 FR 63669).

In this interim final rule, we are simply adopting at § 422.10, for purposes of the M+C program, the user fee provisions now set forth at § 417.472(h). Our reasons for adopting the methodology reflected in these regulations are set forth in the preamble to the December 2, 1997 rule. We intend to respond to comments received on the December 2 interim final rule, as well as comments on this rule, in a future rulemaking document.

B. Eligibility, Election, and Enrollment

1. Eligibility to Elect an M+C Plan (§ 422.50)

Section 1876 background: The provisions that have in the past applied to managed care entities (and continue to apply until these entities become M+C organizations) are in section 1876 and part 417 of this chapter. Section 1876(d) provides that Medicare beneficiaries who are entitled to benefits under Part A and enrolled in Part B, or enrolled under Part B only, except those with ESRD, residing in the service area of the plan are eligible to receive all their Medicare benefits through an HMO or CMP that has a contract with HCFA. Regulations at § 417.423(b) excluded beneficiaries who elect hospice care from enrolling in an HMOs or CMPs as long as the hospice election remains in effect. Existing regulations at § 417.460(f) require that HMO or CMP disenroll individuals who move out of their geographic areas, except that § 417.460(f)(2) allows enrollees to remain enrolled in an HMO or CMP under the following circumstances: (1) During a temporary move from the service area for up to 90 days, or (2) during a move to a new area for as long as 1 year if the HMO or CMP has elected to offer this option under § 417.460(f)(2).

a. Eligibility. The BBA established a new section 1851(a) that includes the eligibility criteria an individual must meet in order to enroll in an M+C plan, as defined in § 422.4. Accordingly, except as discussed below at section B.1.b. regarding the transition of Part B only individuals, § 422.50 states that individuals who are entitled to Part A and enrolled in Part B are eligible to enroll in an M+C plan. These individuals are referred to as ''M+C eligible individuals.''

Individuals with end stage renal disease (ESRD) are not permitted to be new enrollees of an M+C organization offering an M+C plan. Section 1851(a)(3)(B) excludes individuals with ESRD from enrolling in an M+C plan generally, but provides that an individual who develops ESRD while an enrollee in an M+C plan may ''continue to be enrolled'' in that plan. For purposes of this provision only we are considering individuals who are enrolled in a private health plan offered by the M+C organization to have been enrollees of the M+C plan when they developed ESRD. In section 422.50(a)(2), therefore, we provide that an individual who develops end-stage renal disease while enrolled in an M+C plan, or in a private health plan offered by the M+C organization offering an M+C plan, may continue to be enrolled in the M+C organization as an M+C plan enrollee.

We take this position because we believe that Congress intended in section 1851(a)(3)(B) to permit individuals with ESRD who are enrolled with an M+C organization to remain enrolled with that organization. If an individual develops ESRD as an enrollee of the organization *after* becoming Medicare eligible, he or she clearly would be permitted under section 1851(a)(3)(B) to remain enrolled with the organization. We do not believe that enrollees of an M+C organization should be penalized because they develop ESRD prior to becoming Medicare eligible rather than after. This position is consistent with our existing policy implementing a similar ESRD exclusion under section 1876, and therefore is supported by section 1856(b)(2), which provides for the retention of ''standards established under section 1876 to carry out analogous provisions of such section.''

We are not continuing the § 417.423(b) exclusion policy on hospice; individuals who elect hospice coverage may elect an M+C plan. Unlike ESRD patients, individuals who elect hospice care are not specifically excluded from participating in the M+C program. In fact, section 1853(h) contains special rules for M+C organizations that enroll hospice patients.

Section 1851(b) states that, except as the Secretary may otherwise provide, individuals must live in the geographic area served by the M+C plan in order to enroll in that plan. We have exercised the discretion provided in this provision to provide that those individuals converting from health plans in which they were enrolled prior to Medicare entitlement who reside out of the plan's service area may also continue enrollment in the M+C organization if they reside in the continuation area of the plan.

An M+C organization must disenroll beneficiaries who permanently move from the service area, unless the plan has chosen to provide a continuation of enrollment option in the area to which the enrollee moved, as allowed in section 1851(b)(1)(B) and the enrollee chooses to remain with the plan. We discuss continuation of enrollment in detail in section b.2., ''Continuation of Enrollment.'' Section 4002 enrollment transition for 1876 risk contracts.

Section 1876 risk contracts cannot be renewed for a contract year beginning on or after January 1, 1999. Current risk contractors that remain in compliance with current standards and that demonstrate compliance with new requirements established by this regulation will be able to transition into the M+C program by entering into an M+C contract, as an M+C organization, with a contract effective date of January 1, 1999.

Section 4002(c) of the BBA provided for a seamless transition of enrolled membership. An individual who is enrolled on December 31, 1998 with an eligible organization under section 1876 shall be considered to be enrolled with that organization on January 1, 1999 under the M+C program if that organization has a contract under Part C of title XVIII for providing services on January 1, 1999, unless the individual has disenrolled effective on that date.

In addition, section 4002(b) provides that an individual who is enrolled in Part B only and is enrolled in an eligible organization with a risk-sharing contract under section 1876 on December 31, 1998, may continue to be enrolled in the

organization in accordance with our regulations. This means that on January 1 there will be a small population of ''grandfathered Part B only'' enrollees retained in organizations formerly with risk contracts that now hold contracts under the M+C program. However, this is a one time opportunity, and an individual who is enrolled in Part B and not entitled to Part A and who disenrolls from the M+C organization is not eligible to elect a plan offered by another M+C organization.

In summary, we are interpreting the statute to allow an individual to transition enrollment from the 1876 program without regard to location of residence or whether the individual has end-stage renal disease and to choose to enroll in any plan offered by the M+C organization into which they are transitioning.

2. Continuation of Enrollment (§ 422.54)

As stated previously, section 1851(b)(1)(B) allows M+C organizations to offer enrollees the option of continued enrollment in the M+C plan when enrollees leave the plan's service area to reside elsewhere, we have to interpieted this to mean on a permanent basis.

M+C organizations that choose the continuation of enrollment option must explain it in marketing materials and make it available to all enrollees in the service area. Enrollees may choose to exercise this option when they move or they may choose to disenroll.

Before an M+C organization may offer a continuation of enrollment option to Medicare beneficiaries, the organization must obtain HCFA approval of the continuation area, its marketing materials, and the organization's assurances that it will meet access requirements. Under section 1851(b)(1)(B), the organization must provide enrollees with reasonable access within the continuation area to the Medicare covered benefits described in section 1852(a)(1)(A).

The payment rate at which the M+C organization will receive payment from HCFA will be based on the rate and adjustment factors that correspond to the beneficiary's permanent residence. The M+C organization must, at a minimum, provide or arrange for the provision of Medicare covered benefits in the continuation area as described in the first sentence of § 422.100(b)(1), and the plan must meet access and cost-sharing requirements for all basic benefits.

Because the rate that we pay to M+C organizations includes amounts that ordinarily must be used to provide additional benefits (see preamble for subpart G), we believe that M+C organizations should be required to provide additional benefits in the continuation area. As noted above, however, section 1851(b)(1)(B) requires only that Medicare benefits be provided to continuation enrollees. We accordingly are considering a legislative proosial to require M+C organizations to provide all services in section 1852(a)(1), including required additional benefits under section 1852(a)(1)(B).

Section 1851(b)(1)(B) requires that ''reasonable access'' be provided in the continuation area, and that enrollees be subject to ''reasonable cost-sharing.'' We are requiring that M+C organizations satisfy the access requirements in § 422.112, and provide services either through written agreements with providers or by making payments that satisfy the requirements in § 422.100(b)(2).

We are defining ''reasonable cost-sharing'' in the continuation area to be limited to (1) the cost-sharing amounts required in the M+C plan's service area (in which the enrollee no longer resides) if provided by contract providers; (2) the cost-sharing amounts required by the continuation area plan if provided through agreements with another M+C plan; or (3) the amount for which a beneficiary would be liable under original Medicare if noncontracting providers furnish the services.

We have included two items in these regulations that reflect our prior experience with similar situations. They are: (1) that plans may require prior notification from members of their intention to use the continuation of enrollment option, but this requirement must be in their marketing materials, and (2) appeals and grievances in the continuation area must be handled in the same timely fashion as in the service area, but the ultimate responsibility for the appropriate handling of appeals and grievances is with the organization that is receiving payment from HCFA.

3. Limitations on Enrollment in an M+C MSA Plan (§ 422.56)

While most M+C eligible individuals can choose to receive benefits through one of the M+C plans defined in § 422.4, the statute places limitations on eligibility to enroll in M+C MSA plans.

Sections 1851(b)(2) and (b)(3) specifically exclude certain individuals from enrolling in M+C MSA plans. We have specified at § 422.56(b) of this section, that individuals who are enrolled in a Federal Employees Health Benefit program (FEHB) plan, or who are eligible for health care benefits through the Veterans Administration (VA) or the Department of Defense (DoD) may not enroll in an M+C MSA plan. The statute provides that the restrictions on FEHB enrollment may be eliminated if the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted polices that will ensure that the enrollment of FEHB participants in M+C MSA plans will not result in increased expenditures for the Federal government. The Office of Personnel Management has indicated to HCFA that they would not be able to certify that FEHB costs would not increase at this time. Under our authority in section 1851(b)(2)(B), we intend to apply the same rules for enrollment restriction to individuals who are eligible for health benefits through the VA and DoD. Additionally, in § 422.56(c) we have incorporated the statutory requirement under section 1851(b)(3) that individuals who are entitled to Medicare cost-sharing under a State plan under title XIX are not eligible to enroll in M+C MSA plans. In addition, an individual who receives health benefits that cover all or part of the annual deductible under an M+C MSA plan may not enroll in an M+C MSA plan.

Note that M+C MSA plans are described in detail in Section III of this preamble.

4. Limited Enrollment Under M+C RFB Plans (§ 422.57)

Section 1859(e)(1) states that Religious Fraternal Benefit Society (RFB) plans may limit the enrollment of individuals to those who are members of the church, convention or group with which the society is affiliated. We have included the restrictions on enrollment in RFB plans at § 422.57.

5. Election Process (§ 422.60)

Under section 1851(c)(1) the Secretary is required to establish a process through which elections in M+C plans are made and changed, including the form and manner in which they are done. In § 422.60, we describe the election process for enrollment with the M+C organization. Where applicable we have included existing rules from 42 CFR § 417.430 with conforming changes.

As stated at § 422.66(a), M+C eligible individuals who wish to elect an M+C plan may do so by filing the appropriate election form with the M+C organization. At § 422.60(a), we specify that M+C organizations must accept without restriction, except as specified in § 422.57 for RFB plans, individuals who enroll in an M+C plan during the

election periods described in section 1851(e)(6) and set forth at § 422.62 of the regulation.

As provided by section 1851(e)(6), and stated at § 422.60(a), and displayed in the following chart, M+C organizations are required to accept enrollments during the initial coverage election period, the annual election period, and special election periods, but M+C organizations are not required to be open for enrollment during open enrollment periods.

WHEN ELECTIONS MAY BE MADE OR CHANGED*

Coverage Election Periods	When: § 422.62	M+C Plans Required to Accept Enrollments: § 422.60	Effective Date of Coverage: § 422.68
Initial Coverage Election Period ...	3 months before entitlement to Part A and Part B.	Yes	1st day of month of entitlement to Part A and Part B.
Annual Election Period	Annually in November	Yes	January 1.
Special Election Period	Starting 2002, if beneficiary moves, plan terminates, etc.	Yes	To Be Determined—depends on situation.
Special Election Period at Age 65	Starting 2002, in first 12 months after initial election of M+C plan.	No—Election is original Medicare	1st day of the month after month of election.
Open Enrollment Periods	Anytime 1998–2001 Jan–Jun 2002 Jan–Mar 2003+.	No—Plans have option of accepting enrollments.	1st day of the month after month of election.

*Refer to referenced regulation text for detail.
Note that different rules apply to M+C MSA plans.

As provided at § 422.306(a)(2) to reflect the requirements in section 1854(a)(1)(B), M+C organizations must submit by May 1 of each year the enrollment capacity of each plan they offer. Section 422.60(b) then provides that if HCFA determines that the M+C plan has a capacity limit, the plan may limit the enrollment of M+C eligible individuals if the plan accepts first those individuals who elected the plan prior to the HCFA determination and then accepts others in a manner that does not discriminate on the basis of health status.

We note that we have not included regulation text to address the last sentence of section 1851(g)(2) regarding ''nonrepresentative'' enrollment. As written, the sentence disallows a capacity limit if enrollment would become substantially nonrepresentative of the Medicare population in the plan's service area, as determined in accordance with regulations of the Secretary. We cannot envision circumstances under which the imposition of a capacity limit on enrollment would by itself lead to an enrollment ''substantially non-representative'' of the Medicare population in an M+C plan's service area. We particularly cannot envision circumstances under which the non-representativeness of enrollment would be so ''substantial'' as to justify possible risks to patient access and quality of services as the result of overloaded capacity. We accordingly are not promulgating regulations at this time implementing the authority in the last sentence in section 1851(g)(2). We invite comments on this provision, and would consider including guidance on this matter in a final regulation based upon comments received.

At § 422.60(c) we indicate requirements for the election form. The form must comply with HCFA instructions regarding content and format, must be completed and signed by the beneficiary (or the individual who will soon be entitled to Medicare benefits), and must include authorization for disclosure and exchange of necessary information between HCFA and the M+C organization. Persons who assist beneficiaries in completing forms must sign the form and indicate their relationship to the beneficiary. The forms must also be filed and retained by the M+C organization.

In general, and as indicated by our requirement that the beneficiary complete and sign the form, we believe that an M+C eligible individual should personally complete and sign any election form or disenrollment request (referenced at § 422.66(b)) whenever possible. If for some reason a beneficiary is unable to sign for himself or herself, we recognize and defer to state laws on who may sign for other persons, which is also the policy in the Section 1876 program.

In § 422.60(d), we specify that an election is considered to have been made on the date it is received by the M+C organization. We believe it is necessary that we define ''when an election is made'' because it is a determining factor in establishing the effective date of M+C plan coverage. Note that HCFA's liability for payment is not as of the election date, but rather, is as of the effective date of coverage. Effective dates of coverage are specified at § 422.68.

We have also set forth at § 422.60(e) a process for handling of forms, including for providing written notification of acceptance or denial in the M+C plan.

6. Election of Coverage Under an M+C Plan (§ 422.62)

Section 1876 background: Section 1876(c)(3)(A)(i) requires that HMOs and CMPs hold an open enrollment period for Medicare beneficiaries of at least 30 consecutive days during each contract year to qualify for a Medicare contract. For Medicare beneficiaries who enroll during the open enrollment period, § 417.450(a)(2) states that the effective date of coverage cannot be earlier than the first month, nor later than the third month, after the month in which HCFA received the information necessary to include the beneficiary in its records. In § 417.450(b), HCFA reserves the option to approve a later month if requested by the organization and the beneficiary. HMOs and CMPs can also offer continuous open enrollment outside of the 30-day period.

In the M+C program under section 1851(a)(1), M+C eligible individuals may elect to receive Medicare benefits under original Medicare or through election of an M+C plan. Section 1851(e) describes the various election periods available to M+C eligible individuals. Many of these provisions allow the individual to ''change the election under subsection (a)(1)'' during these periods. If section 1851(a)(1) were read narrowly, it arguably would only allow an eligible individual to change between original Medicare or the M+C program under Part C. We have taken a broader approach in interpreting section (a)(1) to allow eligible individuals to not only make a change between the original Medicare program and an M+C plan, but also among M+C plans. Therefore, an M+C eligible individual

who changes his or her election may change from an M+C plan to original Medicare, from an M+C plan to another M+C plan or from original Medicare to an M+C plan.

The BBA establishes specific parameters in which elections can be made and/or changed. Individuals who wish to elect an M+C plan or subsequently change their election, must do so during the periods established under section 1851(e). That section requires that elections or changes in election be made during the following periods: The initial coverage election period, continuous open enrollment periods, an annual coordinated election period or special election periods. Note that the Medigap implications of a change of election to original Medicare are discussed at section II.B.12 (Extended Period of Guaranteed Access to Medigap Plans) of this preamble.

a. Initial Coverage Election Period. Section 1851(e)(1) requires that the Secretary specify an initial coverage election period during which an individual who is initially entitled to Part A and enrolled in Part B may elect an M+C plan. The statute further stipulates that if an individual elects an M+C plan during that period, coverage under the plan will become effective as of the first day on which the individual may receive that coverage. We believe that Congress intended that we give a newly eligible individual the opportunity to be enrolled in an M+C plan as soon as he or she would be entitled to actually receive both Medicare Part A and Part B coverage.

In other contexts, we have interpreted the concept of ''entitled'' to mean that an individual has met all of the necessary requirements for a benefit (that is, is eligible for the benefit), and has actually applied for and been granted coverage. An individual is considered to be ''enrolled'' under section 1837, on the other hand, when he or she has applied for Part B coverage (or is deemed to have applied). Under some situations, an individual may apply for or be deemed to have applied for Part B before he or she is actually entitled to receive coverage. For example, if an individual applies for Part B coverage and becomes ''enrolled'' after he or she reaches age 65, the individual may not actually be entitled to Part B coverage under section 1838 until one or several months after the month of application and enrollment. If we were to interpret section 1851(e)(1) to give effect to an M+C plan election when an individual has only enrolled in Part B, he or she could be entitled to the benefits of the M+C plan before actually being entitled to Medicare Part B coverage. In order to avoid such a result, we have interpreted ''enrolled'' in Part B as ''entitled'' to Part B.

We believe our interpretation is consistent with section 1851(e)(1), which requires the Secretary to specify an initial coverage election period that would result in coverage under the plan becoming effective as of the first day on which the individual may receive that coverage.

In establishing the initial coverage election period we considered the statutory process of entitlement to Part A and enrollment in Part B. Section 226 of the Act provides that individuals who are age 65 and entitled to retirement benefits under title II or the Railroad Retirement Board Act and those who are under age 65 and have been entitled (or deemed entitled) to disability benefits under title II or the Railroad Retirement Board Act for 24 months shall be entitled to Part A under the Medicare program and eligible to enroll in Part B. Part A coverage is effective the month an individual attains age 65, or the 25th month he or she is entitled to disability benefits. If an individual is entitled to disability or retirement benefits at least 3 months before reaching age 65 or, in the case of a disabled individual, three months before the 25th month in which he or she is entitled to disability benefits, the individual is deemed enrolled in Part B at that time. Under section 1838, Part B is effective with the month an individual reaches age 65 or in the 25th month he or she is entitled to disability benefits.

In order for an individual to have coverage under an M+C plan effective as of the first day on which the individual may receive such coverage, the individual must elect an M+C plan before he or she is actually entitled to Part A and Part B coverage. We have therefore defined the initial coverage election period as the 3-month period that begins 3 months prior to the month the individual is first entitled to both Part A and Part B and ends the last day of the month preceding the month of entitlement.

This approach also permits individuals who do not enroll in Part B at initial eligibility (i.e. at age 65 or in the 25th month of disability entitlement) to elect an M+C plan at the time of subsequent enrollment in Part B. Section 1837(i) provides for a special enrollment period for individuals who defer enrollment in Part B because they are covered under a group health plan based on their own employment or that of a spouse (in the case of the disabled, the employment may be that of any family member). Enrollment in Part B may occur during any month the individual is covered under the group health plan based on current employment or during the 8-month period that begins the first full month the individual is no longer covered under the group health plan based on current employment. Under section 1838(e), Part B coverage is effective the first day of the month the application is filed or, at the individual's option, the first day of any of the following three months when enrollment occurs while the individual is covered under the group health plan based on current employment or during the first full month when not so covered. Therefore, an individual may file an application for Part B up to three months in advance of entitlement. Consequently, individuals who enroll in Part B during the special enrollment period may elect an M+C plan during the 3-month period prior to entitlement to Part B.

Additionally, section 1837(e) allows individuals who fail to enroll for Part B during their initial enrollment period (3 months before they are entitled to Part A or within 3 months after the month they are entitled to Part A) to enroll for Part B during a general enrollment period, which runs from January through March of every year, with coverage effective July 1 of the year of enrollment. In this case, the Part B application may be filed up to 6 months in advance of the month of entitlement. (Individuals who enroll in a general enrollment period are subject to an increased premium under section 1839(b), measured by the length of the delay in enrollment.)

In order to be consistent with the 3 month periods that can occur between timely enrollment for Part B and actual entitlement in existing sections of the Medicare statute, we have limited the period during which an individual may elect an M+C plan to the 3-month period prior to actual entitlement to Part B. We believe that this correlation with the 3-month period will be administratively more efficient than a shorter or longer time period.

b. Annual Coordinated Election Period. Section 1851(e)(6) establishes that organizations offering M+C plans in January, 1999 must open enrollment to Medicare beneficiaries in November, 1998. In addition, section 1851(e)(3) establishes the month of November of each year beginning in 1999 as the annual coordinated election period.

During the month of November, an M+C eligible individual may elect an M+C plan or change his or her election. Thus, the section 1876 requirement that plans be open any 30-day period is replaced by a requirement that plans

have to be open for enrollment during the month of November.

c. Open Enrollment Periods. Section 1851(e)(2) establishes open enrollment periods during which M+C eligible individuals may elect an M+C plan, if it is open to new enrollees, or change their elections. M+C individuals may not, however, as provided in section 1851(e)(5), elect an M+C MSA plan during open enrollment periods.

Note that as provided by section 1851(e)(6) and stated at § 422.60(a)(2), M+C organizations may, but are not required, to offer continuous open enrollment during open enrollment periods. This is similar to the section 1876 policy which also allowed, but did not require, continuous open enrollment outside of a 30-day period.

Section 1851(e)(2)(A) establishes that at any time during calendar years 1998 through 2001, there will be no limit on the number of elections or changes that an M+C eligible individual can make.

Section (e)(2)(B) establishes the first six months of 2002, (January through June) as the open enrollment period for that year. An M+C eligible individual may elect an M+C plan or change his or her election, but only once during the first six months of the calendar year.

Section (e)(2)(C) establishes the first three months of each year (January through March) beginning 2003, as the open enrollment period. An M+C eligible individual may elect an M+C plan or change his or her election, but only once during the first three months of the calendar year.

Section 1851(e)(2)(B)(i) allows that an individual who becomes an M+C eligible individual in 2002 and elects an M+C plan or original Medicare, to change that election once during the first 6 months of M+C eligibility in 2002. Beginning in the year 2003 and thereafter, a newly eligible individual who has made an election may change that election once during the first 3 months of M+C eligibility in that year. Consequently, those who become M+C eligible individuals late during the year may not have a full 6-month or 3-month open enrollment period. For example, an individual who becomes eligible in August 2002 has an open enrollment period of 5 months, August through December. The sixth month, January, does not occur during 2002 and cannot qualify as part of the open enrollment period.

The limit to one change during the open enrollment periods in the first six months of 2002 and the first three months of subsequent years does not apply to changes in elections that an individual makes during an annual coordinated election period or during a special election period.

In § 422.62, paragraphs (a)(4)(ii) and (5)(ii), we have interpreted the 6 and 3 month periods ''in which the individual is an M+C eligible individual'' in section 1851, paragraphs (e)(2)(B)(i) and (e)(2)(C)(i), as the periods that begin with the month the individual is first ''entitled to both Part A and Part B.'' The statute defines ''eligible for Medicare+Choice'' as eligible for Part A and enrolled in Part B, a definition that we have reflected in § 422.50(a)(1); however, this definition could cause problems for newly eligible individuals during the open enrollment period.

For example, individuals who are newly eligible for M+C in the year 2002 under section 1851(e)(2)(B) will have 6 months, beginning with their eligibility for M+C, to change their election. If we start counting this period from the time individuals enroll in Part B, some will have little or no opportunity to change. Some of these individuals may not actually be entitled to receive benefits for a delayed period, which can be up to 6 months after they have enrolled if they have enrolled during a general election period. Hence, the opportunity to change could have no meaning, with the open enrollment period expiring before the individuals have actually received any M+C coverage.

d. Special Election Periods. Section 1851(e)(4) establishes special election periods beginning in 2002, during which M+C eligible individuals may disenroll from an M+C plan or elect another M+C plan. Special election periods are available if: (1) The service area or continuation area is reduced or the plan terminates or is terminated in the area in which the individual resides; (2) the individual moves out of the plan's service area and the plan does not offer, or the individual does not elect, the continuation of enrollment feature, or there is some other change of circumstances specified by HCFA; (3) the individual demonstrates to HCFA, in accordance with guidelines established by HCFA, that the M+C organization offering the plan substantially violated a material provision of its contract with regard to the individual or the organization, its agent, representative, or plan provider materially misrepresented the plan's provisions in marketing the plan to the individual; or (4) the individual meets such other exceptional conditions specified by HCFA.

The last paragraph in section 1851(e)(4) provides that, effective January 1, 2002, an individual who, upon first becoming eligible for benefits under Part A at age 65, enrolls in an M+C plan (other than an M+C MSA plan), may discontinue the election and elect original Medicare at any time during the 12 month period beginning on the effective date of the M+C election. We have interpreted this provision to apply to individuals who elect an M+C plan (other than an M+C MSA plan) during the initial enrollment period, as defined under section 1837(d), that surrounds their 65th birthday. This period begins 3 months before and ends 3 months after the month of an individual's 65th birthday. We believe that this interpretation fulfills the intention of the statute, which is to provide this special election period to individuals who, upon turning 65 and first becoming entitled to Medicare, elect an M+C plan. Our interpretation takes into account the fact that many, if not most, individuals will be making an election during an initial enrollment period, rather than during the month that they turn 65.

e. Special Enrollment and Disenrollment Rules for M+C MSA Plans. Section 1851(e)(5) establishes special rules for individuals enrolling in M+C MSAs. M+C eligible individuals may elect the M+C MSA option only during an initial coverage election period or during November of any year, beginning in 1998. M+C MSA enrollees may discontinue their election only during November of 1998, during annual coordinated election periods in November of each subsequent year, and during special election periods described in the first sentence of section 1851(e)(4). Individuals who elect an M+C MSA for the first time during the annual coordinated election periods that begin in November of 1999 may revoke their election if they do so before December 15 of the year in which they make the election, i.e., before the M+C MSA coverage begins. M+C MSA plans are described in detail at the end of this preamble.

7. Information about the M+C Program (§ 422.64)

Once these regulations are effective and M+C plans are approved by HCFA, eligible Medicare beneficiaries will be able to choose to receive their Medicare benefits from a new array of health care options. New options will include coordinated care plans such as Health Maintenance Organizations, Preferred Provider Organizations, Provider Sponsored Organizations, as well as Private Fee for Service Plans and Medical Savings Accounts. Medicare beneficiaries will still be able to choose to remain in original Medicare. These choices are designed to offer Medicare beneficiaries a marketplace of options

similar to those available to the non-Medicare population.

Under section 1851(d)(2), the Secretary is obligated to mail an ''open season notification'' at least 15 days before the beginning of each annual coordinated election period to each M+C eligible individual residing in an area and, to the extent practicable, to a newly eligible individual not later than 30 days before the individual's initial coverage election period. The notice must include certain general information listed in section 1851(d)(3) and a list of plans and certain plan comparisons as described in section 1851(d)(4). Section 1851(d)(1) requires that HCFA provide for activities to broadly disseminate information to beneficiaries and prospective beneficiaries on their coverage options under M+C, and section 1851(d)(5) requires HCFA to maintain a toll-free line for M+C inquiries and an Internet site through which individuals can obtain electronic information.

To promote informed choice, HCFA will provide access, via the Internet and through distribution of print materials, to information about original Medicare and M+C options. In accordance with section 1851(d)(3) and reflected in § 422.64(c), HCFA will provide general information to M+C eligible individuals with respect to benefits available under Part A and Part B of original Medicare, including covered services, beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts, including any beneficiary liability for balanced billing. Such general information will also include instructions on how to exercise election options under M+C; procedural rights including the grievance and appeals procedures for original Medicare and M+C and the individual's right to be protected against discrimination based on health status related factors under section 1852(b), including the fact that an M+C organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract and the effect this may have on the individuals enrolled in the M+C plan. Finally, a general description of the benefits, enrollment rights, and other requirements applicable to Medicare supplemental policies under section 1882, including Medicare Select, will be included.

Under section 1851(d)(4) and reflected in § 422.64(c)(6), HCFA will also provide information to M+C eligible individuals comparing M+C plan options, including the benefits covered under the M+C plan; covered services beyond those provided under original Medicare; and beneficiary cost-sharing including maximum limitations on out-of-pocket expenses and, in the case of an MSA plan or M+C private fee-for-service plan, differences in cost-sharing, premiums, and balance billing as compared to other M+C plans and whether the organization offering the plan includes mandatory supplemental benefits in addition to its base benefit package or offers optional supplemental benefits and the premiums and other terms and conditions for such coverage. The M+C monthly basic beneficiary premium and M+C monthly supplemental beneficiary premium, if any for the plan or, in the case of an MSA plan, the M+C monthly MSA premium, will also be included. M+C eligible individuals will also be informed about the extent to which they may obtain benefits through out-of-network health care providers; the extent to which they may select among health care providers and the types of providers participating in the plan's network. M+C eligible individuals will be informed of the M+C organization's coverage of emergency and urgently needed care, service area of the plan, and, to the extent available, M+C plan quality and performance indicators.

The information comparing plan options is crucial to empowering beneficiaries with the knowledge that will help them evaluate M+C options and make informed decisions based on their individual needs. We wish to make clear that our provision of comparative data is intended neither to encourage or discourage beneficiaries from choosing one health care plan over another nor to favor a choice of an M+C plan over original Medicare.

We invite the public to comment or to provide specific guidance on the types of information that should be made available to beneficiaries. Once we have worked out what specific information we will require within the above categories, we will post these at our Internet site.

The Internet site, www.Medicare.gov, is a Medicare beneficiary-centered consumer website designed to provide a broad array of information on program benefits, health system performance, health care choices, healthy behaviors and health promotion. This site will be continuously improved to meet the mandate in section 1851(d)(2)(C) that we provide information in a style and format that is easy to understand. If necessary, we will publish regulations and allow for OMB review, pursuant to the requirements of the Paperwork Reduction Act of 1995.

HCFA's ''Medicare Compare,'' the Managed Care Plans Comparison Database, will be available on the Internet for public use. ''Medicare Compare'' provides a wealth of information on health care plans, allowing users to ''comparison shop'' for plans. Users can look up information in different areas, by state, county or zip code. They can also compare costs for premiums and types of services offered. The information in the database will be updated quarterly. Plan specific quality performance measures from the HEDIS information set and the Consumer Assessment of Health Plans Survey (CAHPS) will be incorporated into information provided to beneficiaries once the data and results have been validated and determined to be accurate and reliable. HCFA is committed to using a public process to determine information and data specifications, including the details of what information will need to be collected and the methods of collection to determine the remaining unspecified data elements that organizations are required to submit. HCFA will work collaboratively with organizations involved with quality and performance standards and measurements, including performance measurement experts, public and private purchasers, and beneficiary representatives in this process. In addition, HCFA will hold public meetings to invite interested parties to comment and provide input in the process of determining the data specifications for additional performance information, e.g., data about appeals or health outcome measures. Finally, HCFA will publish a notice regarding plan data elements to be collected and a summary of public processes used to determine the data elements in question and this document would be available at the discretion of the requestor. Educational information will be made available on the Internet site to prepare consumers on how to use this information when comparing plans and in making decisions about their health care.

In support of efforts to promote informed choice, HCFA will also maintain a toll-free line for M+C information.

Under section 1851(e)(3)(D), we are required to provide in the fall of 1998 for a ''Special Information Campaign'' in the form of an educational and publicity campaign that informs M+C eligible individuals about the availability of M+C plans offered in different areas, and about the election process. Section 1851(e)(3)(C) requires that we provide for a nationally coordinated educational and publicity campaign about M+C plans and the election process in November of each year, beginning in 1999. We may conduct these campaigns

using health fairs, as well as other methods for distributing information.

8. Coordination of Enrollment and Disenrollment Through M+C Organizations (§ 422.66)

a. Enrollment. Section 1851 (c)(1) and (c)(2) provide that individuals who wish to elect an M+C plan may do so through filing an appropriate election form with the organization during an election period specified in section 1851(e), and reflected in § 422.62. Section 1851(c)(1) requires that the Secretary establish a process through which elections in M+C plans are made. Therefore, we reserve the right to develop and provide additional mechanisms for electing an M+C plan. We have provided instructions on how M+C organizations must process elections at § 422.60(e). If necessary, we will publish regulations and allow for OMB review, pursuant to the requirements of the Paperwork Reduction Act of 1995.

b. Disenrollment. Section 1876 background: Under section 1876(c)(3)(B), which covers disenrollment from HMOs and CMPs, a Medicare beneficiary can disenroll from an HMO or CMP at any time. Under the HMO and CMP regulations in § 417.461(a), an enrollee who wishes to disenroll may, at any time, give the organization a signed, dated request in the form and manner we specify. The beneficiary can request a certain disenrollment date, but it can be no earlier than the first day of the month following the month in which the organization receives the disenrollment request. Under section 9312(h) of the Omnibus Budget Reconciliation Act of 1986, Medicare beneficiaries are also permitted to disenroll from an eligible organization under Section 1876 at a local Social Security office.

Section 417.461(b) describes the responsibility of the HMO or CMP to promptly submit a disenrollment notice to HCFA and provide the enrollee with a copy of the request for disenrollment and, in the case of a risk HMO or CMP, an explanation of the date of disenrollment. Section 417.461(c) provides that HMOs and CMPs must reimburse HCFA in cases where a disenrollment notice is not submitted timely to HCFA.

Currently, when an individual enrolls in one HMO or CMP while still enrolled in another, we regard this action as a disenrollment from the first HMO or CMP, and automatically amend our enrollment records to reflect the disenrollment. We do this so that the beneficiary does not have to both submit a disenrollment request to the first HMO or CMP, and an enrollment request to the new HMO or CMP.

To reflect these current policies, § 422.66(b)(1) provides that an individual who wishes to disenroll may change his or her election in the following manner: (i) Elect a different M+C plan during an election period specified in § 422.62 or (ii) submit a signed and dated request for disenrollment to the M+C organization during an election period specified in § 422.62. HCFA also reserves the right to develop and provide additional mechanisms for disenrollments in accordance with section 1851(c). Note that the Medigap implications of a change of election to original Medicare are discussed at section II.B.12 (Extended Period of Guaranteed Access to Medigap Plans) of this preamble.

At § 422.66(b)(2) we specify that a disenrollment request is considered to have been made on the date it is received by the M+C organization. Note that HCFA's liability for payment ends not on the date the disenrollment request is received by the M+C organization, but rather, as of the date of disenrollment. The date of disenrollment is determined at § 422.68 for changes made by enrollees during coverage election periods and at § 422.74 for disenrollments made by M+C organizations.

At § 422.66(b)(3) and (4) we are continuing the § 417.461(b) and (c) requirements for M+C organizations to provide timely notice of disenrollment to HCFA and to provide the enrollee with a copy of the disenrollment request with information on the date of disenrollment and any lock-in requirements of the plan that apply until the effective date of disenrollment. We also state that disenrollment requests must be filed and retained as specified in HCFA instructions.

The regulation also provides that if the M+C organization fails to submit a correct and complete disenrollment notice to us promptly, the M+C organization must reimburse us for any capitation payments it has received after the month in which we would have stopped payment, had the M+C organization met the requirement.

c. Retroactive Disenrollment. Section 1876 background: In the case of section 1876 contractors, HCFA has permitted beneficiaries to be retroactively disenrolled from an HMO or CMP if it determines that there never was a legally valid enrollment, or a valid request for disenrollment was properly made but not processed or acted upon.

In the M+C program, HCFA will continue to consider retroactive disenrollments in cases in which we determine that there never was a legally valid enrollment, or a valid request for disenrollment was made but not processed or acted upon. We have reflected this provision in § 422.66(b)(5).

d. Fee-for-Service Election by Default. Section 1851(c)(3)(A)(i) establishes that newly eligible enrollees who do not choose an M+C plan during the initial coverage election period are deemed to have chosen original Medicare. We have reflected this provision in § 422.66(c).

e. Seamless Continuation of Coverage (Conversions). Section 1876 background: In regulations at § 417.432, an HMO/CMP is required to accept any individual who was already enrolled in the HMO/CMP for the month immediately prior to the month in which he or she was entitled to both Part A and Part B, or entitled to Part B only. HCFA refers to such enrollments as ''conversions'' or ''age-ins.'' The individual's effective month of enrollment in the HMO or CMP as 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.

With the enactment of BBA, a new section 1851(c)(3)(A)(ii) is added to the statute that gives the Secretary discretion to establish procedures under which individuals who are enrolled in a health plan offered by an M+C organization at the time of their initial coverage election periods will ''default'' to or be deemed to have elected an M+C plan offered by the M+C organization, unless these individuals elect a different option. We have chosen not to have individuals default to the M+C plan offered by the organization. At this time we do not have a mechanism in place to capture the information we would need to implement such a process. A default process would require that M+C eligible individuals as well as their relevant health plan information be identified and captured prior to the individual's initial coverage election period. At present, we do not have access to information on which health plans individuals are enrolled in because such plans are private health plans. In addition, we are not given any information if individuals have not previously filed for title II (Social Security) and/or title XVIII (Medicare) benefits.

One option that we may consider would be to specify that M+C organizations which have individuals enrolled in private health plans must notify such individuals 4 months preceding the month in which the individual becomes an M+C eligible individual of their opportunity to ''age-in'' to the M+C plan or to select another option. This would give the individual

the opportunity to select from a range of health care options in a manner that would facilitate seamless continuation of coverage. M+C organizations would be required to transmit to us the necessary plan information for those individuals who are interested in exercising their opportunity to ''age-in''. HCFA would then have the information necessary to ''deem'' or ''default'' M+C eligible individuals into the appropriate M+C plan. We request public comments on this issue and will issue further clarification in the final rule. In the interim, we have retained the conversion of enrollment process described in § 417.432 with conforming changes.

In § 422.66(d) we specify that M+C plans must accept any individual who is enrolled in a health plan (other than an M+C plan) offered by the same M+C organization, during the month immediately preceding the month in which the individual is entitled to both Part A and Part B. Conversion may occur if the individual resides in the service area or continuation area of the plan and regardless of whether an individual has ESRD. We limit conversions to individual in a service area and continuation area in order to ensure that enrollees have access to the full range of services offered by the plan. This policy is also reflected in the section describing eligibility to elect a plan (§ 422.50(a)(2) and (a)(3)). Therefore, an M+C organization's obligation to accept current enrollees extends to enrollees in a service area or a continuation area, or who developed ESRD while enrolled with the organization under a private health plan. Converted beneficiaries who reside out of the plan's service area or who have ESRD cannot, however, later elect to enroll in a plan offered by another M+C organization unless they meet the statutory requirements at sections 1851(b)(1)(A) and 1851(a)(e)(B).

In addition, we allow M+C organizations to reserve vacancies for their plans to accommodate conversions in recognition that M+C organizations must accept conversions. We require the individual who is converting to file an election form in accordance with § 422.60(c)(1). We also stipulate that the M+C organization may not disenroll the individual except under the conditions described in § 422.74.

f. Maintenance of Enrollment. The statute provides at section 1851(c)(3)(B) that an individual who has made an election or is deemed to have made an election is considered to have continued to make that election until the individual changes it or the M+C plan is discontinued or no longer serves the area in which the individual resides. We have stated this rule at § 422.66(e).

9. Effective Dates of Coverage and Change of Coverage (§ 422.68)

Section 1851(f) establishes the effective dates for elections and changes to elections made during the various enrollment periods. Note that the Medigap implications of a change of election to original Medicare are discussed at section II.B.12 (Extended Period of Guaranteed Access to Medigap Plans) of this preamble.

Section 1851(f)(1) states that an election made during the initial coverage election period will take effect on the date the individual becomes entitled to Part A and enrolled under Part B, but gives the Secretary discretion to interpret this provision in a manner, consistent with section 1838, that prevents retroactive coverage. We are interpreting ''enrolled in Part B'' as ''entitled to Part B'' in order to avoid retroactive coverage in an M+C plan that an individual might receive after enrolling in Part B but prior to the time the individual is actually entitled to Part B benefits. Therefore, we have established that an election made during the initial coverage election period is effective the first day of the month of entitlement to both Part A and Part B.

Under section 1851(f)(3), an election or change of election made during an annual coordinated election period is effective the first day of the following calendar year. We have reflected this provision in § 422.68(b).

Under section 1851(f)(2), an election or change of election made during an open enrollment period is effective the first day of the first calendar month following the month in which the election is made. We have reflected this provision in § 422.68(c).

Under section 1851(f)(4), an election that occurs as the result of a special election period is effective, to the extent practicable, in a manner determined by HCFA to promote continuity of coverage. We have reflected this provision in § 422.68(d).

At § 422.68(e) we are stating that an election of original Medicare made during a special election period by an individual age 65 as provided at § 422.62(c) is effective the first day of the first calendar month following the month in which the election is made.

10. Disenrollment by the M+C Organization (§ 422.74)

Section 1851(g)(3) specifies that M+C organizations may only disenroll individuals from an M+C plan for the following reasons: the individual fails to pay any basic and supplemental premiums on a timely basis; the individual engages in disruptive behavior; or the M+C organization terminates its coverage of all M+C eligible individuals in the area in which the individual resides.

In § 422.74, we have set forth the conditions under which M+C organizations can disenroll individuals. Section 1851(g)(3)(A) provides that, except as provided in section 1851(g)(3)(B), ''a Medicare+Choice organization *may not for any reason terminate*'' an individual's enrollment in ''a Medicare+Choice plan it offers.'' [Emphasis added.] We have included the three grounds for termination set forth in section 1851(g)(3)(B) in § 422.74. With respect to the ground in section 1851(g)(3)(B)(ii), under which an enrollee can be disenrolled for ''disruptive behavior'' as specified in standards established in regulations, we have implemented this ground for termination in two separate provisions. First, under § 422.74(b)(1)(ii), we refer to an individual who meets general standards for disruptiveness set forth in § 422.74(d)(2). Section 422.74(d)(2) refers to behavior of an individual that is ''disruptive, unruly, abusive, or uncooperative to the extent that his or her continued enrollment * * * seriously impairs the M+C organization's ability to furnish services. * * *'' We also separately refer to a different kind of ''disruption'' or failure to ''cooperate''; namely, fraud or abuse of the enrollee's enrollment card. This ground for termination is also based on section 1851(g)(3)(B)(ii), and standards for disenrollment on this basis are also included in § 422.74(d), in a separate paragraph (3).

In addition to implementing the grounds in section 1851(g)(3)(B), we also provide in § 422.74 for the termination of individuals who are no longer eligible for enrollment in the M+C plan, because they have left the area, lost entitlement to Medicare, or died. We believe that the prohibition in section 1851(g)(3)(A) on terminating an enrollee on grounds other than those set forth in paragraph (B) applies only to individuals who are otherwise *eligible* for enrollment in the plan. Clearly, if an individual does not meet the threshold requirements for eligibility, disenrollment is not only permissible but required.

We have established specific guidelines in § 422.74(d)(1) that the M+C organization must follow when disenrollment is based on failure to pay basic and supplemental premiums, including the requirement to send a notice of nonpayment within 20 days after the date that delinquent charges

are due. The notice must alert the individual that he or she is delinquent on a premium payment, provide the individual with an explanation of the disenrollment procedures and any lock-in provisions of the plan, and advise the individual that failure to pay the premiums within the 90-day grace period will result in termination of M+C coverage.

Note that in the section 1876 program, disenrollment for non-payment of premiums is treated differently. At § 417.460(c)(2), if a beneficiary pays the basic premium and other charges, but fails to pay the premium for optional supplemental benefits, the organization can discontinue the optional benefits, but cannot disenroll the beneficiary. However, under section 1851(g)(3)(B)(i), an M+C organization may terminate an election of a plan if any M+C monthly basic and supplemental beneficiary premiums are not paid on a timely basis.

We have retained the current processes described in § 417.460 for disenrollment for disruptive behavior and fraud and abuse. In the case of disenrollment for disruptive behavior, the M+C organization must ascertain that the individual's behavior is not related to the use of medical services or to diminished mental capacity. If an individual is disenrolled for disruptive behavior, HCFA will review the documentation submitted by the M+C organization and the beneficiary to determine whether the disenrollment requirements have been met.

We have included a qualifier for disenrollment when the individual no longer resides in the M+C plan's service area to conform to section 1851(b)(1)(B), which permits plans to offer a continuation of enrollment feature if the individual moves out of the service area. We have modified the existing regulatory text at § 417.460(h) which requires disenrollment when the individual loses entitlement to Part B benefits, to require disenrollment when an individual loses entitlement to Part A or Part B benefits. We have also addressed the process for disenrollment for plan termination or area reduction.

For all disenrollment situations, except those due to the death of the individual or loss of Part A or Part B benefits, we require M+C organizations to provide the individual with a written notice of the disenrollment that includes an explanation of why the M+C organization is planning to disenroll the individual and a description of the individual's right to a hearing under the M+C organization's grievance procedures.

The statute provides at section 1851(g)(3)(C) that individuals who are disenrolled from an M+C plan due to disruptive behavior or failure to pay basic or supplementary premiums will be deemed to have elected original Medicare. We have treated fraud and abuse by the enrollee in the same manner as other forms of disruptive behavior, with the individual being disenrolled into the original Medicare program. We believe that the result should be comparable because, in both cases, the individual's disruptive behavior has given the organization cause for the disenrollment. Individuals who lose entitlement to Part A or Part B benefits default to original Medicare because they no longer meet the requirements to receive Medicare benefits through an M+C plan, which requires entitlement to Part A and enrollment in Part B.

As previously discussed, special election periods are available to individuals who are disenrolled (or who disenroll) because of plan termination or service area or continuation area reduction or because they no longer reside in the M+C plan's service area or continuation area. Section 1851(g)(3)(C)(ii), however, stipulates that individuals who are disenrolled and who do not make an election during the special election period are deemed to have elected original Medicare.

11. Approval of Marketing Materials and Application Forms (§ 422.80)

Section 1851(h) contains requirements related to marketing by M+C organizations. These provisions are implemented in § 422.80. Section 422.80(a) implements the requirement in section 1851(h)(1) that all marketing material and application forms be submitted to HCFA for approval 45 days before distribution, and that such materials may only be used if HCFA does not disapprove such use by the end of this 45 day period. In section 422.80(b), we define ''marketing materials'' which must be submitted for approval under § 422.80(a).

Section 1851(h)(2) requires that M+C standards under section 1856 include guidelines for review of marketing materials under section 1851(h)(1) and § 422.80(a). Section 422.80(c) contains guidelines for HCFA's review of marketing materials under § 422.80(a). As provided for in section 1852(b)(2), these guidelines include existing marketing guidelines for HMOs and CMPs in § 417.428, which have been in effect since the inception of the existing Medicare risk contracting program.

Section 1851(h)(3) provides that, if HCFA has not disapproved the distribution of marketing materials or forms with respect to an M+C plan in an area, HCFA is deemed not to have disapproved the distribution in all other areas covered by the M+C plan and organization except with regard to any portion of the material or form that is specific to the particular area. This ''deemed approval,'' or ''1 stop-shopping,'' provision is included in the statute to address the needs of M+C organizations that operate in multiple states and within multiple HCFA Regional Office (RO) regulatory districts. Under the section 1876 program, a marketing piece submitted for HCFA review in multiple ROs was often susceptible to different regulatory interpretations by different RO staff; this occurrence could result in approval by one RO and a request for revisions by another RO. This phenomenon was primarily the result of RO staffs working within the environment of either an ''emerging'' market area or a ''mature'' area. The speed of review and approval of marketing materials should be enhanced by implementation of this statutory requirement.

Section 1851(h)(4) provides that M+C organizations shall conform to ''fair marketing standards'' included in the ''standards under section 1856,'' and requires that these standards prohibit an organization from providing cash or other monetery inducements for enrollment. Standards under section 1854(h)(4) are set forth in § 422.80(e). Again, as provided in section 1856(b)(2), these standards include existing section 1876 standards.

Section 1851(h)(4)(B) indicates that the fair marketing standards ''may include a prohibition against an M+C organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.'' However, we have decided at this time not to prohibit an M+C organization (or agent of such an organization) from assisting beneficiaries in completing the election form. We recognize and understand that we must provide accommodations for persons with disabilities and for situations in which such a prohibition could represent a potential physical burden to beneficiaries. However, in general, we believe that it is good practice that the M+C eligible individual should complete and sign the election form. Currently, we have no way to check for any plan impropriety, especially in situations where beneficiaries require help in completing the enrollment form, except beneficiary allegations and requests for disenrollment. While we cannot

quantify the amount of inappropriate behavior, we know that some plans have completed election forms for beneficiaries fraudulently or have convinced beneficiaries to sign forms without explaining to them the contents and telling them the form is for enrollment (U.S. General Accounting Office report: ''HCFA Should Release Data To Aid Consumers, Prompt Better HMO Performance'', HS–97–23, October 1996.) Therefore, we request public comment on this issue and will provide further guidance in the final rule.

In the interim, we are providing at § 422.60(c) that persons who assist beneficiaries in completing forms should sign the form and indicate their relationship to the beneficiary. In addition, we encourage M+C organizations to use neutral parties such as family members, ombudsmen or counseling programs for those individuals who require assistance in completing forms.

Finally, in § 422.80(f), we specify that HCFA may permit M+C organizations to develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the M+C organization, and to furnish these materials only to such group members. While such materials must be submitted for approval under paragraph (a), HCFA will only review portions of these materials that relate to M+C plan benefits.

12. Medigap

Prior to the enactment of the BBA, Federal law provided only one opportunity for a Medicare beneficiary to purchase a Medicare supplement (Medigap) policy on a ''guaranteed issue'' basis. (Generally this means that the insurance company cannot deny the application, or charge extra, based on the individual's health experience.) This opportunity was during the 6-month period beginning with the date a beneficiary is both age 65 or over, and enrolled in Medicare Part B. Amendments made by the BBA now specify additional situations in which beneficiaries will, after July 1, 1998, be guaranteed access to certain types of Medigap policies on a guaranteed issue basis *if* they apply within 63 days after losing other coverage, and submit evidence of the date the prior coverage terminated. The law also requires the entity that provided the prior coverage to notify beneficiaries of these rights.

Therefore, while this regulation does not implement the Medigap provisions of the BBA, it is important to be aware of the implications for M+C organizations, since some of the situations covered by the Medigap provisions involve beneficiaries who leave M+C plans and return to original Medicare. The situations that will give rise to the obligation to notify the beneficiary will include, for example, termination of coverage by an M+C plan, or loss of coverage under an M+C plan due to a change in the individual's place of residence. The beneficiary also will have the right to guaranteed issue of a Medigap policy if he or she either enrolls in an M+C plan upon first becoming eligible for Medicare at age 65, or enrolls after previously being covered under a Medigap policy, and later disenrolls from the M+C plan within 12 months of the effective date of the M+C enrollment.

Because the Medigap provisions establish specific time deadlines for beneficiaries who wish to take advantage of these new rights, prompt action by M+C organizations to notify beneficiaries of their rights, and by HCFA to provide accurate evidence of recently terminated coverage, will be essential. CFA is committed to providing beneficiaries whose M+C coverage terminates under the specified circumstances with timely and accurate evidence of the recently terminated coverage. There are a number of ways in which we are considering providing the necessary evidence, including enabling Medigap insurers to query HCFA systems, if privacy and security issues can be resolved. HCFA is seeking comments on the most effective way to coordinate with Medigap insurers in order to protect beneficiaries' rights under the statute, and promote continuity of care.

We also urge M+C organizations to keep in mind that they will be obligated to notify beneficiaries whose coverage terminates of their rights under the Medigap provisions. Those provisions are complex—only certain beneficiaries will be entitled to guaranteed issue of Medigap policies, and their choice of policies will depend on the precise reason for termination of their coverage under the M+C plan. Further guidance is available from the National Association of Insurance Commissioners (NAIC), which on April 29, 1998 issued a revised Model regulation that incorporated the Medigap changes made by the BBA.

C. Benefits and Beneficiary Protections

1. General Requirements (§ 422.100)

Subpart C of these regulations details the scope of benefits a Medicare beneficiary is entitled to receive when electing coverage through an M+C plan. The statutory authority for most of the provisions of subpart C is found in section 1852, which outlines benefit requirements and provides authority for beneficiary protections under Medicare Part C. Many of the statutory provisions are the same as, or similar to, benefit provisions of section 1876. Therefore, much of the regulatory language of part 417 is retained for purposes of establishing M+C standards, as provided for in section 1856(b)(2) (which directs that the M+C standards be based on the analogous standards established under section 1876).

A principal difference between section 1876 provisions and the newly enacted law is that the new law permits a wider range of types of entities to assume risk for the coverage of benefits for Medicare enrollees. Section 1876 limited the Medicare contract option to organizations that operated as entities accepting full-risk, prepaid capitation for the provision of a comprehensive range of services and defined ''eligible organizations'' as a Federally qualified HMO (under title XIII of the Public Health Service Act) or a competitive medical plan (CMP). Except in a very few instances where waivers were granted during years when such waivers were authorized, the organizations had to offer such a product in the commercial marketplace in order to have a Medicare contract. From the point of view of benefit requirements imposed on plans, the new types of network plans are subject to the same benefit requirements applicable to organizations that would have met the definition of ''eligible organization'' under section 1876 (HMOs and CMPs). The requirements under the new law for network plans are in many cases identical to the requirements under section 1876.

While adding PPOs, indemnity insurers, and provider-sponsored organizations to the range of entities eligible for Medicare contracts, the BBA also permits non-network plans, such as private fee-for-service plans and M+C non-network MSA plans, to assume prepaid, capitated risk for services used by enrollees of these organizations. Medicare beneficiaries who elect these plans are not subject to the same constraints in use of providers that exist in network plans. Therefore, the benefit requirements applicable to these plans, and cost-sharing requirements, may be very different from those that apply to network plans. This section of the preamble mainly discusses the requirements for network plans. Sections III and IV of the preamble provide more extensive information about benefit requirements applicable to non-network M+C MSA plans and to

private fee-for-service plans, respectively.

All M+C organizations are required to cover the full range of Medicare benefits that enrollees would otherwise have been able to receive under original Medicare, subject to certain rules regarding available networks of providers. M+C organizations are further required to cover Medicare preventive benefits with the same frequency that they are covered under original Medicare (e.g., annual screening mammography examinations). Beneficiaries may be required to contribute to the cost of covered services in the form of cost-sharing provided for under the M+C plan. Beneficiaries may have to cover all costs until a deductible is met (including the high deductible provided for under an MSA plan (see section III of this preamble)), a percentage of costs in the form of coinsurance, or a fixed amount for services, in the form of a copayment. As discussed in subpart G below, there are limits that apply to the cost-sharing that can be imposed on beneficiaries under M+C plans. For benefits that are covered under original Medicare, the benefits must be obtained through providers meeting the conditions of participation of the Medicare program.

Organizations with network plans, which include coordinated care plans and network M+C MSA plans, are required to provide these services directly or through arrangements (i.e., written agreements with providers) in order to meet the availability and accessibility requirements of section 1852(d)(1) and § 422.112, discussed below.

In some situations, an M+C organization, for its network plan or plans, may be required to assume liability for services provided to Medicare enrollees through noncontracting providers. Under § 422.100(b), the organization is required to assume financial responsibility for the following items and services obtained from a provider that does not contract with the M+C organization:

- Emergency services as defined in § 422.2;
- Urgently needed services as defined in § 422.2;
- Renal dialysis services provided while the enrollee was temporarily outside the M+C plan's service area;
- Post-stabilization care as described in § 422.100(b)(iv); and
- For both network and non-network plans, services denied by the M+C organization and found upon appeal (under subpart M of this part) to be services the enrollee was entitled to have furnished or paid for by the M+C organization.

The requirements that the M+C organization assume financial liability for renal dialysis services, and post-stabilization care are new requirements introduced by the BBA that were not included in section 1876 requirements. The BBA also revised the definition of emergency services, as discussed elsewhere in the preamble.

''Post-stabilization care'' (also referred to in the Act as ''maintenance care'') means medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from the M+C organization until—

- The enrollee is discharged;
- A plan physician arrives and assumes responsibility for the enrollee's care; or
- The treating physician and plan agree to another arrangement.

Section 422.100(b)(1)(iv) provides that an M+C organization is responsible for the cost of post-stabilization care provided outside the plan if they were pre-approved, if they were not pre-approved because the organization did not respond to the request by the provider of post-stabilization care services for pre-approval within 1 hour after the organization was asked to approve post-stabilization care, or if the M+C organization could not be contacted for pre-approval. M+C organization liability will extend until the organization has contacted the hospital to arrange for discharge or transfer. These requirements reflect comments we received on post-stabilization care in response to the **Federal Register** notice of January 20, 1998. The majority of commenters advocated that we establish a timeframe for an M+C organization's response to a request for approval. Because we agree that an untimely response to a request for approval would unduly delay the delivery of the post-stabilization care services, thereby compromising their effectiveness, we have established a 1-hour timeframe in the regulation as an enrollee protection. Because a completely accurate assessment of an enrollee's need for post-stabilization care services cannot be made until the enrollee is stabilized, we expect that the provider of the post-stabilization care services will not request the M+C organization's approval of the services until after the enrollee is stabilized, at which time enough details about the enrollee's condition should be known to allow the organization to make an informed decision on whether to approve the care almost immediately. We welcome comments on this issue.

In the case of payments to noncontracting providers for covered items and services, the M+C organization's obligation is met when it provides for payment in an amount the provider would have received under original Medicare (including payment from the organization and beneficiary cost-sharing under the plan).

The benefits offered by an M+C plan may be divided into two major components, ''basic benefits'' and ''supplemental benefits.'' Basic benefits in an M+C plan include all Medicare-covered services (except hospice) and additional benefits. Basic benefits are discussed below, and special rules for M+C enrollees electing hospice are set forth in § 422.266 and discussed in section II.F.9. of this preamble. Supplemental benefits include both mandatory and optional supplements, which we also discuss below.

Section 1852(a)(1) stipulates that M+C organizations offering an M+C plan (or plans) must offer it to all Medicare beneficiaries eligible to elect the plan who reside in the service area of the M+C plan at a uniform premium with uniform cost sharing. An organization may offer more than one plan in the same service area. The premium and cost-sharing may vary among plans within the same organization. We will review each M+C plan offered by the same organization to ensure that it is not designed to promote discrimination, discourage enrollment, steer specific subsets of Medicare beneficiaries to particular M+C plans, or inhibit access to services.

2. Requirements Relating to Basic Benefits (§ 422.101)

With the exception of special rules concerning hospice care and M+C coverage that begins during an inpatient hospital stay (described in §§ 422.266 and 422.264, respectively), a Medicare enrollee is entitled to have the M+C organization provide all Medicare-covered services that are available in the geographic area in which services are covered under the plan.

M+C organizations are required to provide their enrollees with services covered under original Medicare and available to beneficiaries residing in the geographic area in which services are covered under the plan, as we provide at § 422.101(a). Organizations must also abide by our national coverage decisions, as well as specific written policies of the Medicare carrier or intermediary with jurisdiction for claims (if the encounter had occurred under original Medicare) in the

geographic area served by the plan. (These policies are sometimes called ''local medical review determinations.'') In cases where services are covered under the plan in an area that includes jurisdictions of more than one contractor for original Medicare, and the contractors have different medical review policies, the plan must apply the medical review policies of the contractor in the area where the beneficiary lives.

In addition, the organization is required to provide ''additional benefits,'' which include health care services not covered by Medicare, as well as reductions in premiums or cost sharing for covered services. As discussed in section II.A of this preamble, we use the term ''basic benefits'' to encompass all Medicare-covered benefits (except hospice services) and additional benefits. These benefits are determined by our approval of an M+C organization's Adjusted Community Rate (ACR) proposal for a given M+C plan and must be provided uniformly to all Medicare enrollees electing that plan. Additional benefits are generated when the average payment rate for a plan exceeds the adjusted community rate, thereby producing a surplus known as the ''excess amount.'' (See section II.F of this preamble for a more thorough discussion of the requirements that apply to additional benefits, which are set forth under § 422.312.)

In the case of an M+C private fee-for-service plan or a non-network M+C MSA plan, the obligation to cover Medicare services is not limited to services available in the plan's approved service area. Rather, in this context, we interpret ''geographic area served by the plan'' in section section 1852(a)(1)(A) to mean the area within which the M+C private fee-for-service or non-network M+C MSA plan enrollee has the right to receive covered services under the plan.

Under our authority in section 1856(b)(1) to establish standards under the M+C program, § 422.100(h) establishes special rules for influenza vaccine, pneumococcal vaccine, and screening mammography. Section 422.100(h)(2) prohibits enrollee cost-sharing for influenza vaccine and pneumococcal vaccine. Under original Medicare, there is no cost-sharing imposed on these items, and we believe congressional intent is for Medicare beneficiaries to have maximum possible access to both vaccines. We note that original Medicare provides for beneficiary payment of coinsurance for mammography screening; therefore, a plan may also impose copayment or coinsurance for this service.

Also note that beneficiaries under original Medicare may ''self-refer'' and directly access screening mammography and influenza vaccine. We have established a similar standard in § 422.100(h)(1) for M+C enrollees.

3. Supplemental Benefits (§ 422.102)

Section 1852(a)(3) provides for supplemental benefits. These benefits are health care items and services beyond the basic benefits described above and are categorized as either mandatory or optional.

Mandatory supplemental benefits are benefits not included in basic benefits which must be purchased by all beneficiaries who enroll in the M+C plan under which they are included. Mandatory supplemental benefits may be offered under coordinated care plans and fee-for-service plans only, and must be approved by HCFA. HCFA will approve such benefits unless we determine that they would substantially discourage enrollment in the plan. Specifically, we will determine whether the inclusion of the mandatory supplemental benefits would discourage particular subcategories of Medicare beneficiaries from enrolling (e.g., those residing in certain parts of a plan service area). These benefits are addressed in § 422.102(a).

Section 1852(a)(3)(C) provides that nothing in paragraph (3) of section 1852(a), addressing supplemental benefits, shall be construed to prevent a fee-for-service plan from offering supplemental benefits covering the balance billing permitted under section 1852(k)(2)(A)(i) and § 422.216(b)(1) and additional services. See discussion of M+C private fee-for-service plans in section IV of this preamble. The only provision in section 1852(a)(3) that could possibly be construed to prevent a private fee-for-service plan from offering such benefits would be the right of the Secretary, and of HCFA under these regulations, to disapprove mandatory supplemental benefits. We accordingly wish to make it clear that HCFA will not disapprove such benefits in the case of a private fee-for-service plan. (As discussed below in subpart G, HCFA does not have the right to review or approve the amount that a private fee-for-service plan charges for supplemental benefits.) We believe that the foregoing statement is sufficient to give effect to section 1852(a)(3)(C).

Optional supplemental benefits are benefits beyond basic benefits that may be purchased by an M+C plan enrollee at his or her option. If a plan offer optional supplemental benefits, it must offer those benefits to all enrollees in the M+C plan. While optional supplemental benefits may be offered under all types of plans, in the case of MSA plans, there are limits, discussed in section III of the preamble, on the nature of optional supplemental benefits that can be offered.

Under mandatory supplemental benefits for coordinated care plans, an M+C organization may require an enrollee who elects an M+C plan to accept and pay for items and services beyond basic benefits if he or she wants to enroll in a particular M+C plan. If an organization requires supplemental benefits, it must do so uniformly for all Medicare beneficiaries enrolled in that plan. As provided for at section 1852(a)(3)(A), we will approve such offerings unless we determine that would substantially discourage enrollment in the plan. We will determine whether the mandatory supplemental benefits would discourage subcategories of Medicare beneficiaries from enrolling (e.g., those residing in certain parts of a plan's service area).

An organization may also offer optional supplemental benefits within an M+C plan. In this case, the beneficiary is free to choose to accept or decline the supplement. In the case of both mandatory and optional supplemental benefits, the benefits are paid for by (or on behalf of) the individual electing the M+C plan.

Sections 422.103 and 422.104, addressing benefits under MSA plans generally, and optional supplemental benefits under an MSA plan, are discussed in section III. below.

4. Special Rules for Point-of-Service (POS) Option (§ 422.105)

This section of the rule codifies our existing policy for point-of-service plans. Because these policies have not previously appeared in regulations, we welcome comments.

A POS benefit is an option that an M+C organization may offer through an M+C coordinated care plan or network M+C MSA plan to provide Medicare enrollees with additional choice in obtaining specified health care items and services from entities that do not have a contract with the M+C organization. A coordinated care plan may offer a POS option as an additional benefit, a mandatory supplemental benefit, or an optional supplemental benefit. A network MSA plan may only offer a POS option as a supplemental benefit.

Under POS, the health plan generally provides partial reimbursement to enrollees for items and services obtained from non-network providers. The enrollee may be required to pay a premium for the benefit unless the

benefit is offered as an additional benefit. The Act contains two mentions of the term ''point of service'' as it relates to M+C plans. Section 1851(a)(1)(A) states that an HMO may include a POS option, and section 1852(c)(1)(C), requires disclosure to enrollees of ''any point-of-service option (including the supplemental premium for such option).'' Therefore, the Act indicates that HMOs could offer POS products, and that there could be a supplemental enrollee premium for such a product.

We currently permit HMOs and CMPs to offer POS products. There is no specific statutory reference to such a product in section 1876; the statutory basis for allowing Medicare HMOs to provide POS products lies in the additional and supplemental benefit offerings an HMO may have under section 1876. We believe that under the structure of the M+C program, any coordinated care plan or network M+C MSA plan may offer a POS product.

The regulations at § 422.105 governing the POS benefit are largely a restatement of our previously issued guidelines. In issuing the guidelines, we were particularly concerned with assuring the continued accessibility and availability of medically necessary care within the Medicare plan's approved network. We also emphasized that organizations are responsible for: members' continuity of care; ensuring beneficiaries are fully informed about how the POS benefit would be implemented; and the potential financial liability of the individual. We also required organizations to provide data to us about the POS benefit, including expenditures and levels of POS utilization, and the effect on the financial status of the organization. Moreover, the guidelines required the plans to maintain a record-keeping system to make information on utilization of the POS benefit available to plan providers. These previous operational policy requirements are carried over into § 422.105.

There are some changes in § 422.105 to the guidelines we issued under section 1876, however. One has to do with POS coverage available for in-network items and services. Under the guidelines, we permitted HMOs and CMPs to include network providers who could be paid through the POS option. These regulations eliminate that option. Additionally, under § 422.105, we will now require plans to place a cap on a beneficiary's total annual financial liability under a POS benefit. In another change, we are eliminating separate solvency standards for POS products. Each of these changes is discussed below.

Although HCFA guidelines did permit a Medicare beneficiary to use a POS option to seek, for example, ''direct access'' to a specialist within the plan's network, and thereby avoid any prior authorization requirement or other plan rules relating to access to particular providers, we believe such a feature of a POS option is inconsistent with the concept of a network plan and not a desirable feature of a POS option. The basic access and availability requirements both of sections 1876 and 1852(d) require that benefits be made available, through providers selected by the M+C organization, in a manner that ensures availability, accessibility and continuity of care. If the care an individual seeks from a network provider is necessary care, the individual should be able to obtain that care through the network, following network rules. Although the enrollee might not receive treatment from the particular provider he or she prefers, the organization and its contractors are obligated to make covered services available to all enrollees through network providers. We do not believe it is appropriate to use the POS benefit to circumvent network rules.

In § 422.105 we also specify that an M+C organization offering a POS benefit establish an annual limit on a beneficiary's maximum financial liability when using a POS benefit. We require a financial limit to alert beneficiaries to their maximum potential financial liability in using their POS benefit. We consider it a critical part of beneficiary information that enrollees are clearly informed about all of their potential costs when enrolling in an M+C plan.

Another change from existing policy in § 422.105 is the elimination of the additional solvency requirements that have been imposed under the POS guidelines (though reporting requirements relating to solvency remain). The Act gives the States primary responsibility for setting and enforcing solvency standards for M+C plans (other than a provider-sponsored organization with a waiver of the State licensure requirement), and our imposition of additional solvency requirements on POS products is inconsistent with the States' responsibility. (In fact, because of solvency concerns, many States require licensure as an indemnity insurer if an HMO wishes to offer a POS product.) We will continue to require M+C organizations to comply with this reporting requirement, as was the case with Medicare contractors under section 1876. This reporting requirement is not superseded by the Act's preemption provision relating to benefits in section 1856(b)(3)(B).

5. Special Arrangements With Employer Groups (§ 422.106)

An M+C organization may negotiate with an employer group to provide benefits to Medicare members of the employer group who are enrolled in an M+C plan offered by the organization and these benefits must be provided uniformly to members of the group. While these negotiated employer group benefits may be designed to complement benefits available to Medicare beneficiaries enrolled in the plan, they are offered by the employer group independently as the product of private negotiation. These benefits may include contributions on the employee group member's behalf toward M+C plan premiums or cost-sharing for which the Medicare eligible group member is responsible, or benefits not covered by the M+C plan, for which premiums and cost-sharing may be charged. We do not review such employer group benefits, premiums, or cost-sharing amounts.

6. Medicare Secondary Payer (MSP) Procedures (§ 422.108)

As specified in section 1852(a)(4), if a Medicare enrollee receives covered items and services from an M+C organization for which the enrollee is entitled to benefits under a State or Federal workers' compensation law or plan, any no-fault insurance, or any liability insurance policy or plan (including a self-insured plan), the M+C organization may charge the insurance carrier, employer or other entity that is responsible to pay for the provision of those items and services. The M+C organization may also charge the Medicare enrollee to the extent that the enrollee has been paid by the carrier, employer, or other entity for those items and services. In addition, an M+C organization may charge a group health plan or large group health plan for items and services for which Medicare is a secondary payor.

In this area, pursuant to section 1856(b) (1) and (2), we are retaining for M+C organizations the requirements that applied to HMOs and CMPs under part 417.

7. Effect of National Coverage Determinations (NCDs) (§ 422.109)

This provision implements section 1852(a)(5). Under this rule, M+C organizations are not required to assume risk for the costs of certain ''significant cost'' NCDs until an adjustment has

been made in the per capita rate to reflect the NCD. A national coverage determination is a national policy statement regarding the coverage status of a specified service that HCFA makes as a program memorandum or manual instruction. The term does not include coverage changes mandated by statute. Past NCDs have included items such as heart transplants.

On February 22, 1994 HCFA published a notice of proposed rule making (NPRM) to define ''significant cost'' and other requirements for NCDs as they applied to section 1876 risk contracting plans. With one exception discussed below, we are including in this rule the policies included in the February 22, 1994 proposed rule. For example, we have maintained the definition of ''significant cost'' as $100,000 for a single NCD service for calendar years 1998 and 1999. We are providing for an automatic adjustment of a single service threshold amount to reflect rising costs, and will adjust the dollar threshold by the national per capita growth percentage used to calculate the annual capitation rates to pay M+C organizations. We are also providing an alternative definition for lower cost services that will affect a large number of beneficiaries. For the cost of all of the services furnished nationwide as a result of a particular NCD, we have redefined significant cost as 0.1 percent of the national standardized annual capitation rate (which is used in calculating the annual capitation rates used to pay M+C organizations) multiplied by the total number of Medicare beneficiaries nationwide for the applicable calendar year.

This rule also describes how the NCD will be provided to M+C plan enrollees during the period the M+C organization is not at risk for the new or expanded benefit established by the NCD, including procedures to pay M+C organizations and the policies affecting beneficiary liability. It is in this area that this rule differs from the February 22, 1994 proposed rule. That proposed rule reflected the NCD provision that applied to HMOs with risk contracts under section 1876. There is one key difference between the NCD provision in section 1876 and the NCD provision under the new M+C. Like the new NCD provision in section 1852(a)(5), section 1876(c)(2)(B) provided that services required under certain mid-year NCDs were excluded from risk contracts until the first year in which payment for the services is reflected in capitation payments. However, under Section 1876(a)(6), original Medicare coverage of such NCD services was identified as an exception to the rule that only the risk-contracting HMO could receive Medicare payment on behalf of one of its enrollees. Therefore, an HMO enrollee was not required to receive NCD services excluded from the HMO's contract through the HMO, and could receive the services either from the HMO or from any other Medicare provider, and Medicare would pay. This was reflected in the February 2, 1994 proposed rule.

Under the M+C program, however, there is no similar exception for excluded NCD services providing that only an M+C organization may be paid by Medicare on behalf of an enrollee in an M+C plan offered by that organization. We believe that this difference reflects Congress' intent that beneficiaries be required to receive services through their M+C organization, under the same rules that apply to any other non-urgent and non-emergency services. Under the new NCD provision, only the method that HCFA pays the organization for the services, and the cost-sharing that applies to such services differs from other services. If the excluded NCD services are received from, or through, the M+C organization, the organization will be paid on a fee-for-service basis for those services. If the services are not available from the plan, the organization will pay the authorized provider after receiving fee-for-service from the intermediaries or carriers.

Pursuant to our authority under section 1856(b)(1), we are expressly requiring that the M+C organization provide the NCD services in question on a fee-for-service basis.

8. Discrimination Against Beneficiaries Prohibited (§ 422.110)

The current rule reflects section 1852(b), and the details provided in § 422.110 are consistent with existing policy and regulation. In general, M+C organizations may not discriminate among Medicare beneficiaries based on health-related factors with the exception that organizations may not enroll new beneficiaries with end-stage renal disease. For further discussion of discrimination provisions affecting M+C enrollees with ESRD, see the discussion in section II.B.1 of this preamble.

9. Disclosure Requirements (§ 422.111)

In section 1852(c), the Act lists several areas where an M+C organization must disclose specific information to each M+C plan enrollee. These requirements are, in large part, a codification of existing program administration requirements under section 1876, and we detail these requirements in § 422.111 of the regulations. In general, an M+C organization is required to provide in a clear, accurate, and standardized form information relating to: service area; benefits access; out-of-area coverage; emergency coverage; supplemental benefits; prior authorization rules; plan grievance and appeals procedures; disenrollment rights and responsibilities; and information about the M+C organization's quality assurance program.

M+C organizations are also required to provide further information on a beneficiary's request, which we also detail in § 422.111 of the regulation text. These ''upon request'' requirements include: general coverage and comparative plan information; information on utilization control procedures; information on grievances and appeals; information on the financial condition of the M+C organization; and a summary of physician compensation arrangements.

10. Access to Services (§ 422.112)

The requirements of section 1852(d) of the Act (concerning access to services) are being implemented through this rule, in part, by applying existing regulations and policies pursuant to our authority in section 1856(b)(1) to establish standards under the M+C program. We are also addressing recommendations from the President's ''Consumer Bill of Rights and Responsibilities'' (CBRR), and incorporating the ''Quality Improvement System for Managed Care'' (QISMC) standards.

For example, our existing policy shaped the language in § 422.112(a)(1)(i) requiring M+C organizations to maintain and monitor a network of appropriate providers, supported by written agreements sufficient to certify beneficiary access to covered services. The CBRR shaped the access to (and continuity of) specialist services text in § 422.112(a), as well as provisions for provider credentialing and timeliness of access, among other consumer protections. We also include a provision at § 422.112(a)(4)(vii)for M+C organizations to ensure ''cultural competency'' in the provision of health care. This provision reflects CBRR recommendations that M+C organizations make a particular effort to ensure that enrollees with limited English proficiency, limited education, or other socioeconomic disadvantages receive the health care to which they are entitled.

The Consumer's Bill of Rights and Responsibilities also recommends that women be able to choose a women's

health care specialist within network for the provision of routine and preventive women's health care services. In support of this recommendation, § 422.112(a)(1)(iii)(A) requires M+C network plans to provide direct access to a women's health specialist within the network for routine and preventive women's health care services provided as basic benefits, as defined in § 422.2. We note that coverage of routine and preventive health services under original Medicare is limited. For example, original Medicare covers a screening pap smear and a screening pelvic exam, including a clinical breast exam, once every 3 years under normal circumstances. M+C plans must cover routine and preventive health services with at least the same frequency as they are covered under original Medicare and may offer expanded services in these areas as additional benefits.

M+C plans satisfy the requirement in § 422.112(a)(1)(iii)(A) by providing direct access to gynecologists, certified nurse midwives, and other qualified health care providers for provision of routine and preventive women's health services. At the same time, M+C plans are required to provide women enrollees with continued access to their primary care physician to ensure continuity of care. We welcome comments on this issue.

In § 422.112(a)(1)(iii)(B), we require that plans have HCFA-approved procedures—

- To identify Medicare enrollees with complex or serious medical conditions;
- For assessment of those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and
- For establishment and implementation of a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. To meet these requirements and those of § 422.112(a)(5)(v)(A), M+C plans must conduct a baseline and establish a treatment plan for people with complex or serious medical conditions. This assessment should be completed within timeframes deemed appropriate by M+C plans based on the needs of its enrollees, but, in general, should occur within 90 days of the effective date of enrollment.

Section 422.112(a)(5)(v)(A) also requires M+C plans to conduct a baseline health assessment for all new Medicare enrollees (i.e., not limited to those with complex or serious medical conditions) in a timely manner. We believe that this initial assessment should also be performed based on timelines deemed appropriate by the plan, but not later than 90 days after the effective date of enrollment. We welcome comments regarding timely baseline assessments both for new enrollees and those with complex or serious medical conditions.

Note that, as indicated in the heading of § 422.112(a), some access provisions apply only to network organizations, (i.e., coordinated care plans and network MSAs), while others (§ 422.112(b)) apply to all M+C organizations.

Section 422.112(b) states that M+C organizations must provide coverage of emergency services and urgently needed services even in the absence of the organization's prior approval and without regard to the provider's contractual relationship with the M+C organization. For definitions of emergency and urgently needed services, see § 422.2.

This section continues the prohibition at § 417.414(c)(1) on prior authorization requirements for emergency services as explicitly provided by 1852(d) and continues the § 417.414(c)(1) regulatory prohibition on prior authorization requirements for urgently-needed services. This section also establishes a prohibition on prior authorization requirements for emergency services provided within the plan because the prohibition on prior authorization at section 1852(d) applies to services provided both within and outside the organization.

Consistent with the new definition of ''emergency medical condition'' in section 1852(d)(3)(B), we are codifying longstanding *HMO/CMP Manual* policy (§ 2104) of prohibiting retrospective denial for services which appeared, to the prudent layperson, to be emergencies, but which turn out to be nonemergency in nature.

We are establishing that when a physician or other representative affiliated with the organization instructs the enrollee to seek emergency services within or outside the organization, the organization is responsible for payment for medically necessary emergency services provided to the enrollee.

We are codifying in regulation an *HMO/CMP Manual* policy (§ 2104) specifying that the decision of the examining physician treating the individual enrollee prevails regarding when the enrollee may be considered stabilized for discharge or transfer.

We are establishing limits on cost-sharing for emergency services obtained outside of the M+C plan's provider network equal to of the lesser of $50 or what the organization may charge for emergency services provided within the plan's provider network. We are imposing this requirement in order to facilitate and ensure access to covered emergency services provided other than through the organization. We do not view this requirement as overly burdensome. A review of 1997 data on what Medicare HMOs and CMPs charged for emergency services found that 93 percent of contracts charged $50 or less. We believe that it may be appropriate to lower this limit or eliminate cost-sharing altogether, and would welcome comments on this subject.

Note that an M+C organization's failure to provide medically necessary emergency services could result in intermediate sanctions for failing to provide coverage, or payment, or through actions (such as a prospective refusal of payment) that could result in discharge or transfer of an unstabilized patient. The new coverage requirements for M+C enrollees do not affect the rights of all persons (whether or not they are Medicare beneficiaries) to receive emergency services at any Medicare-participating hospital that offers emergency services (under the patient ''anti-dumping'' statute in section 1867).

11. Access to Services Under an M+C Private Fee-for-Service plan (§ 422.114)

In the case of an M+C organization that offers an M+C private fee-for-service plan, that organization must demonstrate that it has a sufficient number and range of providers willing to furnish items and services under the plan. An M+C organization meets this requirement if, with respect to a particular category of providers, the organization has:

- Payment rates that apply under original Medicare for the provider and service in question;
- Contracts or agreements with a sufficient number and range of providers to furnish the items and services covered under the M+C private fee-for-service plan; or
- A combination of the two.

Additionally, an M+C private fee-for-service plan must permit enrollees to obtain items and services from any entity that is authorized to provide items and services under Medicare Parts A and B and agrees to provide services under the terms of the M+C private fee-for-service plan. For a fuller discussion of M+C private fee-for-service plans, see section IV of this preamble.

12. Confidentiality and Accuracy of Enrollee Records (§ 422.118)

M+C organizations are required to safeguard the confidentiality and

accuracy of enrollee records that identify a particular enrollee, including both medical documents and enrollment information. An M+C organization may circulate this information within the organization to coordinate care for a Medicare enrollee. The M+C organization may not, however, circulate this information outside the organization without specific authorization from the Medicare enrollee. M+C organizations are prohibited from selling (or circulating outside the organization) names and addresses of enrollees for any purpose, including scientific study.

Additionally, the M+C organization must maintain records in an accurate and timely manner and ensure timely access to enrollees who wish to examine their records. Moreover, the M+C organization must abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and enrollee information.

13. Information on Advance Directives (§ 422.128)

Advance directives are documents signed by a patient that explain the patient's wishes concerning a given course of medical care should a situation arise where he or she is unable to make these wishes known. The M+C organization is responsible for documenting advance directives in a prominent part of the Medicare beneficiary's medical record. Accordingly, pursuant to our authority in section 1856(b)(1) and (2) to establish M+C standards, we are retaining for M+C organizations the requirements that applied to HMOs and CMPs under part 417.

14. Protection Against Liability and Loss of Benefits (§ 422.132)

Each M+C organization must adopt and maintain satisfactory arrangements to protect Medicare enrollees from incurring liability for payment of any fees that are the legal obligation of the M+C organization. By reference in § 417.407(f) (implementing regulations for section 1876), enrollee protections described in § 417.122 are unchanged by the BBA, and their application to M+C organizations are carried forward in this section.

Medicare law requires that Medicare contracting M+C organizations make Medicare covered services ''available and accessible.'' Section 1852(d)(1), in describing access to services, allows M+C organizations to select the providers from whom benefits may be obtained so long as ''the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness * * *'' We believe these sections require health plans to provide the same accessibility afforded by HCFA to beneficiaries under original Medicare.

D. Quality Assurance

1. Overview

Subpart D of part 422 contains the quality assurance requirements for M+C organizations. These requirements implement and are based on the provisions of section 1852(e) of the Act. They also incorporate the requirements of section 1851(d)(4)(D), which provides that the information made available to Medicare beneficiaries for plan comparison purposes should include plan quality and performance indicators, to the extent available. Section 1852(e)(1) sets forth the general rule that each M+C organization must establish an ongoing quality assurance program, consistent with implementing regulations, for the health care services it provides to enrollees in the organization's M+C plans. The rest of section 1852(e) contains the required elements of the quality assurance program, requirements for external review, and provisions concerning the use of accreditation organizations to determine compliance with the quality assurance requirements.

The provisions of section 1852(e) represent a significant expansion in the scope of the statutory quality assurance provisions applicable to managed care organizations that contract with the Medicare program. Existing section 1876(c)(6) contains a general requirement similar to that of section 1852(e)(1) that an organization must have a quality assurance program, but it provides very limited guidance as to the nature of this program. The only required elements of a quality assurance program under section 1876(c)(6) are that it stress health outcomes and include physician review of the procedures used in the provision of health care services. Like section 1876(c)(6), existing quality assurance regulations (§ 417.418 and, by reference, § 417.106(a)) contain few detailed requirements concerning quality assurance. The regulations basically restate the statutory requirements relating to health outcomes and physician review and then add two broad requirements regarding data collection and the need for written procedures for taking remedial action.

In contrast, section 1852(e) sets forth a series of specific elements that now must be addressed in an M+C organization's quality assurance program. As discussed in detail below, these requirements focus on the need for an M+C organization, with respect to each M+C plan that it offers, to operate an outcome-oriented quality assessment and performance improvement program that achieves demonstrable improvements, across a broad spectrum of care and services, in the health, functional status, and satisfaction of its enrollees. (Note that some of the specific performance improvement requirements of the statute do not apply to M+C non-network MSA plans or PFFS plans, as addressed under § 422.152(e).) The collection, evaluation, and reporting of the data necessary to demonstrate quality improvements are also critical elements of each M+C organization's quality-related responsibilities.

2. Origins of the Quality Assessment and Improvement Requirements

The regulations to implement sections 1852(e)(1) and (2) and section 1851(d)(4)(D) incorporate each of the explicit statutory requirements into new subpart D. Consistent with our explicit statutory authority under section 1851(e), these regulations include additional detail to clarify how an M+C organization can meet the statutory requirements. Like Congress, we recognize that the state of the art in quality assurance has evolved from a problem-focused approach, with an emphasis on remedial action, to a proactive approach aimed at achieving continuous, systemic quality improvement. In recent years, HCFA, the States, and other managed care purchasers have been involved in a series of initiatives aimed at improving the quality of care and services provided to managed care enrollees. Examples of such efforts include:

- The Quality Assurance Reform Initiative (QARI), which developed and tested standards for States to use in monitoring and improving quality in Medicaid contractors, with a particular emphasis on plans' own internal quality improvement efforts.
- Uniform data collection and reporting instruments, such as the Health Plan Employer Data and Information Set (HEDIS 3.0), which was developed by the National Committee for Quality Assurance (NCQA). Use of HEDIS 3.0 is now a contract requirement for Medicare risk-based managed care plans, under section 1876 and is intended to allow assessment and comparison of plan performance.
- Projects to enhance the role of Medicare Peer Review Organizations (PROs) in evaluating and improving managed care plan quality, including

the development and testing of a minimum set of performance evaluation measures and quality improvement projects developed through collaboration between PROs and managed care organizations. States have undertaken similar efforts through Medicaid External Quality Review Organizations (EQROs).

Among the most comprehensive of recent quality-related initiatives is the Quality Improvement System for Managed Care (QISMC). During the past 2 years, HCFA has been working closely with other Federal and State officials, as well as representatives of beneficiary advocacy groups and the managed care industry, to develop quality standards that can better ensure that managed care organizations that contract with HCFA protect and improve the health and satisfaction of their enrollees. QISMC is the product of these efforts. Originally drafted based on the authority of section 1876, it builds on a variety of recent HCFA and State efforts, like those mentioned above, to promote the assessment and improvement of managed care quality. The QISMC standards are in the final stages of development at this time and are being modified to reflect the quality-related requirements under the BBA. Once QISMC is complete, we believe it will offer a uniform set of quality standards that can be used by HCFA and the State Medicaid agencies to determine whether a managed care organization can meet the quality assurance requirements necessary to become and remain eligible to enter into a Medicare or Medicaid contract.

The QISMC initiative is substantially in accord with the quality assurance requirements of new section 1851(e). For example, both the statutory requirements and the QISMC quality standards emphasize measurement of health outcomes, consumer satisfaction, the accountability of managed care organizations for achieving ongoing quality improvement, the need for intervention to achieve this improvement, and the importance of data collection, analysis, and reporting. Moreover, as noted above, representatives of all segments of the managed care community have contributed to the development of QISMC, and generally support HCFA's intention to eventually require managed care organizations to meet the QISMC standards. Given the shared goals of the BBA and QISMC standards, and HCFA's implementation plans for QISMC, we believe it is appropriate to establish new M+C quality assurance regulations that reflect those QISMC standards that mirror the intent of the statute.

Although we have not included in the regulations the level of detail embodied in QISMC, we have attempted to build into the regulations some principles from QISMC that can guide M+C organizations in meeting the quality requirements established by the statute. For example, § 422.152(d) establishes objective standards concerning the improvement projects that are required of M+C organizations, in accordance with the statutory requirements concerning an organization's responsibility to take action to improve quality (such as section 1852(e)(2)(A)(xi) of the Act.

Although QISMC remains an evolving document, several of the discussions below of the ways in which organizations can meet the M+C quality requirements are informed to some degree by the underlying details contained in QISMC. Also, as discussed below, we anticipate that requirements pertaining to a plan's quality assessment and performance improvement responsibilities may be implemented as part of the M+C contracting process. QISMC standards may be a guide in implementing the requirements in the BBA and these regulations. Eventually, we believe QISMC can serve to define what HCFA's expectations are with regard to an M+C organization's quality assessment and improvement responsibilities. (A copy of the most recent version of QISMC is available at HCFA's website, www.hcfa.gov/quality/qlty-3e.htm.)

3. Quality Assessment and Performance Improvement Requirements (§ 422.152)

This section of the regulation implements paragraphs (e)(1) and (2) of section 1852. Subject to certain exceptions for M+C PFFS and non-network MSA plans, which are discussed below, the statute requires that an organization's quality assurance program meet the following requirements with respect to each plan that it offers:

(i) Stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that HCFA recognizes) that will permit measurement of outcomes and other quality indices.

(ii) Monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions.

(iii) Evaluate the continuity and coordination of the care that enrollees receive.

(iv) Be evaluated on an ongoing basis as to its effectiveness.

(v) Include measures of consumer satisfaction.

(vi) Provide HCFA access to the information it needs to monitor and ensure the quality of the care provided.

(vii) Provide for physicians and other health care professionals to review the process followed in providing health care services.

(viii) Establish written protocols for utilization review, based on current standards of medical practice.

(ix) Have mechanisms to detect both underutilization and over utilization of services.

(x) Establish or alter practice parameters when areas needing improvement are identified.

(xi) Take action to improve quality and assess the effectiveness of that action through systematic follow-up.

(xii) Make available to HCFA information on quality and outcomes measures to facilitate beneficiary comparisons and choice of health care options (in such form and on such quality and outcomes measures as HCFA determines is appropriate).

As noted above, section 1852(e)(1) also requires that the organization's quality assurance program be consistent with any regulation developed by HCFA. Therefore, § 422.152 reflects the statutory requirements listed above, as well as those implementing requirements that are consistent with, and necessary to accomplish, the intent of the Act. While certain requirements in section 1852(e)(2) that expressly refer to ''improvement'' in quality do not apply to all types of M+C plans, we believe that all of the requirements in section 1852(e) are geared toward improving quality, not simply monitoring it. For this reason, we are using the term ''quality assessment and performance improvement program'' to refer to the program that is required of all M+C plans, which section 1852(e)(1) refers to as a ''quality assurance program.'' We accordingly use the term ''quality assessment and performance improvement program'' in the heading of § 422.152 and in the general rule at § 422.152(a).

a. Requirements for M+C Coordinated Care Plans and Network MSA Plans. Sections 422.152(b) through (d) set forth requirements that M+C organizations must meet with respect to M+C coordinated care plans and network MSA plans. As alluded to above, as directed by section 1852(e), these requirements reflect a departure from the problem-focused approach to ensuring quality that was prevalent in the past. Thus, under these regulations, it will no longer be sufficient for organizations to identify and correct problems in their operations—they must now focus on systemic quality

improvement as well. This approach is also consistent with HCFA's responsibility to demand value in the form of positive outcomes from the organizations with which we contract.

To implement this approach, § 422.152(b) establishes two basic quality assessment and performance improvement requirements: (1) measurement and reporting of performance; and (2) conducting performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of both clinical care and nonclinical care areas that can be expected to affect health outcomes and member satisfaction. The specific requirements associated with the measurement and reporting of performance and the execution of performance improvement projects are set forth under § 422.152(c) and (d), as discussed in detail below. Before turning to that discussion, however, we note that § 422.152 also incorporates statutory requirements from section 1852(e)(2)(viii), (ix), and (xii), as listed above, concerning written utilization review protocols, the identification of underutilization and overutilization of services, and the availability of information on quality and outcome measures as needed to facilitate beneficiary comparisons and choices among M+C plans.

b. Performance Measurement and Reporting. Section 422.152(c) elaborates on paragraph (b)(1) by requiring that the organization: (1) measure and report its performance to HCFA using measures required by HCFA, and (2) for M+C coordinated care plans, achieve any minimum performance levels that may be established locally, regionally, or nationally by HCFA. The first requirement is based directly on the requirement under section 1852(e)(2)(A)(i) of the Act concerning outcome measurement and reporting. Thus, it applies both to M+C coordinated care plans and network MSA plans (as well as to M+C non-network MSA plans and PFFS plans, as discussed below in section II.D.2.d of the preamble). The second requirement enables HCFA to evaluate a plan's ability to meet the objectives of sections 1852(e)(2)(A)(x) and (xi) of the Act concerning quality assessment and improvement. It also reflects HCFA's responsibility to require that the services we purchase meet minimum quality standards. (We note that although the requirements of sections 1852(e)(2)(A)(x) and (xi) of the Act apply to M+C network MSA plans as well as to M+C coordinated care plans, we are not requiring in this interim final rule that M+C network MSA plans achieve minimum performance levels. In keeping with the demonstration status of the M+C MSA plans, we intend to evaluate the performance of these plans in the context of the evaluation provisions of section 1851(b)(4)(B) of the Act.)

Health plan performance measurement and reporting is in its early stages. Consensus regarding what aspects of plan performance can and should be measured, how this information should be reported, how it should be audited, and which measures are collectible for which types of organizations, is only now being developed. HCFA, large private purchasers, managed care organizations, and others have made important progress in defining and measuring health plan performance. This regulation must move us toward enhancing health plan accountability while leaving flexibility for the specific reporting and performance requirements to progress as we learn more about performance measurement. We want to be able to respond rapidly to new developments in the state of the art of quality measurement and improving performance levels.

We do not intend to adopt a ''one size fits all'' approach that assumes that reporting under all types of M+C plans will be possible in the same manner for all measures. We will balance our efforts to increase uniformity to facilitate consumer comparison of plans with sensitivity to the different organizational structures of plans and their different abilities to affect provider behavior.

In general, an M+C organization should not be held accountable for improving services that it does not promise to provide under a plan, nor for reporting information to which it does not reasonably have access under a plan. At the same time, an organization should be held accountable for improving plan performance with respect to the benefits provides under the M+C program and all applicable M+C standards, and for having the information needed to maintain and improve the quality of the services it delivers or arranges for. Organizations should be expected to improve their capacity to collect and analyze information about the delivery of M+C benefits, consistent with changes that are occurring in the health plan market place. We believe that Congress intended us to take the actions that any prudent purchaser would take to hold M+C organizations accountable for the benefits they promise to provide under a plan.

For these reasons, we are not specifying the particular measures for which reporting will be required or the minimum performance levels that M+C coordinated care plans will be expected to achieve. Instead, the regulation clarifies the general clinical and nonclinical areas to be addressed by the performance reporting, such as effectiveness of care, use of services, and access to services. The performance measures to be reported and the minimum performance standards that the M+C plan or plans offered by an organization will be required to meet will be addresses on an organization and plan-specific basis, as described below.

Section 422.152(c)(1) establishes that standard performance measures may be specified in data collection and reporting instruments required by HCFA. For example, as mentioned earlier, HCFA has already begun requiring reporting of standardized quality measurement data through instruments such as HEDIS © 3.0, as well as reporting of standardized consumer satisfaction data through the Consumer Assessment of Health Plans Study (CAHPS). We expect that in contract year 1999, the standard performance measures for M+C organizations will include most HEDIS measures and a member survey, with the possibility of additional measures. (Where data on particular measures are not reasonably available with respect to a given plan, organizations can report ''not available''. HCFA will work with M+C organizations to identify those measures for which data are and are not reasonably available for a given plan.) To the extent that we do include HEDIS measures, we will use the HEDIS measurement specifications. Before the beginning of the next contract year, we will decide on the measures on which reporting will be required for contract year 1999 and will notify organizations of those measures through the contracting process.

We expect to develop a core set of measures on which reporting will be required under all plans. We also expect to identify additional reporting requirements to reflect the plan's characteristics (such as supplemental benefits, type of delivery system) and past performance.

In adopting minimum performance requirements for coordinated care plans, we intend to ensure that the targets are achievable, meaningful, and equitable. We intend to move toward minimum uniform national performance standards

based on what plans across the nation are able to achieve.

We expect to start with standards that are adjusted to reflect performance in the plan's region and the individual plan's or organization's historical performance (or performance in Medicare fee-for-service where the plan has no history). Performance requirements will be established only for measures for which there are sufficient historical data available to establish regional standards based on actual performance of a number of plans. (We will therefore require reporting on measures for which performance standards have not been established.) Other criteria will also guide the selection of measures for which minimum performance levels will be established, including their significance for the health of the enrolled population under a plan and the likelihood that they fairly reflect the organization's performance.

Because the process of identifying achievable, meaningful and equitable minimum performance levels will require a significant amount of data collection and analysis, we expect that it will be several years before a full complement of minimum performance levels can be established. At this point, it is uncertain whether any minimum performance levels will be established for the 1999 contract year. We will identify minimum performance levels on a measure by measure basis, after evaluating baseline data and the distribution of organization performance and considering potential opportunities for improvement. The process of identifying minimum performance levels will evolve as new methods of performance measurement develop.

HCFA is committed to public involvement in the selection of measurement topics. HCFA will also work collaboratively with organizations involved with quality and performance standards and measurements, including performance measurement experts, health plans, public and private purchasers and beneficiary representatives in the selection of specific measures and setting of minimum performance levels. As we develop minimum performance standards, we will consider how our goal of maintaining maximum consumer choice in the M+C program should affect our expectations concerning plan performance.

When we have identified minimum performance levels, we plan to establish them prospectively upon contract initiation and renewal, so that an organization will have the entire contract year in which to take action to meet them. By the end of the contract year, the organization must meet any identified minimum performance levels. In some cases, we believe that the next contract year will have already begun by the time HCFA learns whether the organization has met the minimum performance levels established for the previous year. Therefore, we specify that HCFA may decline to renew an organization's contract in the year that HCFA determines that the organization failed to meet the minimum performance levels, even if the failure itself was in the prior contract year.

c. Performance Improvement Projects. Section 422.152(d) establishes the requirements for performance improvement projects, beginning with the requirement that performance improvement projects focus on specified areas of clinical and nonclinical services. It also explains that HCFA will set M+C organizational and plan-specific requirements for the number and distribution of these projects among the required areas. In addition, it authorizes HCFA to direct an M+C organization to undertake specific performance improvement projects and participate in national and State-wide performance improvement projects. Section 422.152(d) reflects many of the provisions of section 1852(e)(2) of the statute, including for example the requirements for projects in areas such as high-volume and high-risk services and continuity and coordination of care (sections 1852(e)(2)(A)(ii) and (iii), respectively).

Section 422.152(d)(1) explains what is meant by a project. All projects must involve the measurement of performance, system interventions (including the establishment or alteration of practice parameters), improving performance, and systematic follow-up on the effect of the interventions.

Section 422.152(d)(2) requires that projects address the entire population to which the performance measure is relevant. Thus, once a topic has been selected, the organization must assure that its measurement and improvement efforts are at least plan-wide. (Note that we do not intend to prohibit an M+C organization from conducting performance improvement projects that would cut across plans.) We expect that, to the extent feasible, each project should reach all enrollees and providers in the plan network who are involved in the aspect of care or services to be studied. This does not mean that a project must involve review of the performance of each provider who furnishes the services that are the subject of the project, or that it must survey every affected enrollee. Sampling is acceptable if the organization can demonstrate that its samples are genuinely random. An organization could do so by showing, for example that:

- Each relevant provider and enrollee has a chance of being selected; no provider or enrollee is systematically excluded from the sampling.
- Each provider serving a given number of enrollees has the same probability of being selected as any other provider serving the same number of enrollees.
- Providers and enrollees who were not included in the sample for the baseline measurement have the same chance for being selected for the follow-up measurement as providers and enrollees who were included in the baseline.

Section 422.152(d)(3) states that HCFA will establish M+C organizational and M+C plan-specific obligations for the number and distribution of projects among the required clinical and non-clinical areas. Sections 422.152(d)(4) and (5) then specify the minimum clinical and nonclinical focus areas that must be addressed through these projects. These minimum focus areas are:

- Clinical areas—prevention and care of acute and chronic conditions; high volume services and high risk services; continuity and coordination of care.
- Nonclinical areas: appeals, grievances, and other complaints; access and availability of services.

Note that these areas represent minimum requirements, and organizations are likely to carry out projects in other areas in order to meet their contractual performance improvement obligations. The length of the performance improvement cycle, that is, the period of time during which an organization must conduct a project that demonstrates improvement in each of the required focus areas, will be one of the contractual performance improvement obligations. Within each clinical and nonclinical focus area, an organization will have considerable freedom to select its own particular topics for measurement and improvement, so that it can initiate projects relating to aspects of care and services that are significant for its plan-specific population. Our goal is to achieve a balance between encouraging flexibility and innovation and ensuring that every organization conducts meaningful projects over a broad spectrum of care and services. As noted above, however, there may be instances where it is necessary for HCFA to direct the organization to address a specific

topic within a given focus area. Thus, § 422.152(d)(6)(i) provides that, in addition to requiring that an organization initiate its own performance improvement projects, HCFA may direct an organization to conduct particular performance improvement projects that are specific to the organization. We believe this could be necessary, for example, when an organization demonstrates a significant weakness in a particular performance area, but the area is not addressed in the organization's own performance improvement projects. Similarly, § 422.152(d)(6)(ii) provides that HCFA may require an organization to participate in national or statewide performance improvement projects. These performance improvement projects would focus on aspects of care that we believe are of high priority, and would be designed by HCFA (or possibly by other entities, such as the external quality review organizations affiliated with Medicaid managed care organizations).

In general, we believe that when an organization initiates a project, the clinical or nonclinical issue selected for study should affect a substantial portion of the plan's M+C enrollees (or a specified subpopulation of enrollees) and have a potentially significant impact on enrollee health, functional status, or satisfaction. There may be instances in which less frequent conditions or services warrant study, as when data show a pattern of unexpected adverse outcomes; however, the prevalence of a condition or volume of services involved should be sufficient to permit meaningful study.

A project topic may be suggested by patterns of inappropriate utilization—for example, frequent use of the emergency room by enrollees with a specific diagnosis. However, the project should be focused clearly on identifying and correcting deficiencies in care or services that might have led to this pattern, such as inadequate access to primary care, rather than on utilization and cost issues alone. This is not to say that an organization may not make efforts to address overutilization, but only that such efforts may not meet the requirements of § 422.152, unless the primary objective is to improve outcomes. Thus, it would be acceptable for a project to focus on patterns of overutilization that present a clear threat to health or functional status, for example, a high risk of iatrogenic problems or other adverse outcomes.

Because the achievement of demonstrable improvement is a central criterion in the evaluation of projects, the projects should necessarily address areas in which meaningful improvement can be effected through system interventions by the organization. Thus, organizations should focus on areas in which there is significant variation in practice and resulting outcomes within a plan, or in which performance as a whole falls below acceptable benchmarks or norms.

Organizations are encouraged to undertake complex projects or innovative projects that have a high risk of failure but that offer potential for making a significant difference in the health or functional status of enrollees. We recommend that M+C organizations look to the independent quality review and improvement organizations with which they have agreements (see the discussion below about the external review requirements of § 422.154) for assistance in designing and executing performance improvement projects.

Section 422.152(d)(7) requires that an organization assess performance for each project using one or more quality indicators, that are objective, clearly defined, and based on current clinical knowledge or health services research. In accordance with the emphasis section 1852(e)(2)(A)(i) places on outcomes, the regulation requires that the quality indicators measure outcomes such as changes in health status, functional status, and enrollee satisfaction, or measure valid proxies of these outcomes. We recognize that relatively few existing standardized performance measures actually address outcomes. For example, of the 16 effectiveness measures in HEDIS 3.0, only one (health of seniors) is truly outcome-based. Even when outcome measures are available, their utility as quality indicators for projects may be limited if the outcomes are dictated largely by factors outside the organization's control.

Therefore, we do not require that quality indicators be limited to outcome measures. Process measures are acceptable so long as the plan can show that they are valid proxies, that is, there is strong clinical evidence that the process being measured is meaningfully associated with outcomes. To the extent possible, this determination should be based on published guidelines that support the association and that cite evidence from randomized clinical trials, case control studies, or cohort studies. An M+C organization may furnish its own similar evidence of association between a process and an outcome, as long as this association is not contradicted by a published guideline. Although published evidence is generally required, there may be certain areas of practice for which empirical evidence of process/outcome linkage is limited. At a minimum, an organization should be able to demonstrate that there is a consensus among relevant practitioners as to the importance of a given process.

While we consider enrollee satisfaction an important aspect of care, improvement in satisfaction may not be the sole demonstrable outcome of a project in any clinical focus areas. Some improvement in health or functional status must also be measured. (Note that this measurement can rely on enrollee surveys that address topics in addition to satisfaction. For example, self-reported health status may be an acceptable indicator.) For projects in the nonclinical areas, use of health or functional status indicators is generally preferred, particularly for projects addressing access and availability. However, there may be some nonclinical projects for which enrollee satisfaction indicators alone are sufficient.

Section 422.152(d)(8) requires that performance assessment be based on systematic, ongoing collection and analysis of valid and reliable data. Data will most commonly be derived from administrative data generated by an organization's health information system or from review of medical records. (In assessing nonclinical services, other sources such as enrollee or provider surveys may be appropriate.) When data are derived from the health information system, their reliability is obviously a function of the general reliability of the system. When data are derived from direct review of medical records or other primary source documents, steps must be taken to assure that the data are uniformly extracted and recorded. Appropriately qualified personnel must be used; this will vary with the nature of the data being collected and the degree of professional judgment required. We expect there to be clear guidelines or protocols for obtaining and entering the data; this is especially important if multiple reviewers are used or if data are collected by multiple subcontractors. Inter-reviewer reliability should be assured through, for example, repeat reviews of a sample of records.

Section 422.152(d)(9) requires that interventions achieve improvement that is significant and sustained over time. In general, we will judge improvement to be significant when a benchmark level of performance is achieved in the percentage of enrollees who exhibit a negative outcome defined by the indicator.

Again, specific acceptable performance measures will be defined for each M+C organization and M+C

plan. Currently, we are considering requiring a 10 percent reduction in negative outcomes as evidence of significant improvement. An organization would meet this requirement if, for example, its flu immunization rate under a plan is 80 percent in the baseline and increases to 82 percent, because the percentage of enrollees *not* immunized has dropped from 20 percent to 18 percent, a 10 percent reduction. A plan whose baseline rate was 60 percent would have to reach 64 percent (a reduction in nonimmunized enrollees from 40 percent to 36 percent).

We are considering requiring a 10 percent reduction in adverse outcomes as evidence of significant improvement for several reasons. First, the use of a constant percentage reflects the likelihood that change is harder to achieve when an organization's baseline performance is already superior. Thus, under a plan with an 80 percent immunization rate, we would expect a 2 percentage point improvement, while under a plan with a 60 percent rate, a 4 percentage point improvement would be expected. Second, the 10 percent level is consistent with results HCFA has observed in successful improvement projects sponsored by the agency. Finally, we believe that smaller improvements would generally be of little clinical significance. We invite comment on the issue of whether § 422.152(d)(9) should be revised to provide for a 10 percent reduction in adverse outcomes.

Note that improvement in an *indicator* is not necessarily the same as improvement in the health or functional status of enrollees. For example, the ''health of seniors'' indicator under HEDIS 3.0 will track, over time, changes in the functional status of elderly enrollees. Each enrollee's functional status may remain stable or actually decline. However, an organization would demonstrate improvement on the indicator if it slowed the rate of decline, whether or not it actually improved enrollees' functional status. HCFA is considering judging improvement to be sustained under a plan if it can be demonstrated through continued measurement that performance gains have endured for at least one year.

We recognize that many organizations still have limited experience in conducting well-designed performance improvement projects, and that any given project may take some time to produce measurable improvement. Therefore, we intend to permit a gradual phase-in of the number of focus areas for which improvement must be demonstrated consistent with the individual circumstances of an M+C organization.

Section 422.152(d)(10) concludes the performance improvement requirements by providing explicitly that an organization must report the status and results of each project to HCFA upon request. This requirement is necessary to implement the reporting requirements embodied in sections 1852(e)(2)(A)(vi) and (xii) and 1851(d)(4)(D) and (d)(7), which call for HCFA to make available to M+C eligible individuals information comparing M+C plan options, including information on quality and performance.

d. Requirements for M+C Private Fee-for-Service and Non-Network MSA Plans. In enacting the quality assurance provisions of the BBA, Congress recognized that not all of the quality assessment and performance improvement activities that are appropriate for a plan with a defined provider network would be appropriate for an M+C non-network MSA plan or an M+C private fee-for-service plan. (Section 1852(e)(2)(C) defines a non-network MSA plan as an MSA plan that does not provide any of the covered benefits through a defined set of providers under contract to the organization or under arrangements made by the organization, and we have incorporated this provision into § 422.4(a)(2)(ii).) As a result, section 1852(e)(2)(B) establishes different required elements of a quality assessment and performance improvement program depending on the type of plan involved. Specifically, the Act exempts M+C non-network MSA and PFFS plans from the requirements of paragraphs (e)(2)(A)(vii) through (xii) of section 1852, which include the utilization review requirements discussed above as well as the explicit requirement to take action to improve quality and assess the effectiveness of such action through systematic follow-up. However, the statute continues to require that organizations offering these types of plans stress outcomes, provide for the data collection, analysis, and reporting necessary to measure outcomes, and monitor and ensure the quality of care they provide.

Consistent with the statute, the specific requirements to achieve minimum performance levels and undertake performance improvement projects will not apply to M+C non-network MSA and PFFS plans. Both requirements are derived primarily from the statutory requirements from which these types of plans have been exempted (that is, sections 1852(e)(2)(A)(x) and (xi). Instead, we have established separate requirements that apply for these types of plans under § 422.152(e). These requirements parallel the requirements for other types of plans to the extent permitted under the statute. For example, § 422.152(e)(1) requires that under these plans, an organization must measure its performance, using standard measures established or adopted by HCFA. These measures will focus on the prevention and care of acute and chronic conditions, high-volume and high-risk services, and enrollee satisfaction. We invite comment on whether additional areas for standard measures should be added to § 422.152(e)(1). Section 422.152(e)(2) requires evaluation of the continuity and coordination of care that enrollees receive. Together, the requirements under § 422.152(e)(1) and (2) reflect the requirements of paragraphs (e)(2)(A)(i), (ii), (iii), and (v) of section 1852.

Sections 1852(e)(2)(B)(ii) and (iii) specify that if an M+C non-network MSA or PFFS plan has written protocols for utilization review, those protocols must be based on current standards of medical practice, and have mechanisms to evaluate utilization services and inform providers and enrollees of the results of such evaluation. These requirements are incorporated into § 422.152(e)(3).

e. *Requirements for All Plans: Health Information.* In order to support the measurement of performance levels and the conduct of its performance improvement projects, if applicable, all plans must maintain a health information system that collects, analyzes, integrates, and reports data. This requirement is covered at § 422.152(f). Although an encounter data system may often be the most efficient means of meeting the requirements of this standard, the plan may use any methods or procedures for the collection of quality data, so long as it can demonstrate that its system achieves the objectives of the requirement.

The strategy of relying on performance measurement and performance standards to assess and improve quality is heavily dependent on the validity of the data collected and reported by plans. Therefore, § 422.152(f)(1)(ii) requires that an organization ensure that the information received from its providers is reliable and complete. If the organization receives individual encounter data directly from providers, it must have a system for comparing reported data to a sample of medical records, to verify the accuracy and timeliness of reporting or transmission. The objective is to assure that, to the extent feasible, there is a

one-to-one correspondence between items included in an organization's summary data and specific services entered in medical records or equivalent source documents. (That is, no reported service was not performed, and no service performed was not reported.) If the organization receives aggregate information, instead of individual patient encounter reporting, from any provider, under a plan the organization must approve the provider's own system for collecting, recording, aggregating, and reporting the data, and must assure that the provider has its own mechanisms for validation. Identified deficiencies in reported data should be addressed through provider education or other corrective action. The organization's process for recredentialing or recontracting with practitioners and providers should specify the actions to be taken in the event of ongoing failure by a contractor to meet the organization's health information standards.

In addition to requiring that the information collected be accurate and complete, § 422.152(f)(1)(iii) requires that the organization make all information collected available to HCFA. This requirement reflects section 1852(e)(2)(A)(vi), which recognizes that HCFA cannot adequately monitor and ensure the quality of health care services without access to appropriate information. For example, access to this information will allow HCFA to validate the accuracy and completeness of the information and to evaluate performance improvement projects. Note that although HCFA may disclose whether an organization has met its requirements for performance improvement, we will not make public the results of an organization's performance improvement projects, as these results may involve enrollee-specific information.

f. *Program Review.* Section 422.152(f)(2) requires that for each plan an organization have a process for formal evaluation, at a minimum annually, of the impact and effectiveness of the quality assessment and performance improvement program strategy. The evaluation should assess both the progress in implementing the strategy and the extent to which the strategy is in fact promoting the development of an effective quality assessment and performance improvement program. It should consider whether quality-related activities in the organization's workplan are being completed on a timely basis or whether commitment of additional resources is necessary. The evaluation should include recommendations for needed changes in program strategy or administration. These recommendations should be forwarded to and considered by the policymaking body of the organization. These requirements reflect the evaluation provisions of section 1852(e)(2)(A)(iv).

4. External Review (§ 422.154)

Section 1852(e)(3) requires, subject to the exceptions discussed below, that each M+C organization, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization (review organization) approved by HCFA to perform functions of the type described in part 466 of chapter 42, which establishes review responsibilities for utilization and quality control Peer Review Organizations (PROs). This requirement appears in § 422.154(a).

PROs are physician-sponsored or physician-access organizations that review services ordered or furnished by other practitioners in the same professional field for the purpose of determining whether such services are or were reasonable or medically necessary, and whether the quality of such services meets professionally recognized standards of health care. Because PROs generally are already accomplished at the activities the statute requires of review organizations, HCFA will approve as review organizations the PROs and PRO-like entities who are currently under contract with HCFA to perform the functions of part 466. The current PRO contract will expire on March 31, 1999. The entities awarded the next contract, known as the Sixth Scope of Work, will be approved to serve as review organizations as of April 1, 1999.

An important element of both the current and next contract is a strategy to continuously improve quality of care and strengthen the ability of health care organizations and practitioners to assess and improve their own performance. Under this strategy, known as the Health Care Quality Improvement Program, part 466 contractors use statistical information to examine medical processes and outcomes of health care and provide feedback to providers so that this information can be used to benchmark progress toward improved practice and outcomes.

HCFA will establish guidelines for the agreements between M+C organizations and review organizations modeled on the guidelines found in part 466. The guidelines will specify that an M+C organization must allocate adequate space for the review organization to carry out its review (during the period of the review); and that the organization must provide enrollee care data and other pertinent data to the review organization on a timely basis as needed to facilitate making its determinations. These requirements appear in § 422.154(b)(1).

With respect to M+C non-network MSA and PFFS plans, for which utilization review is not a requirement, section 1852(e)(3)(A) of the statute exempts organizations from the requirement that there be an agreement with a review organization. Section 1852(e)(3)(B) also provides an exemption for review organization activities with respect to accredited plans that HCFA determines would be duplicative of activities conducted as part of the accreditation process. In the case of review of quality complaints, this exemption does not apply, however, and the requirement for investigation by the review organization would apply even with respect to an accredited plan. This exemption appears in § 422.154(b)(2). While the statute only mandates that the Secretary exempt accredited plans from the duplicative review by review organizations, we believe that the same logic extends to review activities that would be duplicative of HCFA monitoring review. Thus, pursuant to our general authority under section 1856(b)(1) to establish standards under Part C, we are providing in § 422.154(b)(2) that M+C organizations are also exempt from review by a review organization that would be duplicative of HCFA monitoring review.

Under section 1852(e)(3)(C), HCFA may waive the requirement that an M+C organization have an agreement with a review organization if HCFA determines that an organization has consistently maintained an excellent record of quality assessment and performance improvement and compliance with the other requirements of this part. As discussed in detail above, § 422.152 establishes requirements for a plan's quality assessment and performance improvement (QAPI) program. After the rule is effective, and HCFA has had the opportunity to assess QAPI implementation, we will be in a position to establish waiver criteria, which we intend to promulgate through notice and comment rulemaking.

5. Deemed Compliance Based on Accreditation (§§ 422.156 Through 422.158)

a. *Compliance Deemed on the Basis of Accreditation (§ 422.156).* Section 1852(e)(4) gives HCFA the authority to deem that an M+C organization meets certain requirements if the M+C organization is accredited and

periodically reaccredited by a private organization under a process that HCFA has determined ensures that the M+C organization, as a condition of accreditation, meets standards that are no less stringent than the applicable HCFA requirements. We do not believe that HCFA could effectively determine whether a potentially unlimited number of small, regional accreditation organizations meet the standard in section 1852(e)(4). Section 422.156 accordingly limits the deeming provided for under section 1852(e)(4) to national accreditation organizations. National accreditation organizations are those that offer accreditation services that are available in every State to every organization wishing to obtain accreditation status.

The process that HCFA will use to deem compliance with M+C requirements will mirror the process used for deeming compliance with fee-for-service requirements, because that process is equally applicable to the managed care setting. Therefore, many of the requirements of this section, as well as those in §§ 422.157 and 422.158, are essentially restatements of their fee-for-service equivalents in subpart A of part 488 of existing Medicare regulations.

Section 422.156(a) specifies the conditions under which an M+C organization may be deemed to meet the HCFA requirements permitted to be deemed under section 1852(e)(4). (These requirements are identified in the regulations at § 422.156(b).) The first condition is that the M+C organization be fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by HCFA. Only full accreditation offers HCFA adequate assurance that the M+C organization meets the applicable HCFA requirements. M+C organizations that are conditionally or provisionally accredited (or the equivalent thereof) by their accreditation organization do not meet all of their accreditation organization's requirements, and for this reason, will not be deemed to meet the HCFA requirements. The second condition is that the M+C organization be accredited using the standards approved by HCFA for the purposes of assessing the M+C organization's compliance with Medicare requirements. Given that certain accreditation organizations have multiple accreditation processes (for example, other product lines aside from their Medicare product line), this requirement is necessary to ensure that only M+C organizations with the appropriate accreditation are deemed to meet HCFA requirements.

Section 422.156(b) specifies the requirements that may be deemed. In accordance with the statute, these include the quality assessment and performance improvement requirements of § 422.152, and the requirements of § 422.118 related to confidentiality and accuracy of enrollee records. An M+C organization accredited by an approved accreditation organization may be deemed to meet any or all of these requirements, depending on the specific requirements for which its accreditation organization's request for approval was granted.

Given the complexity and breadth of the benefits and services offered under the M+C program, we believe that we should analyze the standards applied by accreditation organizations on a standard-by-standard basis. In the past, in the context of original fee-for-service Medicare, we have taken an ''all or nothing'' approach in approving accreditation organizations. If an organization was approved, it was approved for purposes of all requirements, and all requirements were accordingly deemed. Since section 1852(e)(4) refers to deeming of ''the requirements involved,'' however, we intend under this authority to determine on a standard-by-standard basis whether an accreditation organization applies and enforces requirements no less stringent than those in part 422 with respect to the standard at issue. We will determine the scope of the accreditation organization's approval (and thus the extent to which M+C organizations accredited by the organization are deemed to meet HCFA requirements) based on a comparison of the accreditation organization's standards, and its procedures for assessing compliance, with the deemable HCFA requirements and our own decision-making standards.

As mentioned above, the requirements that may be deemed are the quality assessment and performance improvement requirements of § 422.152, and the confidentiality and accuracy of enrollee records requirements of § 422.118. We will approve an accreditation organization only for those requirements for which it applies and enforces standards that are as least as stringent as the HCFA requirements. For instance, § 422.152(e) requires that an M+C organization conduct performance improvement projects that achieve significant and sustained improvement. An accreditation organization will not be approved for this requirement unless we determine that, as a condition of accreditation, the accreditation organization's requirements concerning the conduct of performance improvement projects are as rigorous as the HCFA requirements, with a similar emphasis on outcomes. We will make such determinations on the basis of the application materials submitted by accreditation organizations seeking HCFA approval in accordance with § 422.158. We would also do surveys to validate the accreditation organization's enforcement on a standard-by-standard basis.

Section 422.156(c) establishes when deemed status is effective. Deemed status is effective on the later of the following dates: the date on which the accreditation organization is approved by HCFA, or the date that the M+C organization is accredited by the accreditation organization.

Section 422.156(d) establishes the obligations of deemed M+C organizations. An M+C organization deemed to meet Medicare requirements must submit to surveys to validate its accreditation organization's accreditation process, and authorize its accreditation organization to release to HCFA a copy of its most current accreditation survey, together with any information related to the survey that HCFA may require (including corrective action plans and summaries of unmet HCFA requirements.) These two activities are part of HCFA's ongoing oversight strategy for ensuring that the accreditation organization applies and enforces its accreditation standards in a manner comparable to HCFA's.

Section 422.156(e) addresses removal of deemed status. HCFA will remove part or all of an M+C organization's deemed status if: (1) HCFA determines, on the basis of its own survey or the results of the accreditation survey, that the M+C organization does not meet the Medicare requirements for which deemed status was granted; (2) HCFA withdraws its approval of the accreditation organization that accredited the M+C organization; or (3) the M+C fails to meet the requirements of paragraph (d) of this section.

The final paragraph, § 422.156(f), explains that HCFA retains the authority to initiate enforcement action against any M+C organization that it determines, on the basis of its own survey or the results of the accreditation survey, no longer meets the Medicare requirements for which deemed status was granted. We expect the accreditation organization to have a system in place for enforcing compliance with its standards, perhaps sanctions for motivating correction of deficiencies, but HCFA cannot delegate to the accreditation organization the authority to impose the intermediate

sanctions established by section 1857(g) or termination of the M+C contract.

b. *Accreditation organizations (§ 422.157).* This section of the regulation discusses three conditions for HCFA approval of an accreditation organization. HCFA may approve an accreditation organization if the organization applies and enforces standards for M+C organizations that are at least as stringent as Medicare requirements (as discussed above); the organization complies with the application and reapplication procedures set forth in § 422.158, ''Procedures for approval of accreditation as a basis for deeming compliance;'' and, the organization is not controlled by the managed care organizations it accredits, as defined at 42 CFR 413.17. Control exists if the accredited organizations have the power, directly or indirectly, to significantly influence or direct the activities or policies of the accreditation organization. We have included this requirement to preclude any conflict of interest that should compromise the integrity of the accreditation process.

Section 422.157(b) describes notice and comment procedures. Because the approval of an accreditation organization could have broad impact upon large numbers of organizations, providers, and consumers, we are providing notice and comment opportunities similar to those provided in the fee-for-service arena. HCFA will publish a proposed notice in the Federal Register whenever it contemplates approving an accreditation organization's application for approval. The proposed notice will specify the basis for granting approval; describe how the accreditation organization's accreditation program meets or exceeds all of the Medicare requirements for which HCFA would deem compliance on the basis of accreditation; and provide opportunity for public comment. HCFA will publish a final notice in the Federal Register whenever it grants an accreditation organization's request for approval. Publication of the final notice will occur after HCFA has reviewed the public comments received in response to the proposed notice. The final notice will specify the effective date of the approval, and the term of approval, which will not exceed 6 years.

Section 422.157(c) establishes ongoing accreditation organization responsibilities. These responsibilities largely parallel those currently imposed upon accreditors under original Medicare. One exception is the requirement at § 422.157(c)(4) that an accreditation organization notify HCFA in writing within 3 days of identifying, with respect to an accredited M+C organization, a deficiency that poses immediate jeopardy to the M+C organization's enrollees or to the general public. Although the existing counterpart for this requirement under original Medicare (§ 488.4(b)(3)(vii)) allows an accreditation organization 10 days to provide this notice, we believe that a 3-day time period will better enable HCFA to take any necessary action to protect the health and safety of enrollees or the general public in a situation that poses immediate jeopardy. (Note that we also intend to address this issue in our planned comprehensive revision of the deeming requirements under original fee-for-service Medicare.)

Section 422.157(d) establishes specific criteria and procedures for continuing oversight and for withdrawing approval of an accreditation organization. Oversight consists of equivalency review, validation review, and onsite observation.

Equivalency review. HCFA compares the accreditation organization's standards and its application and enforcement of those standards to the comparable HCFA requirements and processes when HCFA imposes new requirements or changes its survey process; an accreditation organization proposes to adopt new standards or changes in its survey process; or the term of an accreditation organization's approval expires.

Validation review. HCFA or its agent may conduct a survey of an accredited organization, examine the results of the accreditation organization's own survey, or attend the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, HCFA identifies any accreditation programs for which validation survey results indicate (1) a 20 percent rate of disparity between certification by the accreditation organization and certification by HCFA or its agent on standards that do not constitute immediate jeopardy to patient health and safety if unmet; or (2) indicate any disparity at all on standards that constitute immediate jeopardy to patient health and safety if unmet. Our beneficiary-centered approach to managed care oversight dictates zero tolerance of accreditation organization failures to identify noncompliance that expose beneficiaries to such serious risks. At the conclusion of a validation review, HCFA also identifies any accreditation programs for which validation survey results indicate, irrespective of the rate of disparity, that there are widespread or systematic problems in an organization's accreditation process such that accreditation no longer provides assurance that the Medicare requirements are met or exceeded. Accreditation programs identified as noncompliant through validation review may be subject to withdrawal of HCFA approval.

Onsite observation. HCFA may conduct an onsite inspection of the accreditation organization's operations and offices to verify the organization's representations and assess the organization's compliance with its own policies and procedures. The onsite inspection may include, but is not limited to, reviewing documents, auditing meetings concerning the accreditation process, evaluating survey results or the accreditation status decision making process, and interviewing the organization's staff.

Notice of intent to withdraw approval. If a comparability review, validation review, onsite observation, or HCFA's daily experience with the accreditation organization suggests that an accreditation organization is not meeting the requirements of this subpart, HCFA gives the organization written notice of its intent to withdraw approval.

HCFA may withdraw its approval of an accreditation organization at any time if we determine that deeming based on accreditation no longer guarantees that the M+C organization meets the Medicare requirements, and failure to meet those requirements could jeopardize the health or safety of Medicare enrollees or constitute a significant hazard to the public health; or the accreditation organization has failed to meet its obligations under §§ 422.156, 422.157, 422.158.

The final provision of § 422.157(d) addresses reconsideration. An accreditation organization dissatisfied with a determination to withdraw HCFA approval may request a reconsideration of that determination in accordance with subpart D of part 488 of this chapter.

c. *Application and reapplication procedures for accreditation organizations (§ 422.158).* As mentioned, the process that HCFA will use to deem compliance with M+C requirements is virtually identical to the process that is being used for deeming compliance with fee-for-service requirements. This section of the regulation is modeled on § 488.4, ''Application and reapplication procedures for accreditation organizations.'' One requirement that appears in § 422.158 does not appear in § 488.4 is the requirement that an

accreditation organization applying for approval of deeming authority submit the name and address of each person with an ownership or control interest in the accreditation organization. Such information will be used to determine whether the accreditation organization is controlled by the organizations it accredits, for the purposes of § 422.157. The remaining requirements of this section, which pertain to other required information and materials, the mechanics of the approval process, and the reconsideration of an adverse determination, are essentially restatements of the requirements of § 488.4.

E. Relationships With Providers

Subpart E focuses on requirements for relationships between M+C organizations and health care professionals with whom they contract or enter agreements to provide services to Medicare beneficiaries enrolled in an M+C plan. These requirements encourage communication, coordination, and cooperation between organizations and health care professionals on plan rules and policies. This subpart also includes other new provider protections enacted as part of the BBA; incorporates provisions affecting health professionals that are consistent with the recommendations contained in the Consumer Bill of Rights and Responsibilities, as recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry, the model act adopted by the National Association of Insurance Commissioners, credentialing standards of nationally accepted accrediting bodies, and QISMC standards; and incorporates policies already applicable to provider and plan relationships included in the current part 417 or other policy issuances. In February 1998, an executive order was issued directing the Secretary to comply to the extent possible through administrative activities with the standards contained within the Consumer Bill of Rights presented to the President in November 1997. Many of the issues were addressed in the BBA and implementation of the regulations will expand compliance with the directive.

1. Participation Procedures (§ 422.202)(a))

Section 1852(j)(1) requires an M+C organization that offers benefits under an M+C plan through agreements with physicians to establish reasonable procedures relating to their participation under the plan. This is a new federal requirement for Medicare contracting managed care organizations. Current rules in part 417 do not mandate that HMOs/CMPs adopt provider participation rules. However, some Medicare contractors have adopted provider participation policies in response to state laws or plan policies.

We are interpreting this provision to apply to all M+C organizations that operate M+C plans providing benefits through a limited network of contracting health care professionals or groups of health care professionals, that is, all types of M+C coordinated care plans, such as HMOs, PPOs, etc., as well as network M+C MSA plans. In the case of M+C private fee-for-service plans and non-network M+C MSA plans, there are no limits on the number of health professionals who may provide services covered under the M+C plan, as long as they accept the plan's terms and conditions for payment. These plans in essence operate on an ''any willing provider'' approach to which the procedures in section 1852(j)(1) would not be relevant. Since any provider has the right to participate, rules requiring a notice of adverse participation decisions, and appeals from such decisions could have no applicability. It also would not be feasible to provide the notices required under section 1852(j)(1) and § 422.202(a) (discussed below) to the virtually unlimited number of providers who would be entitled to provide services to a M+C private fee-for-service or non-network M+C MSA plan enrollees.

The statutory requirements in section 1852(j)(1) focus on three procedural aspects—ensuring that providers are aware of the plan participation rules; requiring written notice when participation decisions are adverse; and affording the provider an opportunity to appeal adverse plan participation decisions. The statute specifies that these procedures apply to plan relationships with physicians. In reviewing the model act of the National Association of Insurance Commissioners (NAIC), QISMC standards, and many state laws and regulations, we found that these procedural protections generally have been applied to all health care professionals who are responsible for delivering services to beneficiaries of the plan, not just physicians. Since Medicare-payments can be made to practitioners other than physicians and since M+C organizations may furnish services utilizing a range of licensed health care professionals, we believe it is appropriate to apply these requirements to all health care professionals if coverage for their services is provided under the M+C plan. For purposes of § 422.202 and § 422.204, these include, but are not limited to, a physician, podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, nurse practitioner, clinical nurse specialist, certified nurse anesthetist, and certified nurse-midwife and licensed certified social worker. Thus, under our authority under section 1856(b)(1) to establish standards for M+C organizations, § 422.202 requires that all professionals as listed above should be provided with rules of participation, written notices of participation decisions and an appeal process.

With regard to types of procedures that are subject to disclosure, written notification and appeal requirements, we are adopting a broad definition of procedures that might affect participation in the plan or network. In § 422.202 we specify that procedural requirements should include any rules that affect the process of direct delivery of services by a health professional to a Medicare beneficiary. The examples include terms of payment, utilization review, quality improvement programs, credentialing, data reporting, confidentiality, guidelines or criteria for furnishing services, and other rules related to administrative policy. All of these procedures affect how a health care professional would participate in a plan and should therefore be divulged up front prior to a health care professional's agreement to participate in the plan. In addition, we believe that full disclosure in advance, to potential participating health care professionals, of the broad range of procedures relating to participation should reduce subsequent challenges or appeals. While the disclosure requirement in § 422.202(a)(1) does not apply directly to M+C private fee-for-service plans, as discussed below, M+C organizations offering such plans will be required to make the information described in § 422.202(a)(1) available to providers treating enrollees of the plan.

Section 1852(j) requires the provision of written notice of the participation rules. We are requiring in § 422.202 that any material changes in rules must be provided in writing in advance of implementation. Such advance communication would enable health care professionals to evaluate their continued participation prior to instituting a formal appeal process regarding any rules they believe are adverse. This benefits M+C organizations and providers in allowing the health care professional to judge what is adverse as this can vary among

individual health care professionals; what is adverse to one physician or health care professional may not be adverse to another.

2. Consultation (§ 422.202(b))

Consistent with section 1852(j)(2), § 422.202(b) requires an M+C organization to consult with physicians or relevant health care professionals who have entered into participation agreements/contracts with the organization regarding the organization's medical policy, quality and medical management procedures. Pursuant to our authority in section 1856(b)(1) to establish standards under the M+C program, in addition to requiring consultation on any aspect of clinical policy, we have included three specific standards relating to the development of practice guidelines—(1) practice guidelines and utilization management guidelines must be based on reasonable medical evidence or consensus of relevant practitioners, developed in consultation with participating practitioners, and reviewed and updated periodically; (2) the guidelines must be communicated to practitioners and, as appropriate, enrollees; and (3) decision making in utilization management, enrollee education, interpretation of covered benefits, and other areas to which the guidelines are applicable must be consistent with the guidelines. These three standards are taken from QISMC discussed in section II.D. of this preamble. These national standards also are consistent with the NAIC model act and language adopted for state laws regarding managed care. We believe these standards ensure that practitioners are fully consulted in all aspects of the use of practice guidelines from development to application.

3. Treatment of Subcontracted Networks (§ 422.202 (c))

In today's business environment, managed care organizations delegate not only the provision of services to subcontracted networks, but also a variety of policy making and implementation responsibilities. Each health care professional is an integral part of the organization's health care delivery system, whether he contracts directly with the organization or through an intermediary entity, such as an Independent Practice Association (IPA). Therefore, under our authority in section 1856(b)(1) to establish M+C standards, in § 422.202(c) we require provider protections not only for direct contracting physicians and health care professionals but also for all subcontracted arrangements. Extension of the BBA provisions to subcontracts means that providers within subnetworks (e.g. an IPA) receive the rules of participation, written notices, and have an opportunity to appeal. Thus, health care professionals within the subcontracted groups should be included in the procedures established for participation appeals and in the formulation of medical policy for the organization. In cases where subnetworks maintain most of the medical records for the Medicare beneficiaries they serve, it is essential that the formulation of policy includes all of the resources that contribute to fair and equitable treatment for beneficiaries. We also believe that subnetworks should have the ability to grieve or appeal decisions for the providers within their subnetworks.

4. Provider Credentialing and Provider Rights (§ 422.204)

Section 422.204(a), ''Basic Requirements,'' states that the M+C organization must have a system for credentialing physicians and other health care professionals. The M+C organization must ensure that providers meet applicable State and Federal requirements. Basic benefits must be provided through, or payments must be made to, providers that meet applicable requirements of title XVIII and part A of title XI of the Act. Also, in the case of providers meeting the definition of ''provider of services'' in section 1861(u), basic benefits may only be provided through such providers if they have a provider agreement with HCFA permitting them to provide services under original Medicare. An M+C organization may not employ or contract with providers excluded from participation in Medicare. M+C organizations, at a minimum, should check the OIG website at http://www.dhhs.gov/progorg/oig for the listing of excluded providers and entities. These requirements are promulgated pursuant to our authority under section 1856(b)(1) to establish M+C standards by regulation, and are based on (1) the requirement in section 1852(a)(1) of the Act that Medicare covered services be furnished through Medicare qualified providers, (2) existing requirements in § 417.416, and (3) detailed standards developed under QISMC, discussed in section D. above.

Section 422.204(b), ''Discrimination Prohibited,'' prohibits M+C organizations from discriminating with respect to provider participation, provider reimbursement, or provider indemnification to any provider acting within the scope of his license or certification under applicable State law, solely on the basis of such license or certification. These requirements are based on section 1852(b)(2). This does not prohibit plans from including providers only to the extent necessary to meet the needs of the plan's enrollees, ensure quality and control costs, and does not prohibit an organization from reimbursing different specialty providers differing fees for their services. It is however, the responsibility of the organization to adopt policies related to participation, reimbursement, and indemnification based on reasonable criteria. Organizations may want to consider such measures as health outcomes, satisfaction surveys, market saturation of the provider type or other legitimate reasons.

Under § 422.204(c), ''Denial, suspension, or termination of a contract,'' organizations offering coordinated care or network MSA plans are required to provide information on their plan participation criteria and an appeals process for participation decisions, including decisions involving denial, suspension or termination of contracts. We have incorporated the timeframes for contract termination notification between the M+C organization and its providers contained within the NAIC model act. As discussed in section C. above, we have incorporated similar timeframes for notice to enrollees about changes in the provider network, including changes that result from a termination covered under § 422.204(c).

The notice and appeals requirements in this part are based on the requirement in section 1852(j)(1)(C), requiring a process for appealing adverse participation decisions, and, as noted above, on the NAIC model act, and our authority under section 1856(b)(1) to establish standards under Part C.

5. Interference With Health Care Professionals' Advice to Enrollees Prohibited (§ 422.206)

Section 422.206 (a) incorporates the requirements set forth in section 1852(j)(3)(A). This section prohibits an M+C organization from interfering with the advice of a health care professional to an enrollee who is his or her patient. Thus the health professional may act within his or her scope of practice in advising the enrollee about their health status, all relevant medical or treatment options available regardless of whether care or treatment is provided under the plan. For purposes of § 422.206, the term health care professional includes those listed in section 1852(j)(3)(D) of the Act. Pursuant to our authority in section 1852(b)(1) to establish standards

under the M+C program, § 422.206(a) includes standards from the Consumer Bill of Rights that further delineate the types and mode of communication between patients and health care providers regarding health care treatment options within which interference is prohibited. While the scope of this section governs communication regarding care or treatment advice, we recognize that patients seek advice from physicians regarding insurance coverage choices as well as treatment option choices. Physicians can disclose their participation in M+C organizations, however, we are concerned about any inappropriate steerage based on knowledge of a beneficiary's health status or the physician's financial interest. Program instructions will be issued as HCFA continues to clarify policy in the area of provider marketing and the role of physicians and other health care professionals in disseminating M+C information to beneficiaries.

6. Conscience Protection (§ 422.206)

Section 422.206(b) incorporates the requirements of section 1852(j)(3)(B). The regulations state that the prohibition against interference with the content of advice a health care provider gives to enrollees regarding medical treatment should not be construed as requiring counseling by a professional or a referral to a service by that professional, if there is an objection based on moral or religious grounds, and the M+C organization fulfills certain notification requirements to prospective and current enrollees. The regulation incorporates the notification process and time frames included in the law and clarifies that the plan must also notify HCFA at the time of application and within 10 days of submitting its ACR proposal. With respect to current enrollees, the organization is eligible for the exception to the rule in § 422.206(a)(1) if it provides notice within 90 days after adopting the policy at issue; however, under § 422.111(d), notice of such a change must be provided in advance.

7. Physician Incentive Plans (§§ 422.208 and 422.210)

Consistent with section 1852(j)(4), regulations at §§ 422.208 and 422.210 outline the limitations on the operation of physician incentive plans. The provisions in this section are the same as those previously included in § 417.479 with some reduction in the amount of data that must be disclosed by the organization. HCFA has determined that the capitated data is no longer required because other sources of data, such as encounter data required by the Act and the National Data Reporting Requirements (NDRR) are available. The provisions are consistent with the provisions under section 1852(j)(4) which prohibit specific payments as a disincentive to provide services to an individual enrollee and which place limits on the transfer of substantial financial risk for referral services to physicians or physician groups contracting with the M+C organization. The provisions in these sections apply to all coordinated care and network MSA plans. M+C private fee-for-service plans are prohibited from having a physician incentive plan because they may not place their providers at financial risk. The physician incentive plans regulations require that M+C organizations conduct customer satisfaction surveys of both enrollees and disenrollees if any physician or physician group in an M+C organization's network is placed at substantial risk for referral services as defined in § 422.208. (Please note that there are at least two other uses of the term ''substantial financial risk'' contained in legislation or regulation. Specifically, section 216 of the Health Insurance Portability and Accountability Act of 1996 addressing safe harbors from the anti-kickback statute and the determination of substantial financial risk related to PSOs (63 FR 18124, April 14, 1998)) M+C organizations may satisfy their requirement for enrollee surveys either by their mandated inclusion in HCFA's national administration of the Consumer Assessments of Health Plans Study (CAHPS) or, if the organization is excluded from CAHPS due to not having contracted with us for at least one year, by conducting their own surveys.

8. Limitation on Provider Indemnification (§ 422.212)

Section 422.212 prohibits an M+C organization from having a provider, or group of providers, indemnify the organization against any liability arising from the organization's denial of medically necessary care. This prohibition is a very narrow exception for a civil action brought by, or on behalf of, an enrollee where the damage is due to a determination by the M+C organization to deny medically necessary care. The regulation includes the statutory language from section 1852(j)(5) without elaboration.

9. Special Rules for Services Provided by Noncontract Providers (§ 422.214)

Consistent with section 1852(k) and section 4002(e), the regulations in § 422.214 require any health care provider that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan to accept as payment in full, the amounts that could have been collected if the beneficiary were enrolled in original Medicare. An M+C organization (other than an M+C MSA plan) satisfies its liability for Medicare covered services if the provider receives the total amount that would have been received if the beneficiary were enrolled in original Medicare. This amount equals the total of Medicare's payment (including any applicable deductible and coinsurance amounts) and any balance billing amount that would have been allowed by original Medicare. In the case of a participating physician or supplier, this amount would equal the Medicare fee schedule amount for the service. For a nonparticipating physician, this amount would equal 115 percent of the fee schedule amount for nonparticipating physicians (which is 95 percent of the fee schedule amount applicable to participating physicians). Of these amounts, the provider could collect from the M+C plan enrollee the cost sharing amount required under the M+C plan, as approved by HCFA under subpart G of part 422 and the remainder from the M+C organization.

Section 1866(a)(1)(O) places a limitation on what a provider of services (as defined in section 1861(u)) must accept as payment in full for services furnished to an M+C plan enrollee. The limit is applicable to those institutional type providers of service that do not have in effect a contract with the M+C organization establishing payment amounts for services furnished to an enrollee. The limitation equals the amount that would have been payable for a beneficiary enrolled in original Medicare less any payments that could be collected directly from Medicare representing graduate medical education (both direct and indirect).

10. Special Rules for M+C Private Fee-for-Service Plans

Special rules for M+C private fee-for-service plans are discussed in section IV of this preamble.

11. Exclusion of Services Furnished Under a Private Contract (§ 422.220)

Section 422.220 prohibits an M+C organization offering an M+C plan from paying for services furnished to an

enrollee by a physician or other health care professional who has signed a private contract as described in section 1802(b). Section 4507 of the BBA specifies that nothing in title XVIII of the Act shall prohibit a physician or practitioner from privately contracting with a beneficiary to furnish services for which no claim shall be submitted to Medicare and no Medicare payment shall be made directly or indirectly or by any organization paid by Medicare where the physician or practitioner has opted out of Medicare for 2 years. Therefore, no payment may be made by an M+C organization for services furnished to Medicare enrollees by a physician or practitioner who opts out of Medicare where he or she has signed a private contract with an enrollee. There is one exception: the physician or practitioner who has opted out of Medicare may not ask a beneficiary who requires emergency or urgent care to sign a private contract. Therefore, where a physician or practitioner who has opted out of Medicare provides emergency or urgent care to an enrollee of an M+C organization, the organization must pay for the emergency or urgent care the enrollee required. For purposes of this provision, we consider ''urgent care'' to mean urgently needed services as defined in § 422.2.

12. M+C Plans and the Physician Referral Prohibition

One other item that relates to M+C organizations but is not contained within the part 422 regulations is the physician referral prohibition.

a. *The prepaid health plan exception:* Under section 1877, if a physician or a member of a physician's immediate family has a financial relationship with a health care entity (through an ownership interest or a compensation relationship), the physician may not refer Medicare patients to that entity for any of 11 designated health services, unless an exception applies. Under an exception in section 1877(b)(3), the prohibition on referrals does not apply to services furnished by certain prepaid health plans. To qualify for the exception, the services must be furnished by one of the following organizations to its enrollees:

- Organizations with a contract under section 1876, which authorizes us to enter into contracts with HMOs and competitive medical plans (CMPs) to furnish covered items and services on a risk-sharing or reasonable cost basis.
- Organizations with health care prepayment plans, as described in section 1833(a)(1)(A), which authorizes payment for Medicare Part B services to prepaid health plans on a reasonable cost basis.
- Organizations receiving payments on a prepaid basis under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or section 222(a) of the Social Security Amendments of 1972.
- Qualified health maintenance organizations, within the meaning of section 1310(d) of the Public Health Service Act.

As discussed in section I. of this preamble, beginning in January 1999, the new M+C program replaces the HMO and CMP risk contracting program provided for in section 1876.

In enacting the BBA, Congress failed to revise section 1877(b)(3) to except the services furnished under M+C coordinated care plans. We believe that this must have been an oversight, since Congress expressed no intention in the legislative history for the BBA of subjecting existing managed care entities to the self-referral law. In addition, subjecting physicians who have an ownership interest in an M+C organization offering a coordinated care plan in which the physicians participate, to the self-referral rules would be contradictory to Congress' purposes in establishing PSOs as coordinated care plans. PSOs are defined in the BBA provisions as entities that must be organized and operated by a provider (which may be a physician) or a group of affiliated health care providers (which may include physicians). These providers must share a substantial financial risk for the provision of items and services and have at least a majority financial interest in the entity. The self-referral provisions, on the other hand, are specifically designed to discourage physician ownership of entities that provide a broad range of services to Medicare beneficiaries.

b. *No risk of program or patient abuse exception—Coordinated Care Plans:* Although there is no statutory exception for services furnished under coordinated care plans, section 1877(b)(4) allows us to create an exception to the referral prohibition for a financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse. An example of program abuse is Medicare payment for unnecessary services. We will pay M+C organizations for enrollees in coordinated care plans on a capitated basis and beneficiaries will be responsible for premiums and cost sharing. Section 1854 limits HCFA's capitation amount and the total amount of beneficiary premiums and cost-sharing. Because M+C organizations offering coordinated care plans will not be paid for each additional service they provide, we believe that there is no risk of over-utilization of services. Because HCFA's capitation amount and the total amount of beneficiary premiums and cost sharing is limited, we believe that there is no risk of program or patient abuse.

Therefore, we are excluding from the physician referral prohibition services furnished under a coordinated care plan to an enrollee. This exception applies in all cases in which a physician has an ownership interest in or a compensation relationship with the M+C organization offering the coordinated care plan. We are making a change in the regulation text at § 411.355(c)(5).

c. *No risk of program or patient abuse exception—M+C MSA Plans:* M+C organizations offering an M+C MSA plan are paid a fixed capitation amount for beneficiaries enrolled in the plan, and section 1853(a) limits HCFA's capitation amount and section 1859(a)(3)(A) limits the amount that M+C organizations under M+C MSA plans will pay entities for furnishing covered services. Section 1859(a)(3)(B) limits the annual deductible amount. However, the Act does not similarly limit the amount that a beneficiary will have to pay as premiums and costsharing; that is, there is no limit on beneficiary balance billing by the entities that furnish health care services. *See* section IV. below. Thus, although there is no risk of program abuse, there is a risk of patient abuse. Therefore, we are not excluding from the physician referral prohibition services furnished under an M+C MSA.

d. *No risk of program or patient abuse exception—Private fee-for-service plans:* Section 1853(a) also limits HCFA's capitation amount to be paid to M+C organizations under private fee-for-service-plans. Because there will not be excessive payments by the Medicare program, there is no risk of program abuse. However, section 1859(b)(2)(A) provides that the plans will pay an individual or entity furnishing services on a fee-for-service basis. Since beneficiaries are responsible for coinsurance amounts, copayments, and balance billing amounts under private fee-for-service plans (*see* section IV. of this preamble), beneficiaries are subject to added out-of-pocket liability if physicians providing services under a fee-for-service plan order additional unneeded services in order to obtain additional fee-for-service payments from the M+C organization offering the private fee-for-service plan. Thus,

although there is no risk of program abuse in this case, excessive Medicare payment, there is a risk of patient abuse. Therefore, we are not excluding from the physician referral prohibition services furnished under a private fee-for-service plan.

F. Payments to M+C Organizations

1. General Provisions (§ 422.250)

Subpart F of part 422 sets forth rules that govern Medicare payment to M+C organizations, including the methodology used to calculate M+C capitation rates. These rules also apply for 1998 under section 1876 risk contracts.

Payments and Adjustments: We provide in § 422.250(a)(1) that, with the exception of payments under M+C MSA plans and payments for ESRD enrollees in all other plans, which we discuss below, we will pay M+C organizations for each enrollee in an M+C plan they offer, a monthly payment that is equal to 1/12th of the county-wide (or, in the case of ESRD enrollees, 1/12th of the State rate) ''capitation rate'' under § 422.252 that applies for the county in which the enrollee lives, adjusted by demographic factors applicable to that enrollee. Effective January 1, 2000, however, section 1853(a)(3)(C) directs us to implement a risk adjustment methodology that accounts for variation in per capita cost based on health status and demographic factors. Implementation of health status risk adjusters has implications for M+C plan data submissions, and we discuss this issue further below.

In addition to health status and demographic risk adjustments, we make an adjustment, under § 422.250(a)(2)(i)(A), to the payment rate for M+C enrollees with end-stage renal disease (ESRD). Under § 422.250(a)(2)(i)(B), we make an adjustment that is the equivalent to a 50 cent reduction for each renal dialysis treatment that we will use to help pay for the ESRD network program in the same manner as other reductions are used in original Medicare. Finally, under § 422.250(b), we provide for making retroactive adjustments to the aggregate monthly payment to an M+C organization to reflect any difference between the actual number of enrollees and the number upon which we had based the organization's advance monthly payment.

Under § 422.250(a)(2)(ii) for M+C MSA plan enrollees, we make a monthly payment to the M+C organization as described above less the amount (if any) identified in § 422.262(c)(1)(ii) to be deposited in the M+C MSA. In addition, we deposit in the M+C MSA the lump sum amounts (if any) determined in accordance with § 422.262(c). See section III. below for a more complete discussion of payments under M+C MSA plans.

In § 422.250(a)(2)(iii), we provide for adjustments to be made to payments under RFB plans (which are limited to members of a religious and fraternal benefit plan) to ensure that the payment level is appropriate for the actuarial characteristics and experience of [RFB plan] enrollees.

Payment Areas: In § 422.250(c)(1), we reflect the general rule, under section 1853(d) of the Act, that the M+C payment area is a county or equivalent area specified by HCFA. Under § 422.250(c)(2), in the case of beneficiaries with ESRD, the payment area is the State or equivalent area we specify. Additionally, in a significant change to payment area policy from the section 1876 program, section 1853(d)(3) permits Governors of States to request that we approve alternative geographic areas for payment rates. These alternatives are either a single State-wide M+C payment area or a metropolitan-based system in which all nonmetropolitan areas within the State constitute a single payment area, and any of the following constitutes a separate M+C payment area:

- All portions of each single metropolitan statistical area within the State.
- All portions of each primary metropolitan statistical area within each consolidated metropolitan statistical area within the State.
- A consolidation of noncontiguous counties.

Section 1853(d)(3) directs us to approve a Governor's request; however, this section of the Act also directs us to subject these requests to a budget neutrality requirement, and any payment for alternative geographic areas cannot exceed the aggregate payments for that State absent the adjustment. Additionally, the Governor's request must be submitted to us no later than February 1 of the year preceding the contract year. This provision is implemented in § 422.250(e).

2. Annual Capitation Rates (§ 422.252)

Among the more significant payment changes in section 1853 is the incremental separation of capitated Medicare payments from local fee-for-service rates. Previously, Medicare had paid risk contractors according to the Adjusted Average Per Capita Cost (AAPCC) payment methodology. The AAPCC was based on Medicare fee-for-service expenditures by county and was used to pay risk contractors through December 31, 1997. These fee-for-service expenditures were adjusted for demographic factors (that is, age; sex; institutional, welfare, and employment status).

The AAPCC had been legitimately criticized for its wide range of payment rates among geographic regions—in some cases it varied by over 20 percent between adjacent counties. It was also criticized for its poor risk adjustment capabilities and inappropriate provision of graduate medical education funds to some Medicare risk plans. Moreover, the AAPCC was criticized for setting erratic annual payment updates, which often made it difficult for contracting health plans to engage in long-term business planning. The BBA introduces a new payment methodology that addresses these and other concerns, and we discuss them in detail below.

''Greater of'' Payment Rate: Since January 1, 1998, Medicare capitation rates paid to section 1876 risk contractors for each calendar year have been the greater of a blended capitation rate, a minimum amount rate, or a minimum percentage increase. This same methodology will apply to payments under M+C contracts.

- The blended capitation rate is a blend of the area-specific (local) rate and the national rate, with the latter adjusted for input prices. The blended capitation rate is then adjusted by a budget neutrality factor.
- The minimum amount rate will equal $367 per month per enrollee in 1998 for all areas in the 50 States and the District of Columbia. Outside the 50 States and the District of Columbia, the rate is not to exceed 150 percent of the 1997 AAPCC for those areas. The minimum amount rate will be adjusted each year using the update factors described below. (On an individual basis, our monthly payment may be more or less than the minimum amount due to the demographic or other risk factors applicable to that individual used to adjust the minimum amount rate.)
- The minimum percentage increase is 2 percent. The minimum percentage increase rate for 1998 is 102 percent of the 1997 AAPCC. Thereafter, it is 102 percent of the prior year's rate.

3. Calculation and Adjustment Factors (§ 422.254)

Blend of Area-Specific and National Percentages: The 1997 AAPCC capitation rates serve as the base for both the area-specific rates in the blend and the minimum percentage increase rates. Section 1853(c)(2) stipulates that the blended area-specific/national rate

(discussed further below) will be implemented over a 6 year transition period from 1998 through 2002 according to the following schedule:

- 90 percent area-specific/10 percent national in 1998
- 82 percent area-specific/18 percent national in 1999
- 74 percent area-specific/26 percent national in 2000
- 66 percent area-specific/34 percent national in 2001
- 58 percent area-specific/42 percent national in 2002
- 50 percent area-specific/50 percent national in 2003 and thereafter.

Section 1853(c)(6) also provides for a ''national per capita M+C growth percentage.'' Each year, from 1998 through 2002, this national growth percentage is applied to the national and local components of the blended rate and to the floor rate (discussed below). The national per capita growth percentage is HCFA's projection of per capita expenses, reduced by the following amounts established in section 1853(c)(6): 0.8 percentage points in 1998 and 0.5 percentage points each year from 1999 through 2002. After 2002, the reduction amount is zero. This provision is implemented in § 422.254(d).

As indicated above, the blended rates are adjusted by a budget neutrality factor. Section 1853(c)(5) provides for a ''budget neutrality'' adjustment to the blended capitation rate under § 422.252(a), designed to ensure that the aggregate amount paid under the M+C payment methodology equals the amount that would have been paid if payments were based entirely on area-specific rates (as they were under section 1876(a)). The statute requires that this budget neutrality adjustment apply only to the blended capitation rate under § 422.252(a), rather than to the final capitation rate under § 422.252. Since the capitation rate is based upon the *highest* of the blended capitation rate, the minimum payment, and the prior year's payment plus 2 percent, the budget neutrality adjustment cannot produce any further savings once the blended capitation rate is reduced to the point where it is lower than the other two amounts in every county. This is what happened for 1998 and 1999. For these years, the budget neutrality adjustment reduced the blended rate to the point where no county's payment rate is based upon the blended rate, since one of the two other rates is higher in every county. Yet, even with this reduction, the goal of the budget neutrality provision in section 1853(c)(5) was not met for 1998 and 1999. We are considering seeking a statutory change to address this problem.

Area-Specific Component of the Blended Capitation Rate: Above we discussed the relationship between area-specific and national rates and how they are intended to develop into a 50/50 balance by the year 2003. Here we discuss features of the area-specific (local) rate and, directly below, features of the national rate.

In 1998, the base for the area-specific rate is the 1997 AAPCC, adjusted for 20 percent of the indirect medical education/direct graduate medical education (GME) carve-out. This is a significant change to payment policy under section 1876 Medicare ''risk'' contracts. In accordance with section 1853(c)(3)(B), under § 422.254(e)(2), we will remove all graduate medical education payments in the base rate between 1998 and 2002 on the following schedule: 20 percent in 1998; 40 percent in 1999; 60 percent in 2000; 80 percent in 2001; and 100 percent in 2002 and thereafter. These GME funds will be removed from the area-specific portion of the blended rate. Since the national portion of the blend is computed based on the adjusted local rates, it also reflects removal of these GME funds. Teaching hospitals will be paid directly for the GME costs associated with Medicare managed care enrollees under § 412.322.

Additionally, pursuant to section 1853(c)(3)(C)(ii), in § 422.254(e)(3), to the extent we estimate that the 1997 per capita base rate reflects payments to State hospitals under section 1814(b)(3), we will make appropriate adjustments to the M+C payment rate. Payments are made to hospitals located in Maryland under this provision.

Finally, pursuant to section 1853(c)(3)(D), in § 422.254(e)(4), we provide that HCFA may substitute a rate for the 1997 capitation rate a rate that is more representative of the costs of the enrollees in the area if the 1997 rate varied by more than 20 percent from the 1996 rate.

National Component of the Blended Capitation Rate: The national component of the blended capitation rate has two major features: (1) the national standardized annual capitation rate; and (2) the national input-price-adjusted capitation rate.

The national standardized annual capitation rate is a weighted average of all area-specific rates adjusted for risk factor weights used to calculate payments as though all eligible individuals were members of an M+C plan. The calculation for the national standardized annual capitation rate is described at § 422.254(f).

The input-price-adjusted annual national capitation rate is adjusted for geographic variation in the prices of goods and services used to produce medical services and is the sum of the products of three amounts:

- The national standardized annual capitation rate for the year, which consists of the weighted average of all area-specific capitation rates.
- The proportion of the rate that is attributable to each type of service.
- An index that reflects (for that year and that type of service) the relative input price of services in the area, as compared to the national average input price for these services.

The input-price-adjusted annual national capitation rate is described in § 422.254(g).

4. Adjustments to Capitation Rates and Aggregate Payments (§ 422.256)

Beginning with 1999 payment rates, we will adjust all area-specific and national capitation rates (and beginning with the 2000 payment rates, the minimum amount rate) for the previous year to reflect any differences between the projected national per capita growth percentages and the current estimates of those percentages.

We will also adjust for national coverage determinations (NCD) that were significant cost as defined in § 422.109 and defined above. An NCD is a national policy statement regarding the coverage status of a specified service that we make under administrative authority and publish in the **Federal Register** as a notice of HCFA Ruling. (The term does not include coverage changes mandated by statute.)

If we determine that the cost of furnishing a service subject to an NCD is ''significant,'' we will adjust capitation rates for the next calendar year to take into account the cost of that service. Until the new capitation rates are in effect, the M+C organization would be paid through original Medicare for the provision of such services.

Risk Adjustment: Section 1853(a)(3) requires us to develop and submit to the Congress, by March 1, 1999, a report on a proposed method of risk adjustment of M+C payment rates. We are also required to implement a risk-adjustment methodology for payment periods beginning on or after January 1, 2000. We provide for such risk adjustment in § 422.256(d). Under the previous payment methodology, the AAPCC, we used a demographic risk adjuster that has been criticized as an inadequate predictor of health care costs.

Nonetheless, until the new risk adjustment methodology is implemented in 2000, we will be using the same demographic adjusters used under the AAPCC method to make demographic adjustments under § 422.256(c) to the capitation rate determined under § 422.252. Section 1853(a)(3)(C) specifically directs HCFA to implement health-status based risk adjusters, as well as ''other demographic factors.'' Section 1853(a)(3)(D) requires that, with the exception of enrollees in M+C RFB plans, the same risk adjustment methodology be used for all enrollees in M+C plans, regardless of plan type. The implementation of health-status based risk adjusters has major implications for M+C organizations' data requirements, as discussed directly below.

5. Encounter Data (§ 422.257)

Section 1853(a)(3)(B) addresses the collection of encounter data from M+C organizations needed to implement the risk adjustment methodology. The Act requires that the collection of inpatient hospital data for discharges beginning on or after July 1, 1997 and allows the collection of other data no earlier than July 1, 1998. The statutory language is tied to the creation of risk-adjusted payment rates, as defined at § 422.256(c) and (d) of this rule. Requirements concerning collection of encounter data apply to M+C organizations with respect to all their M+C plans, including and private fee-for-service plans.

There are two different ways encounter data are used for risk-adjustment purposes. To calculate payment rates, encounter data are necessary to tie payment to expected patient resource use using diagnosis codes. The initial risk-adjusted payment will be based on inpatient hospital encounter data. However, use of an inpatient-based system in the long run has two major weaknesses: (1) It provides M+C organizations with an incentive to hospitalize their enrollees in order to receive additional payment; and (2) a risk-adjustor system based only on inpatient hospital diagnosis codes will not allow more accurate payment for the chronically-ill-but-not-hospitalized. For both of these reasons, we have developed a more comprehensive risk-adjustment methodology that uses diagnosis data from physician services and hospital outpatient department encounters. In addition, physician services data include data from limited license practitioners, such as clinical psychologists and nurse midwives who provide services independently, but do not include nonprofessional services ordered by physicians as a result of the initial physician services furnished, such as laboratory services and durable medical equipment.

Encounter data are also necessary to ''recalibrate'' any risk-adjusted payment model. Recalibration is necessary to adjust the payment models for improved coding. For example, upcoding may occur if plans improve coding of beneficiary diagnoses and, as a result, the average use of resources for enrollees in a particular category may be less than when the relative payment rates were determined. When this happens, the average actual expenditures per enrollee for these diagnoses are less than the average expenditures used to assign the original payment weights. The result is overpayment for some diagnoses in the risk adjustment model. To account for possible coding changes, all risk adjustor payment model diagnosis weights would be recalculated, or ''recalibrated'' based on encounter data gathered after implementation of risk adjustment. A preferred method for full recalibration requires that all services provided to each M+C plan enrollee be priced and the total cost of care determined for each enrollee. This approach would require that organizations submit encounter data for all services provided to each enrollee. An alternative approach would require the organizations to submit to HCFA the cost of providing medical care for each Medicare enrollee, but organizations might oppose such a requirement as too intrusive.

While the purpose of collecting the encounter data will be to calculate risk-adjusted payments, there are a wide variety of other uses of whatever data we collect. Quality improvement targets can be identified using encounter data. Our ability to monitor the care received by M+C enrollees through targeted special studies (such as an examination of post-acute care utilization patterns) will be greatly enhanced by the availability of encounter data. Encounter data will also be useful for program integrity functions, both by providing additional utilization norms for original Medicare billing and by providing additional information regarding M+C organizations' behavior.

Timing of Encounter Data Collection: The first issue to address with regard to data collection is the ability of the organizations to generate the necessary data and to ensure accurate transmission. While some organizations will be able to transmit encounter data quickly and with little difficulty, others will be further behind in their internal information systems development. To the extent that organizations have capitated arrangements with their providers, they may not currently require encounter-type data from those providers. The ability to generate encounter data may well vary by type of service provided as well as by type of organization submitting the data. All organizations will have to conform to the HIPAA information system standards regarding encounter data formats by 24 months (36 months for small organizations) after the effective date of the final rule (currently estimated to be published in the fall of 1998), so the main issues with regard to the organizations should be transition issues rather than long run implementation issues.

HCFA has issued instructions delineating a specific timetable for M+C organizations to submit inpatient hospital data. M+C organizations will be required to select a fiscal intermediary designated by HCFA to transmit data.

Given any start date, comprehensive risk-adjusted payments will be made about 3 years after the year of the initial collection of outpatient hospital and physician encounter data. Similarly, recalibration of the risk-adjusted payments to reflect managed care practice patterns could occur about 3 years after the complete data are collected. In order to minimize the period for which payments are determined based on inpatient hospital data only, we will provide advance notice to M+C organizations to collect and submit physician, outpatient hospital, SNF, and HHA data beginning no earlier than October 1, 1999; and all other data HCFA deems necessary beginning no earlier than October 1, 2000.

Because M+C organization payments will depend on the data transmitted and because M+C organizations are the entities with which HCFA contracts, we will hold the M+C organization responsible for transmission of the data. If the M+C organization is held responsible, it follows that they should transmit the data directly, rather than monitoring the transmission by their providers. We will allow organizations to hire third party data transmitters, but the M+C organization will be responsible for the accuracy and completeness of the data transmitted.

Data Format: The format of the data we will require will be identical to the data we require of original Medicare providers of similar services, because pricing of the data using original Medicare's methods is necessary for recalibration. The data will be processed using designated HCFA contractors. Providers are familiar with the HCFA

1500 (or its electronic equivalent) and the electronic UB–92 (or other electronic equivalent) through their original Medicare billings. In addition, organizations will have mechanisms in place to receive UB–92 data from hospitals and send it to fiscal intermediaries by July 1, 1998, because of the requirements for submission of inpatient encounter data. It would clearly be beneficial to all parties to use the UB–92 and this transmission format for any other required data that is currently submitted on the UB–92 in original Medicare. There are no current organization-to-carrier links for data HCFA currently processes on the electronic version of the HCFA 1500. From the provider, contractor, and HCFA point of view, it is clear that use of the electronic version of the HCFA 1500 would minimize any data collection burden.

Data Accuracy: Audit of the data will be necessary to ensure accuracy; any audit efforts will include medical record review for a portion of the submitted data. Statistical analysis (for example, examination of hospitalization rates for various organizations and inquiry into outliers) will be combined with traditional audit methods in order to maximize our examination of the data while managing the amount of contractor resources used for audit.

6. Announcement of Annual Capitation Rates and Methodology Changes (§ 422.258)

Previously, under section 1876, we were required to announce Medicare risk contractor payment rates by the first week in September, no later than 45 days after publishing for comment our mid-July announcement of payment methodology changes. This schedule was designed to allow HMOs and CMPs time to consider the coming year's payment rates, decide about their continued participation in the Medicare program, calculate their Adjusted Community Rate (ACR) proposal, and, finally, afford us the time to approve or disapprove the ACR proposal prior to the January 1 contract effective date.

Under section 1853(b)(1), starting in 1998, we must announce rates by March 1 of the year prior to the year the rates apply. We must include in this announcement a description of the risk and other factors and explain the methodology in sufficient detail to enable M+C organizations to compute monthly adjusted capitation rates for individuals in each of their payment areas.

The March 1 announcement will ensure that subsequent events can occur to meet the November annual coordinated election period stipulated in section 1851(e)(3). As under prior law, 45 days prior to announcing payment rates on March 1, section 1853(b)(2) requires us to provide notice of changes in the methodology and assumptions used in the previous year.

7. Special Rules for Beneficiaries Enrolled in M+C MSA Plans (§ 422.262)

The BBA establishes special rules for beneficiaries enrolled in M+C MSA plans, and we discuss them in detail under section III. below.

8. Special Rules for Coverage That Begins or Ends During an Inpatient Hospital Stay (§ 422.264)

The BBA contains special payment rules for situations where an M+C enrollee's coverage begins or ends while the Medicare beneficiary is a hospital inpatient. Section 1853(g) provides that, where a beneficiary is receiving inpatient hospital services from a hospital covered under original Medicare's prospective payment system (PPS) or another M+C organization on the effective date his or her M+C election of a new M+C plan, payment for inpatient services (up until the date of discharge) would continue to be the responsibility of the original Medicare program or previous M+C organization. The M+C organization offering the newly elected M+C plan would not be responsible for inpatient hospital service payment until the date of discharge, and original Medicare or the previous M+C organization would pay the full amount for that beneficiary for that inpatient episode, even if it extends beyond the effective date of a beneficiary's M+C election.

In the case of a beneficiary's M+C plan election ending while he or she is a hospital inpatient, the M+C organization remains responsible for payment for inpatient hospital services furnished by a hospital after expiration of enrollment up until the date of discharge. Payment for these services would not be made under Medicare's PPS system, and the responsible M+C organization would not receive any payment from us for the hospitalized individual during the period the individual was not enrolled.

9. Special Rules for Hospice Care (§ 422.266)

Section 1853(h) of the BBA contains special provisions for Medicare beneficiaries who elect hospice care concurrent with their enrollment in an M+C organization. Specifically, an M+C organization must inform each Medicare enrollee eligible to elect hospice care under section 1812(d)(1) about Medicare hospice programs within the M+C plan's service area. If it is common practice to refer patients to hospice areas outside the service area, the organization must inform the M+C enrollee of that as well. This information must be provided to beneficiaries in a manner that objectively presents all available hospice providers, including a statement of any ownership interest held by the M+C organization or a related entity. If the M+C organization has an ownership or other financial interest in one or more of the available hospice providers, M+C plan enrollees cannot be required to use that hospice provider.

BBA payment provisions for hospice care state that our monthly payment to the M+C organization will be reduced to an amount equal to the adjusted excess amount in the M+C plan's approved ACR. Beyond the adjusted excess amount, we pay through original Medicare for hospice care furnished to the M+C plan enrollee. We also pay through original Medicare (to the M+C organization), for other Medicare-covered services furnished to the hospice patient.

Unless the individual disenrolls from the M+C plan, an M+C enrollee electing hospice continues his or her enrollment in the plan and is entitled to receive through the plan any benefits, other than those that are the responsibility of the Medicare hospice.

10. Source of Payment (§ 422.268)

As under the section 1876 risk program, we will determine which proportion of payments to M+C organizations comes from the Hospital Insurance Trust Fund (Part A) and which proportion of payments comes from the Supplementary Medical Insurance Trust Fund (Part B). We determine these proportions based on the actuarial value of total benefits under both parts.

G. Premiums and Cost-Sharing

Subpart G of part 422 details provisions found in section 1854 for the M+C program. In this subpart we discuss how limits on M+C plan enrollee premiums and other cost sharing are established through the ACR approval process. The ACR process is applicable to all M+C plans except M+C MSA plans. M+C MSA plans are not required to submit an ACR, but other information must be submitted for HCFA's review (see discussion below). We discuss limitations that the process imposes on other cost-sharing that M+C organizations may impose on Medicare enrollees for the M+C plan they elect.

Note that there are a number of terms pertinent to the following discussion, and they are defined in § 422.302 of this rule. ACR and APR are terms that were used under section 1876 risk program. Section 1854(b) discusses the definition of the terms relating to beneficiary premiums. The term additional revenues is discussed in detail in section 5 below.

As under the section 1876 risk program, the ACR process under the BBA serves three important purposes. First, HCFA examines an M+C organization's ACR proposal for each M+C plan to determine whether Medicare payments in excess of the amount the organization would charge commercially for Medicare-covered benefits are passed on to beneficiaries in the form of added additional benefits. Second, we review ACR proposals to determine whether the structure of premiums, deductibles, copayment, and coinsurance charged to beneficiaries are within the limits established by law as required under section 1854(f)(1)(A). Third, benefit package information is reviewed to determine whether the benefit package is in compliance with the principles contained in subpart C.

We have taken into account that the M+C program is a significant departure from the section 1876 risk contracting program it replaces. Therefore, we are allowing a special period during which organizations will be able to add benefits (at no additional cost to the M+C plan enrollee) or lower premiums or cost-sharing mid-year. We also are providing for the submission of ACRs on a date other than May 1 if a contract will begin on a date other than January 1. The transition rules for this period are found in § 422.300(b). This special period will end on December 31, 2001.

1. Rules Governing Premiums (§ 422.304)

This section of the regulation implements provisions of the BBA relating to premiums paid by (or behalf of) beneficiaries. Each Medicare enrollee must be afforded the opportunity to pay the M+C plan premium on a monthly basis and, as under the section 1876 risk program, pursuant to Section 1128B(b) of the Act, the M+C organization may not provide for cash or other financial rebate as an inducement for enrollment (or for any other reason).

As discussed in above, section 1852(a)(1) requires an M+C organization to include in its M+C plan all services covered under original Medicare (except hospice care) that are available to Medicare beneficiaries in the area in which services are covered under the M+C plan. In addition, additional benefits must be provided to all enrollees electing the M+C plan (see section 1854(f)(1)). Section 1852(a)(3) allows an M+C organization to add supplemental benefits to the M+C plan either at the M+C organization's discretion (with our approval) or at the enrollee's election. For these benefits offered through a coordinated care plan, section 1854(e) does not allow the M+C organization in total, for the year, to impose a total average cost to the beneficiary, with an actuarial value greater than the actuarial value of original Medicare's deductibles and coinsurance for items and services covered by original Medicare plus the actuarial value approved through the ACR process for supplemental services. For M+C PFFS and M+C MSA plans, see discussion below.

Section 1854(c) provides that M+C basic and supplemental beneficiary premiums and M+C MSA premiums may not vary among individuals enrolled in the plan. This means that all enrollees in a given M+C plan must be charged the same premium amount for basic benefits and for any supplemental benefits the M+C organization may choose to offer. In the case of coordinated care plans, this uniform premium counts toward an overall limit on the actuarial value of beneficiary liability in section 1854(e) (discussed further below). Thus, in the case of coordinated care plans, the actuarial value of any cost-sharing imposed under the plan would also be uniform, since a uniform premium would be subtracted from a uniform overall limit to determine the amount that can be charged in cost-sharing.

We believe that section 1854(c) reflects congressional intent that all beneficiaries enrolled under a particular M+C plan pay the same amount. While cost-sharing amounts are not expressly mentioned, in the case of coordinated care plans, there is a uniform limit on the actuarial value of cost-sharing. Accordingly, pursuant to our authority in section 1856(b)(1) to establish M+C standards, we are providing in § 422.304(b) that M+C organizations may not vary the level of copayments, coinsurance, or deductibles charged for basic benefits or supplemental benefits among individuals enrolled in an M+C plan.

2. Submission of Proposed Premiums and Related Information (§ 422.306)

Section 1854(a) requires each M+C organization to submit no later than May 1 information about the M+C plan the organization wants to offer in the subsequent year. As under the Medicare section 1876 risk program, except in the case of M+C MSA plans, such information includes a complete description of the services included in the M+C plan, ACR and service area information, premium amounts, and descriptions of enrollee cost sharing. For M+C MSA plans, organizations have to submit the MSA premium that is used to determine the MSA deposit. No ACRs are required for M+C MSA plans. Pursuant to our authority in section 1856(b)(1), we have added a new requirement that M+C organizations also submit information on amounts collected in the previous contract period for basic benefits. We have done this to assure Medicare enrollees are not being charged cost-sharing that exceeds the limits in section 1854(e)(see § 422.308).

Section 422.306(a) reflects the requirement in section 1854(a)(1) that the information in paragraphs (b), (c), and (d) of § 422.306 be submitted by May 1 of the year prior to the year for which the information is submitted. This information is needed timely in order for HCFA to comply with the requirement in subpart B that comparative information on M+C plans be provided to Medicare enrollees. As noted above, during the transition period prior to 2002 provided for in § 422.300(b), M+C organizations may be permitted, at HCFA's discretion, to submit applications and ACR information on a flow basis and as discussed in section K below, under § 422.504(d) contracts could begin on a date other than January 1. In such a case, benefit package and pricing structures must be approved before the contract can take effect. Beginning with the 2002 calendar year, however, anyone wishing to offer an M+C plan in that year *must* submit an ACR by May 1 of the previous year (May 1, 2001 in the case of 2002).

If the information submitted is not complete, accurate, or timely, HCFA has the authority to impose sanctions under subpart O or may choose not to renew the contract.

We will review and approve all information submitted except for any amounts submitted by M+C MSA plans and premiums submitted by M+C private fee-for-service plans. Premiums and cost sharing will be reviewed in accordance with the rules established in § 422.310. Benefits offered under the M+C plan will reviewed in accordance with the rules established in Subpart C.

3. Limits on Premiums and Cost-Sharing Amounts (§ 422.308)

The rules in this section set the limits on the amount an M+C organization may charge a Medicare enrollee of an M+C plan. Section 1854(b) specifies that

the premium that a beneficiary is charged under an M+C plan other than an M+C MSA plan is the M+C monthly basic premium, plus any M+C supplemental premium. In the case of an M+C MSA plan, the beneficiary is charged only any M+C supplemental premium that may apply. The limits of Medicare enrollee liability are:

- For M+C basic benefits (Medicare covered services and additional benefits) offered by coordinated care plans: 12 times the basic monthly premium, plus the actuarial value of plan cost-sharing (copayments, coinsurance, and deductibles) for the year, cannot exceed the actuarial value of original Medicare's deductibles and coinsurance for the year or, if less, the amount authorized to be charged in the ACR (see § 422.310).
- For M+C basic benefits (Medicare covered services and additional benefits) offered by M+C private fee-for-service plans: the actuarial value of plan cost sharing (copayments, coinsurance, and deductibles) for the year, cannot exceed the actuarial value of original Medicare's deductibles and coinsurance for the year or, if less, the amount authorized to be charged in the ACR (see § 422.310).
- For supplemental benefits offered by a coordinated care plan: 12 times the M+C monthly supplemental premium plus the actuarial value of plan cost sharing (copayments, coinsurance, and deductibles) cannot exceed the ACR for such benefit or, if less, the amount authorized to be charged in the ACR (see § 422.310).

It is possible for an M+C organization to have M+C plan enrollees that are entitled to Medicare Part B benefits only. Section 1876(k)(2) specifies that existing Part B enrollees under section 1876 risk contracts on December 31, 1998 may remain as enrollees of the organization in accordance with regulations under section 1856(b)(1) if the organization enters into an M+C contract on January 1, 1999. Pursuant to sections 1876(k)(2) and 1856(b)(1), this final rule provides for such continued Part B-only enrollment, and § 422.308 provides that the limit on enrollee charges is the same as the limit that applies to other enrollees, except that the limit is based only on the actuarial value of cost sharing paid under Part B of original Medicare.

Also pursuant to our authority in sections 1876(k)(2) and 1856(b)(1), in § 422.308(a)(3), we impose a limit on the liability of Part B-only enrollees for an M+C organization's coverage of services that would be covered by Medicare Part A if the enrollee had Part A coverage. Specifically, we provide that the premium and cost sharing charged for such coverage may not exceed the lesser of what Medicare would pay an M+C plan in capitation for the services, plus the actuarial value of Medicare Part A deductibles and coinsurance, or the ACR for such services.

The above-described limits on enrollee liability apply to enrollee costs incurred for services furnished by noncontracting providers as well as providers that contract with the M+C organization offering the M+C plan in which the beneficiary is enrolled. In the case of contracting providers, limits on enrollee liability would generally be delineated in the contract between the provider and the M+C organization. Also, in the case of most coordinated care plans (for example, HMOs), it could be assumed that most nonemergency services will be obtained through contract providers.

Thus, to the extent an M+C coordinated care plan provides for different cost sharing in the case of noncontracting providers, it is not difficult to estimate the percentage of services that will be obtained at that level of cost sharing, when making the overall projection of the actuarial value of the cost sharing structure. In the case of M+C private fee-for-service plans, it is less clear to what extent noncontracting providers will be used, and the information on actual cost sharing from the prior year will be particularly valuable in assessing the accuracy of actuarial projections by the M+C organization. We note that in all cases, beneficiary liability is limited to the cost sharing provided for under the plan in the case of noncontract provider services. While sections 1852(k) and 1866(a)(1)(O) require noncontracting providers to accept as payment in full the amounts that they would be required to accept under original Medicare, balance billing to the beneficiary may be permitted under original Medicare but it is not permitted under the M+C plan in question. The M+C organization must hold beneficiaries harmless against any such balance billing. *See* section IV. below for a discussion of this issue in connection with M+C private fee-for-service plans and section III in connection with M+C MSA plans.

4. Incorrect Collections of Premiums and Other Cost Sharing (§ 422.309)

This section contains procedures to be used in situations where an M+C organization collects more than the amount that is allowed to be charged to the Medicare enrollee. These procedures were developed using the rules previously applied under section 1876 and promulgated under our authority in section 1856(b)(1) to establish standards under Part C.

Section 1857(d) requires that at least ⅓ of the M+C organizations be audited for, among other things, data used in the submitted ACR and all charges to the M+C plan enrollee for benefits covered under the M+C plan. These audits may reveal that the M+C organization has been overcharging the M+C plan enrollees. Section 422.309 requires the M+C organization to refund these over collections through an adjustment to current and future premiums allowed to be charged across all M+C plan enrollees.

We note that in addition to the above requirements for refunding amounts incorrectly collected, an M+C organization that collects amounts in excess of those permitted is subject to intermediate sanctions and civil money penalties under subpart O. *See* section 422.752(a)(2) and discussion below in section II. O. of the preamble. Refunding amounts improperly collected, at a minimum, would be a prerequisite to the lifting of such sanctions.

5. ACR Approval Process (§ 422.310)

Section 1854 requires that an ACR proposal be submitted each year for each M+C coordinated care plan or M+C private fee-for-service plan, and that premiums be filed for MSA plans. Section 422.310 of this rule sets forth the rules M+C organizations must follow to determine the limits placed on an M+C plan's price structure (premiums, copayments, coinsurance, deductibles, etc.). Since this regulation was not published until after May 1, 1998, new requirements under this rule discussed below will apply to contract periods beginning on or after January 1, 2000. For contract periods beginning before January 1, 2000, M+C organizations shall use the rules promulgated in accordance with section 1876 for risk contractors to determine the limits placed on M+C plan's price structure.

Under the existing ACR process, a M+C organization must establish an initial rate for non-Medicare enrollees for each M+C plan offered. This rate is determined through a community rating method (defined in section 1308 of the Public Health Service Act) or an aggregate premium method. The initial rate is then modified by the relative difference in utilization characteristics of the Medicare population compared to the non-Medicare population included in the initial rate. Additional adjustments may be made with our agreement. Those M+C organizations that do not have a non-Medicare

population cannot establish an initial rate. These M+C organizations will be allowed to use an estimate of the ACR value for a service or services offered using generally accepted accounting principles. These estimated values will be treated as additional adjustments for our review.

The ACR computation places a limit on the beneficiary premiums and cost-sharing amounts of an M+C plan, and we will only approve the beneficiary premiums and cost-sharing amounts proposed by an M+C organization for a specific M+C plan if they do not exceed the ACR limits.

As noted above, § 422.310 contains new requirements for calculating ACRs that will require existing section 1876 contractors to change the methodology they have used to calculate their ACRs under section 1876. We recognize that section 1856(b)(2) provides that consistent with the requirements of Part C, standards established under Part C should be based on standards established under section 1876 to carry our analogous provisions of that section. The requirements in § 422.310 are based on, and fully consistent with, the existing section 1876 requirements in § 417.594. An M+C organization following the methodology set forth in § 422.310 would fully comply with the existing ACR provisions in § 417.594.

However, based upon our years of experience under the section 1876 program, we have determined that the language in § 417.594 permitted HMOs and CMPs to use methods for calculating their ACRs that produced ACRs that we do not believe accurately reflected the statutory standard implemented in that section. Indeed, the existing methodology has been criticized by the General Accounting Office and the Office of the Inspector General as inaccurate, and subject to modification by organizations. The existing methodology also did not provide for necessary adjustments (for example, based upon changes in utilization assumptions in anticipation of changes in cost sharing structures, or changes in Medicare coverage) that we provide for in § 422.310. Also, as discussed below, some of these changes accommodate the fact that some organizations do not maintain data used under the old methodology (service statistics) but do maintain data (cost data) used under the new methodology in § 422.310. Finally, the existing ACR form necessarily has to be changed to adapt to the new options under the M+C program.

For all of the above reasons and others discussed below, pursuant to our authority in section 1856(b)(1) to establish standards for M+C organizations, and consistent with the provision in section 1865(b)(2) that such standards be based on section 1876 standards, we have built on the existing ACR methodology in § 417.594 but refined this methodology in order to ensure the accuracy of ACRs under the M+C program.

Specifically, we have added the following new requirements to the provisions in § 417.594:

1. Revision of data requirements used to develop differences in utilization characteristics of the Medicare population from a relative service ratio to a relative cost ratio (for additional revenue, a relative excess revenue ratio) experienced in a prior period.

2. Separation of the administrative component into two parts—an administrative cost component and a component that reflects revenues collected in excess of costs.

3. Provision for an M+C organization to adjust for relative differences that the organization expects to encounter in the period covered by the ACR that were not reflected in the prior period. Below we discuss each in turn, including where the new process diverges from the former ACR methodology.

Revision of Data Requirements Used to Develop Differences in Utilization Characteristics of the Medicare Population from a Service Ratio to a Cost Ratio Experienced in a Prior Period: Currently, risk contracting plans (HMOs) under section 1876 of the Act use a relative volume/complexity (V/C) factor to modify commercial premiums for each health care component (e.g. inpatient hospital, physician) to account for differences in utilization characteristics between commercial members and Medicare members. The modified commercial premium is the ACR value for that health care component applicable to the Medicare enrollee.

Currently, HMOs are directed to develop the V/C factors using comparative service statistic ratios on a health care component basis. Service ratios require HMOs to supply a large amount of service statistics.

Risk contractors assert that they, as a rule, do not keep service statistics in the same manner, format, and/or detail needed to compute these ratios. Some HMOs have resorted to using statistics gathered from one commercial package to be compared to all Medicare enrollee statistics. Others have used estimations of service statistics (especially for those services not offered by the HMO in the past).

Managed care organizations keep detailed records on the cost of care included in the benefit packages sold. Since the cost of providing medical care is a function of both volume (number of services) and complexity (price of the service), M+C organizations could compare the direct cost of medical care (incurred in a previous period) between the organization's commercial and Medicare populations on an average per enrollee basis to account for differences in utilization characteristics of the respective populations. For those services not offered in the past, the M+C organization could use an estimate of the cost to establish an ACR value for the new service.

We believe this modification of data requirements will make the ACR more accurate, easier to process, and ultimately, easier to verify. Costs could be compared from year to year to establish the reasonableness of the data provided. In addition, cost data as reported could be compared to other required reports and the organization's financial statements. Later, during monitoring visits, costs could be compared to the organization's financial records.

This approach is justified in view of the expanded participation of different types of M+C plans authorized in the BBA. BBA provisions include organizations offering new types of M+C plans that may not have an enrolled commercial population and, without an enrolled commercial population, these organizations would be unable to complete the current ACR. Under the new method, these M+C organizations would be allowed to develop a cost estimate for the purpose of establishing an ACR value for the Medicare population.

Separation of Administrative Component into Two Components—an Administrative Cost Component and a Component that Reflects Revenues Collected in Excess of Costs: Currently, HMOs are directed to bundle that part of the commercial premium that represents any excess revenue over expenses with administration into one component. In § 422.302, we refer to the component of the premium that represents revenue in excess of costs incurred as ''additional revenues.'' Specifically, we define ''additional revenues'' to mean revenues collected or expected to be collected from charges for M+C plans offered by an M+C organization in excess of costs actually incurred or expected to be incurred. Additional revenues would include such things as revenues in excess of expenses of an M+C plan, profits, contribution to surplus, risk margins, contributions to risk reserves, assessments by a related entity that do

not represent a direct medical or related administrative cost, and any other premium component not reflected in direct medical care costs and administrative costs.) The combined component representing administrative and excess revenues was then converted to a Medicare value using the same method the HMO used to compute the amount for commercial enrollees. HMOs have consistently claimed they use a percentage method (For example, administration is calculated as a specific percentage of health care components). In effect, this increases the administration and additional revenues anywhere from 300 percent to 500 percent for Medicare. In addition, this bundling assumes that both administration and additional revenues are similar in nature and should be treated the same.

Under the new ACR, we are requiring M+C organizations to divide the administrative component into two parts and modify each part with a factor that is consistent with each part. We believe this will provide HCFA with data that is both more accurate and more useful.

Administrative costs will be included in the ACR computation in the same manner as they are incurred in commercial premiums. M+C organizations will be required to reveal projected amounts of additional revenues to HCFA for each population group (commercial and Medicare). M+C organizations would be required to justify larger additional revenues projected for the Medicare population in relation to their commercial population.

Construction of a Method for an Organization to Adjust for Relative Differences the Organization Expects to Encounter in the Period Covered by the ACR that Were not Reflected in the Prior Period: Section 1876 allowed for modification of the initial rate by a relative factor of services furnished in a prior period. Implementing regulations did not allow for any other modifications to the initial rate in establishing the ACR for a service or services, and we have since recognized that additional modifications to the initial rate may be necessary. For example, Medicare coverage may be increased from one year to the next. If the organization did not provide the service in the past and no additional modifications to the initial rate were allowed, the organization could not adjust for the new service in its ACR. Organizations also had no method for making adjustments to take into account projected changes in utilization patterns that would result from changes in cost sharing amounts. We have included a provision in this rule to allow for such changes.

M+C organizations will be allowed to further reduce the ACR values so that the ACR values equal the actuarial value of the charge structure of the M+C plan.

6. Requirement for Additional Benefits (§ 422.312)

If the ACR calculation for an M+C plan produces an excess amount (the difference between the average of the M+C per capita rates of payment (APR) and the ACR value (less the actuarial value of original Medicare's deductibles and coinsurance)) for Medicare covered services, the M+C organization is required to use that amount as follows:

- First, the M+C organization may elect to contribute part or all of the excess amount to a stabilization fund;
- Second, the M+C organization may use the remainder to fund additional services not covered by Medicare; and
- Third, the M+C organization must use any remainder to reduce the premium and/or cost sharing allowed for services covered by original Medicare.

A number of rules contained in this section were developed using the rules under section 1876, though certain changes to those rules were made to comply with new provisions in the BBA. For example, the rules for the stabilization fund under section 1876 were largely incorporated in this section. However, section 1854(f)(2) revised the time period and disposition of those funds at the end of that time period. We have incorporated these changes in § 422.312(c).

H. Provider-Sponsored Organizations

This interim final rule makes certain technical and conforming changes to existing subpart H of part 422. These changes are discussed in section II.R. of this preamble.

I. Organization Compliance With State Law and Preemption by Federal Law

1. State Licensure (§ 422.500)

Among the organizational and financial requirements for M+C organizations, section 1855 of the Act requires that an organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers an M+C plan. (An exception to the licensure requirement is made for PSOs, as provided for in part 422 subpart H.) Section 1855(b) specifies the level of risk that an organization assumes under an M+C contract (i.e., full risk for the M+C benefit package), and the extent to which the organization may insure against such risk or may pass off all or part of the risk to subcontracting providers. The requirements of the statute result in a two-pronged test of appropriate licensure, consisting of the licensure requirement itself and a scope of licensure requirement.

Licensure and Scope of Licensure: With regard to the licensure requirement, although the BBA uses the term ''licensure,'' we have interpreted the provision as requiring a license or some other type of certification (such as a certificate of authority) that represents permission granted by the appropriate State authority for the organization to operate within the State as a risk-bearing entity offering health insurance or health benefits. Having met the State licensure requirement, an organization must also show that the ability to offer an M+C plan of the type they wish to offer is within the scope of its State licensure or State authorization. For example, an organization that offers only a prepaid dental plan in a State could be licensed as a risk-bearing entity, but its licensure status may not permit the organization to offer a health benefits plan that includes a comprehensive range of services, as would be necessary under an M+C contract. Similarly, a State may require an organization that is a licensed HMO to obtain separate licensure as an indemnity insurer in order to offer an M+C point-of-service (POS) plan, on the basis that the HMO scope of licensure does not include the ability to offer what is considered an indemnity product. (A State's requirement that an organization have an indemnity license in order to offer a POS product is not superseded by the Federal preemption provisions discussed below.)

In some States, a Medicaid HMO may operate without a license from the department of insurance or other State agency that licenses organizations offering health benefits or health insurance in the commercial and Medicare markets. The Medicaid plans operate under the authority of the State Medicaid agency, which may be the agency establishing solvency standards for such organizations, as required by section 1903(m)(1)(A)(ii). The State authorization for these plans may be viewed as a limited scope licensure, enabling plans to operate as Medicaid contractors only, and not in other segments of the health insurance market.

To establish the licensure status of organizations, and in particular to determine compliance with scope of licensure requirements, we will require, as part of the application process for

new applicants, documentation that both the licensure and scope of licensure requirements are met. Organizations must provide verification from the appropriate State regulatory body authorized to license Medicare risk products demonstrating that the licensure status of the organization enables it to offer the M+C plan, or plans, it intends to offer. This would ensure that, in the case of an organization only authorized to offer a Medicaid plan, for example, solvency standards appropriate to an M+C product are met. In the case of non-commercially licensed entities, we are requiring that they obtain a special certification from the State that they meet appropriate solvency standards.

As noted in the BBA, ''The fact that an organization is licensed in accordance with paragraph [1855(a)](1) does not deem the organization to meet other requirements imposed under this part'' (1855(a)(3)). That is, while the State licensure requirement is imposed on all plans as a prerequisite for contracting as an M+C organization, licensure in and of itself does not guarantee that an organization will be able to obtain an M+C contract. The organization must meet other applicable requirements of this part in order for us to grant an M+C contract.

2. Federal Preemption of State Law (§ 422.502)

Section 1856(b)(3)(A) of the Act provides for a Federal preemption of State laws, regulations, and standards affecting any M+C standard if the State provisions are inconsistent with Federal standards (a preemption policy we refer to below as a general preemption). There is also a specific preemption of State laws (1856(b)(3)(B)) in three areas where Federal standards ''preempt the field''; that is, regardless of whether State laws are inconsistent or not, Federal standards preempt State law, regulations, and standards. The general and specific preemption of State law applies to ''Medicare benefits and Medicare beneficiaries,'' as stated in the conference report that accompanied the BBA. The BBA preemption provisions do not extend to non-Medicare enrollees or activities or non-Medicare ''lines of business'' of organizations that have M+C contracts.

Prior to the BBA, section 1876 of the Act (governing Medicare risk and cost contracts with HMOs and competitive medical plans) did not contain any specific preemption provisions. However, section 1876 requirements could preempt a State law or standard based on general constitutional Federal preemption principles, consistent with the provisions of Executive Order 12612 on Federalism. Under the guidelines of the Executive Order, section 1876 requirements did not preempt a State law or standard unless the law or standard was in direct conflict with the Federal law, or it prevented the organization from complying with the Federal law. Put another way, if Federal law permitted the HMO to do what State law required, there was no preemption. In practice, rarely, if ever, did Federal law preempt State laws affecting Medicare prepaid plans. For example, Medicare risk plans operating in States with mandated benefit laws were generally required to comply with such State laws. Compliance with the State mandated benefit law was not viewed as interfering with the ability of plans to function as Medicare risk contractors under Federal standards. (Because the BBA preemption applies only to M+C plans, this approach to preemption issues will continue to apply to cost contracts governed by section 1876 rules.)

General Preemption: The general preemption provision of the BBA will be applied in the same way that the Executive Order has been applied, in that State laws or standards will be preempted only when they are inconsistent with M+C standards, as clearly indicated in the statute. Because the BBA requires that PSOs operating under a waiver of the State licensure requirement must comply with State quality and consumer protection standards, it seems clear that the Congress expected States, in some cases, to have more rigorous or more comprehensive standards for quality and consumer protection which would enhance, rather than duplicate or be subsumed under, the M+C standards for quality and consumer protection. Thus, unless one of the specific preemptions discussed below applies, State laws or standards that are more strict than the M+C standards would not be preempted unless they prevented compliance with the M+C requirements. This is consistent with the BBA conference report language that notes that State laws apply if they provide ''consumer protections in addition to, or more stringent than'' the BBA. The BBA also provides that the quality and consumer protection standards with which PSOs must comply include only those requirements ''generally applicable to M+C organizations and plans in the State'' which are ''consistent with the standards'' of the BBA. That is, there are likely to be quality and consumer protection standards imposed by States that all M+C plans must comply with, and for which there is no Federal preemption.

Specific Preemption: Though the general preemption provision will be applied in the same way that the Executive Order has been applied, for the three areas in which the Congress provided for a specific preemption of State laws, the M+C standards supersede any State laws and standards. These three areas are:

- Benefit requirements:
- Requirements relating to inclusion or treatment of providers; and
- Coverage determinations (''including related appeals and grievance processes'').

We are adopting a narrow interpretation of the applicability of the three areas of specific preemption, which we believe is justified by the conference report language and the overall structure of the BBA in its delineation of the relative roles of the State and Federal governments. Under the BBA, States have exclusive authority (other than in the case of PSOs) to make the determination of whether organizations are eligible to enter into M+C contracts, while under section 1876 of the Act, it was the Federal Government that designated ''eligible organizations'' (HMOs under title XIII of the Public Health Service Act (a Federal designation) or competitive medical plans (also a Federal designation)). Under section 1876, the Federal Government also determined solvency standards for organizations, while under the BBA this becomes a State responsibility (other than for PSOs). The conference report (p. 638) also clarifies the intended scope of preemption in the three specific areas. The report indicates the conferees seek to put M+C on a par with ''original fee-for-service,'' where the ''Federal government alone set legislative requirements regarding reimbursement, covered providers, covered benefits and services, and mechanisms for resolving coverage disputes.'' The conferees wish to ''[extend] the same treatment to private M+C plans providing Medicare benefits to Medicare beneficiaries.''

Using the analogy of original Medicare, Federal law preempts State laws and standards in certain specific areas. Under original Medicare: States cannot specify what must be included as a Medicare benefit; States do not specify the conditions of participation of Medicare providers (though they license providers and practitioners and determine their scope of practice); States may not specify how a coverage determination is to be made with respect to whether or not the Medicare program covers a benefit; and a State

does not determine the type of appeal mechanism that is to be used to appeal a coverage decision made by a Medicare carrier or intermediary with respect to a Medicare benefit. For M+C plans, the specific preemption of State laws in the three areas would prevent, for example, the application of mandated benefits laws; ''any willing provider'' laws and other laws mandating the inclusion of specific types of providers or practitioners; or laws that supplant or duplicate the Medicare coverage determination and appeal process as it relates to coverage of benefits under the M+C contract. However, States may have various laws and requirements that could still apply to

- Benefits (for example, a plan could be required to have a toll free number to answer benefit questions),
- Providers and practitioners generally in the State (e.g., they must all be licensed by the State and comply with scope of practice laws), and
- Laws and standards which could apply to disputes between members and health plans, as discussed below.

Under our narrow construction of the specific preemptions, and consistent with our definition of the term ''benefits'' at § 422.2, the specific preemption of benefit laws does not extend to State laws and standards relating to cost sharing or other financial liability standards for enrollees of health plans, though we are inviting comments on our position, outlined below, that cost sharing should not fall under the benefits preemption, as well as comments on whether there are types of cost sharing that should or should not be included in the benefits preemption.

Thus, a State law prescribing limits on cost sharing generally, or limits on cost sharing that can be imposed for specific benefits, would not be preempted. If the benefit to which the State cost sharing limits apply is not a Medicare covered benefit, however, the limits on cost sharing would only apply if the M+C organization *chooses* to offer the benefit in question. Thus, to the extent that limits on cost sharing are linked to a benefit mandate, the cost sharing limits could be seen to be *indirectly* ''preempted'' in that the obligation to provide the benefit to which they apply is preempted. If the M+C organization chooses not to provide the benefit that would otherwise be mandated under a preempted benefit mandate, the cost sharing limits that apply to that benefit would never come into play. We note that while cost sharing limits are not specifically preempted under the benefits preemption in section 1856(b)(3)(B)(i) and § 422.402(b)(1), cost sharing limits are still subject to the general preemption in section 1856(b)(3)(A) and § 422.402(a). Thus, to the extent the cost sharing limit would be inconsistent with M+C provisions, it would be preempted. An example of State cost-sharing requirements being preempted because they are inconsistent with M+C provisions would be a State requirement that requires all insurers and health plans to pay 100 percent of the cost of a particular service (e.g., mammography screening or other preventive care). In the case of an M+C MSA plan, we would argue that the general preemption provision applies, because the State requirement is inconsistent with the basis structure of a high-deductible plan under which covered services are not payable under the plan until the deductible is met.

To address a specific question that has arisen, State laws requiring direct access to particular providers (either contracted by the M+C organization or not under contract), and State laws requiring, for example, a second opinion from non-contracted physicians, would be superseded by the benefit and provider participation preemptions (though M+C standards in these regulations dealing with access to particular providers may have an effect that is similar to that of State laws that are superseded). This is because these requirements in essence mandate the ''benefit'' of access to a particular provider's services even where the services of that provider would not otherwise be a covered benefit.

We are also adopting a narrow interpretation of the scope of preemption of coverage determinations. Coverage determinations are made initially by M+C organizations and may be appealed as provided for under subpart M of these regulations. Our view is that the types of decisions related to coverage included in this specific preemption are only those determinations that can be subject to the appeal process of subpart M. These are decisions about whether an item or service is covered under the M+C contract and the extent of financial liability beneficiaries have for the cost of covered services under their M+C plan. The Medicare appeal process applies to basic benefits, mandatory supplemental benefits, and optional supplemental benefits offered under an M+C contract. The specific preemption makes the Medicare appeal process the exclusive remedy for disputes over coverage determinations, displacing any State grievance or appeal process that might otherwise be available in such cases. However, the specific preemption does not preempt State remedies for issues other than coverage under the Medicare contract (i.e. tort claims or contract claims under State law are not preempted). The same claim or circumstance that gave rise to a Medicare appeal may have elements that are subject to State remedies that are not superseded. For example, an M+C organization's denial of care that a beneficiary believes to be covered care is subject to the Medicare appeals process, but under our interpretation of the scope of the specific preemption on coverage decisions, the matter may also be the subject of a tort case under State law if medical malpractice is alleged, or of a state contract law claim if an enrollee alleges that the M+C organization has obligated itself to provide a particular service under State law without regard to whether it is covered under its M+C contract.

We are seeking public comments on our interpretation of the applicability of the three areas of pre-emption specifically the exclusion of cost sharing and financial liability standards from the federal pre-emption and the exclusion of direct access to particular providers.

As noted above, where the BBA preempts State laws and standards, any Federal preemption based on the BBA applies only to the Medicare ''line(s) of business'' of an M+C organization (i.e., Medicare enrollees). As such, there would be no Federal preemption of State laws which are applicable to other enrollees of the organization. Additionally, there would be no Federal preemption of State laws which are applicable to arrangements outside the scope of the BBA, such as arrangements between employers and M+C plans for the provision of negotiated employer group benefits discussed at § 422.106 of these regulations. Neither the specific nor the general preemption would apply to any aspect of such arrangements.

3. Prohibition on State Premium Taxes (§ 422.404)

Section 1854(g) of the Act, introduced in the BBA, provides that ''No State may impose a premium tax or similar tax with respect to payments to M+C organizations under section 1853.'' Section 4002(b)(4) of the BBA makes the prohibition on premium taxes applicable to risk-sharing contracts operating under section 1876 effective the date of enactment of the BBA. This prohibition does not apply to enrollee premium payments made to M+C plans, which are authorized under section 1854.

The regulations provide clarification on the applicability of the prohibition of State premium taxes. The BBA does not

define the term ''State,'' but elsewhere in the Medicare statute (1861(x), referring to 210(h) of the Act), the term ''State'' is defined to include the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa. The regulations include this definition of State for purposes of the scope of the premium tax prohibition.

The BBA is also silent as to whether the prohibition of premium taxes includes county taxes or taxes by other governmental entities within a State. The Federal Employees Health Benefits Program (FEHBP) statute, on the other hand, has more specific language on the applicability of the exemption from premium taxes. The FEHBP statute specifically extends the prohibition to ''any political subdivision or other governmental authority'' of a State (5 U.S.C. 8909(f)(1)).

The BBA conference report does not provide any clarification on this issue. However, a July 31, 1997 summary of the provisions of the BBA prepared by the Senate Finance Committee (''Summary: Health and Welfare Provisions in the Balanced Budget Act of 1997''), stated that ''[t]he current law on federal preemption of state premium taxes or fees on Federal payments from the FEHBP to health plans will be extended to Federal payments to M+C plans and other health plans receiving capitated payments from the Medicare Trust Funds.'' Although the language of the BBA prohibition is not as specific as the FEHBP language, we are clarifying in these regulations that the prohibition does apply to any political subdivision or other governmental authority within a State. We believe such an interpretation is necessary because counties and other State authorities derive their powers from the State. Thus, any prohibition of State actions contained in a Federal statute should be interpreted as prohibitions on actions at any level of State government or any State or local governmental body within a State.

The BBA does not define the phrase ''premium tax or other similar tax,'' other than by reference to the applicability of such a tax to revenue received from the Federal Government for health plan enrollees. Relying again on the FEHBP statute, we have included a provision in the regulations (§ 422.404(b) that serves to clarify the scope of what constitutes a prohibited premium tax. The FEHBP statute expressly permits States to impose taxes on the profits arising from participation as an FEHBP plan, to the extent that the tax on profits, or other taxes or fees, are general business taxes. We have included a similar exception because such taxes are not taxes applied directly and exclusively to premium revenues, and therefore should not be prohibited under section 1854(g).

The BBA premium tax prohibition does not provide for any exception to the prohibition based on the purpose of the tax. For example, some States are using a broadly applicable premium tax to fund health care coverage for individual State residents who might otherwise be uninsured (e.g., financing a State high-risk pool), or to fund a State guaranty fund that could potentially benefit enrollees of an M+C plan in the event of insolvency. Although such premium taxes do provide a social good, and may yield a direct benefit to M+C organizations and their enrollees, there are no exceptions to the premium tax prohibition included in the BBA or in these regulations. By not having allowed any exceptions, we would note that, to the extent participation in a State guaranty fund is used as means of satisfying State (or Federal) requirements for protections in the event of insolvency, M+C organizations that would otherwise have participated in the guaranty fund by paying the premium tax are likely to be required to meet alternative insolvency requirements. An M+C organization may also choose to voluntarily pay premium taxes in order to participate in such a fund.

J. Subpart J of Part 422

Subpart J of part 422 is being reserved.

K. Contracts with M+C Organizations

1. Definitions (§ 422.500)

Section 422.500 of subpart K contains definitions germane to subpart K that address provisions pertaining to contracts with M+C organizations. These definitions, for the most part, have been imported from part 417 under our authority from section 1856(b)(2). The lone exception, *Party of Interest* has been clarified in paragraph (3) to include non-profit entities.

2. General Provisions (§ 422.501)

Section 1857(a) provides that the Secretary will not permit an organization to operate as an M+C organization unless it has entered into a contract with HCFA. The statute also provides that the contract may cover more than one M+C plan.

An applicant, however, must meet certain requirements before HCFA can consider entering into a contract with it. First, in accordance with section 1855(a)(1), the applicant must be licensed (or if the state does not license such entities, hold a certificate of authority/operation) as a risk-bearing entity in the State in which it wishes to operate as an M+C organization; section 1855(a)(2), however, allows for a waiver of this requirement for Federally-waivered PSOs under certain circumstances. Second, the applicant must meet the minimum enrollment requirements specified at section 1857(b). These requirements provide that the organization must have at least 5,000 (or 1,500 if it is a Federally-waivered PSO) individuals receiving health benefits from the organization or at least 1,500 (or 500 if it is a PSO) individuals receiving benefits in a rural area. Section 1857(b)(3) gives the Secretary the authority to waive the minimum enrollment requirements for the first 3 contract years.

Third, an M+C organization must demonstrate certain administrative and managerial capabilities that we believe are essential for HCFA to examine prior to agreeing to contract with any applicant as an M+C organization. For this reason, pursuant to section 1856(b)(2) which provides for the adoption of regulations implementing section 1876, we have adopted the administration and management requirements from §§ 417.120 and 417.124 and have applied them to M+C organizations. In addition, pursuant to our authority in section 1856(b)(1) to establish standards under Part C by regulation, we will require that all M+C organizations establish a plan for complying with all applicable Federal and State standards. The compliance plan must include written policies, procedures, and standards of conduct, the designation of a compliance officer accountable to senior management of the organization, provisions for internal monitoring, auditing, accountability, and an adhered to process for reporting violations of law by the organization or their subcontractors.

Further, pursuant to our authority in section 1856(b)(1) to establish standards for M+C organizations by regulation, we are in this rule establishing an additional condition for entering into an M+C contract. Under this rule, an entity that is accepting new enrollees under a section 1876 cost contract will be ineligible to enter into an M+C contract covering the area it serves under its cost contract. Our reason for establishing this rule is to eliminate the potential for an organization to encourage higher cost enrollees to enroll under its cost contract while healthy enrollees are enrolled in its risk-based M+C plan. This rule is consistent with our longstanding policy that entities not

have both a risk and cost contract under section 1876 in the same area.

Further, we provide at § 422.501(b) that in order to be eligible to contract as an M+C organization, an applicant organization that held a prior contract terminated by HCFA under § 422.510 within the past five years.

Section 1857(c)(5) authorizes the Secretary to enter into contracts with organizations without regard to provisions of law or regulations that the Secretary determines to be inconsistent with the furtherance of the purpose of Title XVIII of the Act. Based on this authority, we provide in § 422.501(c) that HCFA may enter into contracts under part 422 without regard to the Federal and Departmental acquisition regulations set forth in title 48 of the CFR.

Further, section 1857(d)(1) and (2) provide for the auditing of the financial records of at least one third of M+C organizations annually, and the inclusion of specified inspection and auditing rights in M+C contracts. We have incorporated these requirements in § 422.501(d). We likewise specify related requirements that enable HCFA to do so.

Since section 1857(a) allows that an M+C contract may cover more than one M+C plan, we have added paragraph (e), ''Severability of contracts,'' through our authority in section 1856(b)(1). The contract provides that upon HCFA's request (1) the contract will be amended to exclude any M+C plan or State-licensed entity specified by HCFA, and (2) a separate contract for any such excluded plan or entity would be deemed to be in place when such a request is made.

National Contracting

The BBA does not specifically define or otherwise address the issue of national contracting. While we are interested in national contracting, we have not specified it in the regulations and welcome comment on this concept. One option we are considering would allow an M+C applicant to request that HCFA enter into a national contract with the applicant if the applicant holds license as a risk-bearing entity in each state where it operates or has a waiver as provided in § 422.370. The applicant M+C organization would have the option of having a uniform premium and benefit plan across the country, with one service area and a national ACR proposal.

We are considering a different concept of a national agreement with national chain organizations. This concept would apply to those chain organizations that enter into separate contracts in multiple States. The agreement would allow for the chain organization to establish a uniform policy across all of its states as to marketing, quality assurance, utilization review, claims processing, etc. HCFA would have to approve the national policy procedures. HCFA would continue to contract separately with individual, albeit related, M+C organizations affiliated through common ownership or control. We would continue to monitor operational activities for each organization in each State, but having approved national policy, our review at the State and local level would be reduced.

3. Contract Provisions (§ 422.502)

Section 422.502 of this rule sets forth the provisions and related requirements for contracts between HCFA and M+C organizations. In general, Medicare beneficiaries may not elect to enroll in an M+C plan offered by an M+C organization, and no payment will be made to the M+C organization, unless the Secretary enters into a contract with the organization. The provisions that describe this relationship between the Secretary and the M+C organization are based on Part C of title XVIII of the Act and on Medicare contract requirements derived from subparts C and L of part 417.

The provisions of the Act as added by the BBA are generally silent with regard to the specific provisions that must be included in the contract between the M+C organization and HCFA. The Act does, however, specify at section 1857(a) that the contract must provide that the organization agrees to comply with the applicable requirements, standards, and terms and conditions of payment of Part C of title XVIII of the Act. In addition, section 1857(e) provides that the contract shall contain such other terms and conditions not inconsistent with Part C of title XVIII of the Act that the Secretary may find necessary and appropriate. Included in § 422.502(a), ''Agreement to comply with regulations and instructions,'' are the following contract conditions:

- The M+C organization must agree to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments. The M+C organization agrees that it will comply with the prohibition in § 422.108 on discrimination in beneficiary enrollment.
- The M+C organization must agree to provide the basic benefits as required under § 422.101 and to the extent applicable, supplemental benefits under § 422.102.
- The M+C organization must agree to provide access to benefits as required under subpart C of part 422. All benefits covered by Medicare must be provided in a manner consistent with professionally recognized standards of health care.
- The M+C organization agrees to disclose information to beneficiaries as required under § 422.110.
- The M+C organization must agree to operate a quality assurance and performance improvement program, and to have an agreement for external quality review as required under subpart D of part 422.
- The M+C organization must agree to comply with all applicable provider requirements in subpart E of part 422, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans.
- The M+C organization will agree to comply with all requirements in subpart M governing coverage determinations, grievances, and appeals.
- The M+C organization will comply with the reporting requirements in § 422.516 and the requirements for submitting encounter data to HCFA in § 422.257.
- The M+C organization agrees that it will be paid under the contract in accordance with the payment rules under subpart F of part 422.
- The M+C organization will develop annual adjusted community rate proposals and submit all required information on premiums, benefits, cost sharing by May 1, as provided in subpart G of part 422.
- The M+C organization agree that its contract may be terminated or not renewed in accordance with subparts K and N of part 422.
- The M+C organization will agree to comply with all requirements that are specific to a particular type of M+C plan, such as the special rules for private fee-for-service plans in §§ 422.114 and 422.216 and the M+C MSA requirements in §§ 422.56, 422.103, and 422.262.
- The M+C organization will agree to comply with the confidentiality and enrollee accuracy requirement in § 422.118.
- The M+C organization agrees that complying with the aforementioned contract conditions is material to performance of the contract.

Contract requirements that were either not required of HMOs and CMPs

under section 1876, or have been modified to implement the M+C program follow:

- The M+C organization must possess the capabilities to communicate with HCFA electronically.
- The M+C organization is required to provide prompt payment of covered services if these services are not furnished by a provider under contract or agreement in an M+C plan's health services delivery network. Under section 1876, the prompt payment requirement was limited to noncontracting providers. Section 1857(f) duplicates this requirement and adds to it the requirement that if the Secretary determines that an M+C organization fails to pay claims promptly, the Secretary may provide for direct payment of the amounts owed providers. When this occurs, the Secretary reduces the amount of the M+C organization's monthly payment to account for payments to these providers. We explain the full implications of this requirement in the discussion below pertaining to § 422.520.
- Pursuant to our authority in section 1856(b)(1) to establish standards under Part C, we are requiring that M+C organizations maintain records for 6 years. The standard for retention of records for HMO and CMPs was 3 years. We are changing the retention period from 3 years to 6 years so as not to prematurely foreclose our ability to address fraudulent or other abusive activities.
- Pursuant to our authority at section 1856(b)(1) to establish standards under Part C, we specify requirements relating to M+C organizations providing access to facilities and records at § 422.502(e). In this section we assert that M+C organizations allow HHS, the Comptroller General, or their designees to evaluate, through inspection or other means, all aspects of medical services furnished to Medicare beneficiary enrollees, the facilities of M+C organizations, and enrollment and disenrollment records of M+C organizations. We further provide that HHS, the Comptroller General, or their designees may audit, evaluate, or inspect all facilities and records as the Secretary may deem necessary to enforce an M+C contract. HHS's, the Comptroller General's, and designee's right to inspect such facilities and records extends through 6 years from the date of the contract period or completion of any inspection or audit activity, whichever is later. Exceptions to this 6-year inspection timeframe can occur in instances when: (1) HCFA determines there is a special need to retain particular records or a group of records for a longer period and notifies the M+C organization at least 30 days before the normal disposition date, (2) there has been a termination, dispute, or fraud or similar fault by the M+C organization, in which case the retention may be extended to 6 years from the date of any resulting final solution of the termination, dispute, or fraud or similar fault, or (3) HCFA determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit the M+C organization at any time.
- Pursuant to our authority in section 1856(b)(1) to establish standards under Part C, and the provision in section 1856(b)(2) for adopting section 1876 standards, we have included certain disclosure requirements from § 417.486 in § 422.502(f). We have also included additional disclosure requirements to reflect new reporting requirements in § 422.516.
- At § 422.502(f)(2), we add the requirement that M+C plans submit to HCFA specific information necessary to evaluate and administer the program and to enable beneficiaries to exercise informed choice in obtaining Medicare services. Section 1851(d) authorizes the Secretary to obtain this information to enable HCFA to fulfill its responsibility to develop activities to disseminate broadly information to current and prospective Medicare beneficiaries in order to promote an active, informed selection among such options.
- Pursuant to section 1851(b)(4)(B), we have specified requirements at § 422.502(b)(2)(vii) that M+C organizations offering MSA plans disclose to HCFA information that will enable HCFA to evaluate the impact of permitting enrollment in MSA plans.
- Enrollee financial protection provisions are addressed at § 422.502(g). The first item protects beneficiary enrollees from incurring liability for payment of any fee that M+C organizations are legally obligated to bear. Section 422.502(g) contains the enrollee financial protection that has applied to HMO and CMP enrollees under § 417.122 (a)(1), which was made applicable to all section 1876 contractors under § 417.407(f). The beneficiary protection at 422.502(g)(1) is designed to protect beneficiary enrollees from being held financially responsible for fees for which the M+C organization is legally liable. Under the provision, we assert that M+C organizations protect beneficiary enrollees in two ways. First, through inclusion, hold harmless language in its written agreements with the providers that comprised the M+C plan's Medicare provider network. And pursuant to our rulemaking authority at section 1856(b)(1), we also specify that M+C organizations must indemnify beneficiary enrollees for the organization's legal obligations that are derived from health care services provided to enrollee beneficiaries by providers that have not entered into a written agreement to participate in the M+C organization's Medicare provider network. The beneficiary protection at 422.502(g)(2) afford beneficiaries protection against loss of benefits for which the M+C organization is legally obligated to pay. Except in the case of PSOs that have been awarded Federal waivers (see subpart H), States have the primary responsibility under Part C for determining whether an M+C organization has sufficient reserves to assume the risk it takes on under an M+C contract. The State that licenses the entity under applicable State law determines whether an entity has sufficient financial reserves to enter into an M+C contract.

Congress has given HCFA some ongoing responsibility concerning solvency, however. In section 1857(d)(4)(A)(i), M+C organizations are required to provide the Secretary with such information ''as the Secretary may require demonstrating that the organization has a fiscally sound operation.'' Accordingly, we believe that it is appropriate, under our authority in section 1856(b)(1) to establish standards under Part C to require (in § 422.502(g)) that an entity that already has an M+C contract demonstrate to HCFA that it has protections in place ensuring that beneficiaries will not be held liable for the entity's debts. We believe that this can be seen as part of having a fiscally sound operation as provided for in section 1857(d)(4)(A)(i).

- The subsection entitled ''Requirements of Other Laws and Regulations'' at § 422.502(h) requires that contracts reflect the M+C organization's obligations under other laws, specifically, the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, other laws applicable to recipients of Federal funds, and all other applicable laws and rules.
- Pursuant to our authority under section 1856(b)(1) to establish standards under Part C, paragraph (i) of § 422.502 contains requirements that apply to related entities, contractors, and subcontractors of an M+C organization. These requirements promote an M+C organization's accountability and program integrity.

The requirements in paragraph (i) recognize that organizations that are likely to apply for M+C contracts commonly enter into business

relationships with entities that they placed under contract to perform certain functions that otherwise would be the responsibility of the organization to perform including management and provision of services. This section therefore addresses these relationships and establishes requirements that the M+C organizations must adhere to in order to provide HCFA assurances that the M+C organization will be accountable for all contract requirements.

Specifically, this section gives HHS, the Comptroller General or their designee, the authority to audit, evaluate and/or inspect documents, papers, records of all of the organizations mentioned in § 422.502(i); and to obtain information from the M+C organization and other entities described here, six years following the close of a contract or audit. Paragraph (i)(3) of § 422.502 describes provisions that must be included in contracts and other written arrangements between M+C organizations and other entities described in this section.

- Section 422.502(j), which is derived from section 1857(e), states that the contract will contain other terms and conditions consistent with this part as HCFA may find necessary and appropriate.
- Under § 422.502(k), we require that all M+C contracts be severable as discussed previously.

Finally, pursuant to our authority in section 1856(b)(1) to establish standards under Part C by regulation, we are requiring in paragraphs (l) and (m) that an M+C organization request payment on document that certify the accuracy and completeness of relevant data as a condition for receiving its capitation payment and, in the case of the ACR, for retaining the portion of capitation payment associated with the ACR amount (rather than providing additional benefits). Section 422.502(b) also states that the M+C organization's CEO or CFO certify the accuracy of encounter data, and, in instances when encounter data are generated by a related entity, contractor, or subcontractor, such entity likewise certifies the accuracy of the encounter data.

In all of these cases, when an M+C organization submits the data in question to HCFA, we believe that it is making a ''claim'' for capitation payment in the amount dictated by the data submitted, or in the case of the ACR submission, a ''claim'' to retain the portion of the capitation payment that is under the ACR amount, rather than providing additional benefits. We believe it is important that when an M+C organization is claiming payment (or the right to retain payment) in a particular amount based upon information it is submitting to HCFA, it should be willing to certify the accuracy of this information. We believe that these certifications will help ensure accurate data submissions, and assist HCFA and the Office of Inspector General in anti-fraud activities.

4. Effective Date and Term of Contract (§ 422.504)

Section 1857(c) provides that each contract under section 1857 will be for a term of at least 1 year, as determined by the Secretary. This section also provides that the effective date and term of the contract will be specified in the contract, except that in no case will a contract under this section that provides for coverage under an M+C MSA plan be effective before January 1999 with respect to such coverage. Based on these provisions, § 422.504(b) of this rule provides that beginning in 2002, contracts will be for a period of 12 months beginning on January 1 and ending on December 31. We include an exception at § 422.504(d) which indicates that prior to January 1, 2002, HCFA may at its discretion approve contracts for periods longer than 12 months, that begin on a date other than January 1.

HCFA has decided not to exercise the discretion provided in section 1857(a)(1) to make contracts automatically renewable (section 1857(a)(1) provides that contracts ''may'' be automatically renewable from term to term.) Instead, we specify at § 422.504(c) that the contract may be renewed annually only if HCFA affirmatively authorizes a renewal, and the M+C organization has not given HCFA a notice of nonrenewal. We believe that this approach is consistent with HCFA's role as a prudent purchaser and is in the best interest of the tax payer, the Medicare beneficiary and the Medicare program.

Under the current 1876 risk contract program, HCFA receives applications on a continuous basis and also awards contracts on a continuous basis as soon as the review process is complete, and a decision for approval has been reached. We have decided to maintain this process for the next few years under the M+C program. The BBA, however, provides a framework that has encouraged us to consider changing this in the future. The requirements for a coordinated open enrollment policy and printed plan comparison charts and the advent of the lock-in periods starting in 2002 suggests that HCFA move toward a policy of establishing a cutoff date for awarding contracts annually. This cutoff date would be timed to ensure that all new plans are included in the printed plan comparison charts. If we established a cutoff phase, HCFA would implement this change to the application and award processes in the year 2001 in time for the first year of the lock-in. We invite comments on this issue.

5. Nonrenewal of Contract (§ 422.506)

Section 422.506(a) discusses the process that an M+C organization must follow if it decides not to renew its contract. If the M+C organization does not want to renew its contract, it must notify HCFA in writing by May 1 of the year preceding the year that the M+C organization intends to no longer contract with HCFA. In addition, the M+C organization must notify each Medicare enrollee by mail at least 90 days before the effective date of the nonrenewal. It must also notify the general public at least 90 days before the end of the current calendar year by publishing a notice in one or more of the newspapers of general circulation located in the M+C's geographic area.

We also provide that HCFA may accept a nonrenewal notice of an M+C organization's decision not to renew its contract submitted after May 1 if the M+C organization complies with the requirements concerning enrollee and public notification and acceptance would not otherwise jeopardize the effective and efficient administration of the Medicare program. The May 1 deadline is timed to coincide with the ACR submission and internal HCFA timelines that require the timely submission of information necessary for developing annual health fair/open enrollment materials that will be made available to new and already-enrolled Medicare beneficiaries. We believe that the conference committee reports make it clear that the Congress intends for Medicare beneficiaries to make informed choice based on accurate, comparative M+C plan information. The Conferees further make it clear that the Secretary must take all steps necessary to ensure that all Medicare beneficiaries are provided the information needed to make informed choices about health coverage. We assert that the date-specific deadlines by which an M+C organization must notify HCFA of its decision not to renew its contract is a necessary step that promotes and represents the best intent of the law.

Section 1857(c)(4) provides that the Secretary cannot enter into an M+C contract with an M+C organization if, within the preceding five years, that organization has had an M+C contract

that was ''terminated at the request of the organization,'' except ''in circumstances that warrant special consideration, as determined by the Secretary.'' While Congress used the word ''terminated'' rather than ''nonrenewed,'' the only way that a contract could end solely ''at the request of the organization'' would be as the result of a notice of nonrenewal of the contract. In the case of a termination by mutual consent, discussed below, this only occurs if *HCFA* agrees that a termination of the contract is in the best interests of beneficiaries. Even in the case of a termination by the M+C organization under § 422.512 (discussed below), an organization does not have the right simply to ''request'' termination of the contract. Rather, it must show HCFA noncompliance with HCFA's obligations. This has never happened under the Part 417 counterpart of this authority for an organization to terminate its contract (§ 417.494(c)). Thus, we have always interpreted similar language in section 1876 to apply when an organization *nonrenews* its contract. We therefore make this interpretation explicit in § 422.506(a)(4).

HCFA decision not to authorize renewal. In accordance with § 422.506, contracts are renewed annually only if (1) HCFA informs the M+C organization that it authorizes a renewal and (2) the M+C organization has not provided HCFA with a nonrenewal notice. Section 422.506(b)(1) provides that HCFA may decline to authorize a renewal of a contract for any of the following reasons:

- The M+C organization has not fully implemented or shown discernable progress in implementing quality improvement projects;
- The M+C organization demonstrates insufficient enrollment growth. As participation in the M+C program grows it is inevitable that some contracting entities will not enroll sufficient numbers of Medicare beneficiaries to justify the administrative costs associated with regulating meet the applicable minimum enrollment requirements at § 522.514.
- For any of the reasons listed in § 422.510(a) which would also permit HCFA to terminate the contract.
- The M+C organization has committed any of the acts in § 422.752(a) which would support the imposition of intermediate sanctions or civil money penalties under Subpart O.

We believe that these aforementioned reasons for not authorizing renewal of a contract are consistent with HCFA's intent to fulfill its role as a prudent purchaser of health care services.

Section 422.506(b)(2) provides that if HCFA decides not to authorize the renewal of a contract, HCFA gives written notice to—

- The M+C organization by mail by May 1 of the current calendar year;
- The M+C organization's enrollees at least 90 days before the end of the current calendar year; and
- The general public, by publishing a notice in one or more newspapers of general circulation in each community or county located in the M+C organization's service area, at least 90 days before the end of the current calendar year.

Section 422.506(b)(3) provides that HCFA give the M+C organization written notice of its right to appeal the nonrenewal decision in accordance with subpart N.

6. Modification or Termination of a Contract by Mutual Consent (§ 422.508)

We provide guidance at § 422.508(a) that allows for contract termination by mutual consent. If a contract is terminated by mutual consent, except as provided in the § 422.508(b), the M+C organization must provide notice to its Medicare enrollees and the general public as provided in § 422.512(b) (2), and (3). If the contract terminated by mutual consent is replaced on the following day by a new M+C contract, the notice specified above does not need to be provided.

We have developed a mutual consent termination policy because we believe that there are circumstances under which an M+C organization may agree to a mutual termination by consent. This policy gives HCFA the option to offer this alternative to affected M+C organizations. Further, HCFA may decide that it is in the best interests of tax payers, Medicare beneficiaries and the Medicare program to agree to let an M+C organization terminate its contract midyear. Finally, we believe this policy accommodates M+C organizations that may wish to terminate their contract by mutual consent at the end of a calendar year and enter into a new 12 month contract year on January 1 during the years prior to 2002. We invite comment on this proposed policy.

In § 422.508, with some modifications, we have retained the provision for contract modification or termination by mutual consent that applies to contracts under section 1876. As under § 417.494(a), contracts may be modified or terminated at any time by written mutual consent. The two changes we have made are that (1) we have changed the obligation to provide enrollees and the public with notice of a termination to conform to the 60-day notice requirement in § 422.512(b) (2) and (3) (which retained the enrollee notice requirement in § 417.484(c)(2)); and (2) we have provided for an exception to the notice requirement for cases in which a contract being terminated by mutual consent is being replaced by a new contract on the day the termination becomes effective. We continue to require that M+C organizations notify their Medicare beneficiary enrollees of any changes that may occur pursuant to a contract modification by mutual consent within timeframes specified by HCFA.

7. Termination of a Contract by HCFA (§ 422.510)

Section 1857(c)(2) provides that the Secretary may at any time terminate an M+C organization contract if the Secretary determines that the M+C organization—

- Failed substantially to carry out the contract;
- Is carrying out the contract in a manner inconsistent with the efficient and effective administrative of Medicare Part C; or
- No longer substantially meet the applicable conditions of Medicare Part C.

In addition to repeating the above statutory language, we are implementing this language by identifying specific circumstances that we believe constitute examples of an M+C organization substantially failing to carry out either its contract, or carrying out its contract in a manner that is inconsistent with the effective and efficient administration. Specifically, we have identified the following circumstances: The M+C organization commits or participates in fraudulent or abusive activities affecting the Medicare program; the M+C organization substantially fails to comply with requirements in Subpart M relating to grievances and appeals; the M+C organization fails to provide HCFA with valid encounter data as required under § 422.257; the M+C organization fails to implement an acceptable quality assessment and performance improvement program as required under Subpart D; the M+C organization substantially fails to comply with the prompt payment requirements in § 422.520; the M+C organization substantially fails to comply with the service access requirements in § 422.112 or § 422.114; the M+C organization fails to comply with the requirements of § 422.208 regarding physician incentive plans.

Section 1857(h)(2)provides authority for the Secretary to immediately terminate a contract with an M+C organization in instances where the

Secretary determines that a delay in termination resulting from compliance with the procedures in section 1857(h)(1) discussed below would pose an imminent and serious risk to the health of enrolled Medicare beneficiaries.

We have implemented this authority as follows. First, § 422.510(a)(5) provides for termination when an M+C organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or when the organization otherwise fails to make services available to the extent that such a risk to health exists. Second, § 422.510(b)(2) provides that a termination based on § 422.510(a)(5) takes effect immediately. Third § 422.510(c) provides that the opportunity for corrective action does not apply to a termination based upon § 422.510(a)(5). And fourth, subpart N of part 422 provides that in the case of a termination based on § 422.510(a)(5), a hearing is not provided until after the termination takes effect.

Section 1857(h)(1) specifies procedures that must be followed before a termination by HCFA can take effect (unless the exception for an imminent and serious risk to health applies, as discussed above). We specify these requirements at § 422.50(b)(1). Section 1857(h)(1)(A) requires that the M+C organization be provided with a ''reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies'' that were the basis for a decision that grounds for termination existed under section 1857(c)(2). Section 422.510(c) provides for such a corrective action opportunity, consistent with time frames specified in Subpart N, except in cases in which the termination is based upon § 422.510(a)(5), and the ''imminent and serious'' risk to health exception in section 1857(h)(2) applies.

Section 1857(h)(1)(B) requires that the Secretary provide the M+C organization with ''reasonable notice and opportunity for hearing,'' including ''the right to appeal an initial decision * * * *before* terminating the contract.'' (Emphasis added.) Section 422.510(d) implements this provision by requiring that a notice of appeal rights under Subpart N be provided when a termination notice is sent to an M+C organization. This notice would specify that the termination would not be effective until after the hearing and appeal, except in the case of a termination under § 422.510(a)(5).

Also, in instances where it is necessary for HCFA to immediately terminate its contract with an M+C organization for violations prescribed in § 422.510(a)(5), we specify in § 422.510(b)(2) that if a termination notice is sent and takes effect in the middle of the month, HCFA has the right to recover a prorated share of its payment made to the M+C organization at the beginning of the month following notice of said termination.

8. Termination of a Contract by the M+C Organization (§ 422.512)

Paragraph (a) of § 422.512 provides that the M+C organization may terminate the contract if HCFA has failed substantially to carry out the terms of the contract. The paragraph (b) through (d) establishes requirements for giving notice, specifies when the termination is effective, and establishes when HCFA's liability for payment to the M+C organization ends. Paragraph (e) states that organizations that terminate their contract with HCFA cannot enter into an agreement with the Secretary for five years unless there are circumstances that warrant special consideration.

9. Minimum Enrollment Requirements (§ 422.514)

The newly-created section 1857(b) of the Act specifies that HCFA may not enter into a contract with an M+C organization unless the organization has at least 5,000 enrollees (or 1,500 if it is a PSO), or at least 1,500 enrollees (or 500 if it is a PSO) if the organization primarily serves individuals residing outside of urbanized areas. We specify these requirements in § 422.514(a).

Section 1857(b) refers to individuals ''who are receiving health benefits through the organization.'' We considered interpreting receiving health ''benefits'' to mean more than simply receiving health *services.* A hospital or doctor can furnish health services on a fee-for-service basis, or an organization can *administer* health benefits offered by an employer without actually providing ''benefits'' in the form of covered costs. We also recognize that some new organizations, both federally waivered PSOs and new state licensed entities, will apply to enter the M+C program. Thus, such an interpretation would allow some new entities to achieve the minimum enrollment requirement without having any or very little enrollment.

The minimum enrollment requirement is an indicator that the organization applying for an M+C contract can handle risk and capitated payments and also is able to effectively manage a health care delivery system including the enrollment and disenrollment of beneficiaries and the timely payment of claims, provide quality assurance, and have systems to handle grievances and appeals. While having experience with risk based payments indicates the organization can handle risk, it does not provide any assurance that the organization can manage all the contractual requirements of an M+C organization.

We realize that through the waiver process for federally waivered PSOs and the application process for all new entities we require reasonable assurance that the organization will be able to manage their contract. We do not want to add an additional barrier to entry for those organizations that have gone through the waiver process or state licensure but are still start-up organizations.

We have decided to require that the minimum enrollment requirement can only be met counting enrollees in the particular organization. This will show the organization can handle risk and manage their system.

Section 1857(b)(2) contains the statement that the term ''covered lives'' should be substituted for ''individuals'' in applying the minimum enrollment rule to MSA plans. As such, we will count covered lives for MSAs for purposes of meeting the minimum enrollment requirements.

As stated earlier, section 1857(b)(3) allows M+C organizations to request a waiver of minimum enrollment requirements during the first 3 contract years. Therefore, under § 422.514(b) HCFA may waive the minimum enrollment requirement for 1 year to those organization that need a waiver provided such organizations satisfactorily demonstrate: prior experience with risk-based payment arrangements; the ability to bear financial risk under the M+C contract; and marketing and enrollment activities necessary to meet enrollment requirements specified at § 422.514 (a)(1) and (a)(2). Both HCFA actuaries and the National Association of Insurance Commissioners recommend against entering into an contract with a applicant who does not project reaching 500 members within a short timeframe. HCFA will monitor closely the progress of organizations in meeting at least this goal during the first contract year.

If the organization does not meet the applicable minimum enrollment requirement by the end of its first year of operation we may waive the requirements for an additional year if the organization meets the requirement specified in § 422.514(b)(2):

- Requests an additional minimum enrollment waiver at least 120 days before the end of the year;
- Continues to demonstrate an ability to meet its contractual obligations and bear financial risk; and,
- Demonstrates an acceptable marketing and enrollment process. The organization's enrollment projections for the second year of the waiver will become its enrollment standard.

In paragraph § 422.514(b)(3) we state that we will only approve a third and final waiver year if the organization has achieved the transitional enrollment standard that the organization projected in their marketing and enrollment plan required to receive a waiver for their second year.

Finally, if an organization does not achieve the minimum enrollment requirement and is not operating with a minimum enrollment waiver, HCFA may elect not to renew the M+C organization's contract, we specify this at § 422.514(c).

10. Reporting Requirements (§ 422.516)

This M+C regulation contains a number of sections that specify information requirements for M+C organizations. This information is to be provided from organizations to HCFA (see §§ 422.64, 422.502, and 422.512), from HCFA to beneficiaries (see § 422.64), and from the organizations to the beneficiaries (see §§ 422.80 and 422.110).

The following listing summarizes all the information required to be disclosed either to HCFA, to beneficiaries, or to both:

- Benefits
- Premiums
- Service area
- Quality and Performance: Outcomes, HEDIS, Disenrollment, satisfaction
- Supplemental benefits
- Access: Number, mix, and distribution of providers
- Out of area coverage
- Emergency care coverage
- Supplemental premiums
- Prior authorization rules
- Grievances and appeals procedures and data
- Quality assurance program
- Utilization controls
- Compensation methods
- Financial reports
- Encounter data
- Claims
- Enrollment

These represent an extensive amount of information to be disclosed both to HCFA and to beneficiaries. M+C organizations need to be particularly aware of the many requirements to disclose information to beneficiaries as seen in §§ 422.80 and 422.110. They will have to develop management information systems that meet these disclosure requirements. As it is, these sections specify the basic requirements as to information to be disclosed. HCFA will provide more detailed policy guidance on specific contents required for each of these data elements. These additional requirements will be developed with input from the public, such as plans, consumer groups, etc.

M+C organizations also need to take into consideration in the development of these management information systems, that they will soon have to meet the requirements of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996. This act will result in regulations for data standards that effect all components of the health care system. The act will specify standards for the following types of transactions: claims, enrollment and disenrollment, eligibility, payments and remittances, premiums, first report of injury, claim status, referral, providers, patient identifiers, health plan identifiers, and code sets. The organizations will also need to be in compliance with year 2000 changes.

Furthermore, M+C organizations will need to address the confidentiality and privacy provisions of these regulations and related regulations, meet the validation requirements associated with several of the data sets incorporated into this regulation, e.g, encounter data will need to be validated, and be capable of electronically transmitting this information to HCFA in the future, when such is so specified.

Section 1857(d) contains several provisions involving the financial records and financial status of M+C organizations. As discussed above, paragraphs (1) and (2) of section 1857(d) provide for auditing and inspection of M+C organizations' financial records. The paragraph (4) in section 1857(d) specifically requires that organizations ''in accordance with regulations of the Secretary, report to the Secretary financial information,'' which ''shall include'' such information as the Secretary may require demonstrating that the organization has a fiscally sound operation. Under our authority at section 1856(b)(2) to adopt section 1876 standards, we have decided to implement this authority in part by requiring that M+C organizations comply with financial reporting requirements currently set forth in § 417.126. These requirements are set forth in § 422.516(a) and (b). We believe that requirements specified in section 1857(d)(1), which require HCFA to conduct annual audits of the financial records of M+C organizations, compel M+C organizations to provide all required information described at § 422.516(a) and (b). Included in these requirements are—

- Requirement that M+C organizations develop and maintain a system for reporting information to HCFA, its enrollees and the general public, information described elsewhere in the regulation.
- A requirement that each M+C organization report to HCFA a description of significant business transactions.
- A requirement that each M+C organization submit combined financial statements to HCFA on a timely basis, as defined by HCFA.
- A requirement that for any employees' health benefits plan that includes an M+C organization in its offering, the M+C organization must furnish, upon request, the information the organization needs to fulfill its reporting and disclosure obligations (with respect to the particular M+C organization) under the Employee Retirement Income Security Act of 1974 (ERISA).
- A requirement that the organization notify HCFA regarding any loans or other special financial arrangements.
- A requirement that each M+C organization must make financial information available to enrollees upon request.

11. Prompt Payment Requirements (§ 422.520)

Under § 422.520, contracts with M+C organizations must specify that the M+C organization agrees to provide prompt payment of claims that have been submitted by providers for services and supplies rendered to Medicare enrollees when these services and supplies are not furnished by an organization-contracted provider. While this requirement closely follows requirements already in place for section 1876 contractors, (including provisions pertaining to interest to be paid if timely payment is not made), section 1857(f) extends similar prompt payment requirements to claims submitted by Medicare beneficiaries enrolled in M+C private fee-for-service plans. Section 422.520(a) contains this new section 1857(f) requirement, as well as the requirement that applies to non-contracting providers. Further, pursuant to our authority under section 1856(b)(1) to establish standards under Part C, we require organizations to act upon (either approve or deny, not

necessarily pay) all claims within 60 calendar days from the date of request. These claims include the remaining 5 percent of the clean claims not paid within 30 days as well as all other claims.

In addition, pursuant to our authority in section 1856(b)(1) to establish standards under Part C, we are requiring in § 422.520(b) that contracts or other written agreements between M+C organizations and providers and suppliers contain a ''prompt payment'' provision, the terms of which are developed and agreed to by the M+C organization and the relevant provider.

Section 1857(f)(2) also contains another new provision that specifies that if the Secretary determines that the organization fails to make payments promptly to non-contracting providers and suppliers as required under section 1857(f)(1) (and § 422.520(a)), the Secretary may provide for direct payments to affected providers and suppliers. We articulate these requirements in § 422.520(c).

Special Rules for RFB Societies

Enrollment restriction rules may be imposed by religious fraternal benefit society M+C organizations, provided the restriction of enrollment is consistent with the requirements identified in section 1859(e) of the Act. The RFB M+C organizations must still meet the requirements for financial solvency. Moreover, the Secretary may adjust the M+C organization's payment to account for the unique actuarial characteristics of the individuals enrolled in the RFB M+C organization. We specify these requirements in § 422.250(a).

L. Effect of Change of Ownership or Leasing of Facilities During Term of Contract

This interim final rule applies to M+C organizations the provisions concerning the effect of change of ownership or leasing facilities during the term of the contract that are currently set forth with regard to HMOs and CMPs in subpart M of part 417 to M+C organizations. This is accomplished by designating §§ 417.520 through 417.523 as §§ 422.550 through 422.533 in a new subpart L in part 422 and making certain nomenclature changes. (A cross-reference to subpart L of part 422 is included in subpart M of part 417 in order that these provision may continue to apply to Medicare contracts with HMOs and CMPs under section 1876.) We also revise redesignated § 422.550 (formerly § 417.520) to add that an M+C organization that has Medicare contract in effect and is considering or negotiating a change in ownership must provide to HCFA updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization. We also add this requirement to redesignated § 422.552 (formerly § 417.522), which contains requirements relating to novation agreements.

M. Subpart M—Grievances, Organization Determinations, and Appeals (§§ 422.560 Through 622)

1. Introduction

Subpart M of part 422 implements sections 1852(f) and (g), which set forth the procedures M+C organizations must follow with regard to grievances, organization determinations, and reconsiderations and other appeals. Under section 1852(f), an M+C organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any other entity or individual through which the organization provides health care services) and enrollees in its M+C plans. Section 1852(g) addresses the procedural requirements concerning coverage (''organization'') determinations and reconsiderations and other appeals. As discussed in detail below, only disputes concerning ''organization determinations'' are subject to the reconsideration and other appeal requirements under section 1852(g). In general, organization determinations involve whether an enrollee is entitled to receive a health service or the amount the enrollee is expected to pay for that service. All other disputes are subject to the grievance requirements under section 1852(f). For purposes of this regulation, a reconsideration consists of a review of an adverse organization determination (a decision that is unfavorable to the M+C enrollee, in whole or in part) by either the M+C organization itself or an independent review entity. We use the term ''appeal'' to denote any of the procedures that deal with the review of organization determinations, including reconsiderations, hearings before administrative law judges (ALJs), reviews by the Departmental Appeals Board (DAB) and judicial review.

For the grievance, organization determination, and appeal requirements, an M+C organization must establish procedures that satisfy these requirements with respect to each M+C plan that it offers. These requirements generally are the same for each type of M+C plan—including M+C non-network MSA plans and M+C PFFS plans.

The grievance, organization determination, and appeal requirements for M+C organizations that are set forth in this interim final rule are largely based on the existing rules for managed care organizations under part 417, Subpart Q, Beneficiary Appeals. This is in accord with section 1856(b)(2), which directs that the M+C standards be based on the analogous standards established under section 1876, as long as they are consistent with the requirements in part C. Moreover, we note that to some extent the statutory requirements themselves reflect policies contained in the existing part 417 requirements. For example, the requirements under section 1852(g)(3) concerning expedited organization determinations and reconsiderations essentially incorporate the expedited review procedures that were issued in HCFA's April 30, 1997 final rule with comment (62 FR 23368). (That final rule established expedited review processes for organization and reconsidered determinations, and clarified that the definition of an organization determination includes discontinuations of service.)

Thus, the significant differences between the grievance and appeal requirements that apply under the M+C program and the existing requirements in subpart Q of part 417 are: (1) changes that are explicitly mandated under the statute, such as the requirement under section 1852(g)(4) that HCFA contract with an independent outside entity to review coverage denials; and (2) changes that implement statutory intent, such as the reduced timeframe for reconsiderations, which is consistent with both the discretion provided under section 1852(g)(2)(A) and Congress' expectations as stated in the BBA conference report. (As discussed below, the conference report states that the Conferees ''* * * assume that the Secretary will address the issue of [reconsideration] timeframes in the Part C regulations'' and intend that the Secretary adopt timeframes that are shorter than those in existing regulations. See H.R. Rep. No. 105–217, pg. 605 (1997).) The only other substantive changes contained in these requirements are the incorporation into the regulations of several limited policy clarifications that have been issued by HCFA as implementing instructions pursuant to our April 30, 1997 final rule. These changes are discussed in detail below.

In addition to these limited substantive changes, we have also taken the opportunity to make numerous editorial and organizational changes in adopting the part 417 regulation language on beneficiary appeals for

purposes of the M+C program. For example, we have added material that summarizes the rights of M+C enrollees, and we have established distinct sections that clearly explain the timeframe and notice requirements for standard and expedited organization determinations. These types of changes do not affect the rights of beneficiaries or the responsibilities of M+C organizations with regard to grievances, organization determinations, and appeals, but we believe they can help to ensure that these rights and responsibilities are more clearly understood within the managed care community.

2. General Provisions (§§ 422.560–522.562)

Subpart M begins with an introductory section (§ 422.560) that simply sets out the statutory basis and scope for the requirements that follow. Although this material is generally shorter and more concise than the similar provisions of subpart Q in part 417, we are now specifying under § 422.560(b) that the rules concerning notice of noncoverage on inpatient hospital care and immediate peer review organization (PRO) review procedures for noncoverage determinations fall within the scope of the M+C subpart M requirements.

Section 422.561 then sets forth several definitions for terms used in the subpart. Note that some definitions previously located in subpart Q of part 417 (such as ''ALJ'') have now been included in § 400.200, rather than in part 422, since they constitute definitions that apply for all Medicare and Medicaid purposes. Terms included here that are not defined in existing part 417 include ''appeal,'' ''authorized representative,'' ''enrollee,'' ''grievance,'' and ''physician.'' For the most part, these definitions are self-explanatory; they do not impose any new requirements on M+C organizations. For example, we clarify that an ''authorized representative'' is an individual authorized by an enrollee to act on his or her behalf in obtaining an organization determination, or in dealing with any levels of the appeal process, subject to the Social Security regulations in 20 CFR part 404, subpart R. We also specify that, for purposes of subpart M, the term ''enrollee'' includes an enrollee's authorized representative. Together, these definitions should clarify that the rights of enrollees with respect to grievance and appeal procedures can consistently be exercised for them by their authorized representatives, except where specifically proscribed in the regulations. We also establish that ''physician'' is defined according to section 1861(r), which is the standard definition for both original Medicare and the M+C program.

Section 422.562, General Provisions, provides an overview of the rights and responsibilities of M+C organizations and M+C enrollees with respect to grievances, organization determinations, and appeals. The responsibilities of M+C organizations, under § 422.562(a), essentially parallel those in existing § 417.604(a). We have added a provision stating that if an M+C organization delegates any of its responsibilities under subpart M to another entity or individual through which the organization provides health care services, the M+C organization is ultimately responsible for ensuring that the applicable grievance and appeal requirements are still met. This concept is explicitly stated in section 1852(f) concerning grievance procedures, and we believe it is equally germane for purposes of organization determinations and appeals. An M+C organization's responsibility for functions that it delegates is also established under the contract requirements set forth in § 422.502(i). (Although we do not encourage M+C organizations to delegate their grievance, organization determination or appeal responsibilities, we recognize that particularly for an M+C non-network MSA plan or an M+C PFFS plan, an organization offering such a plan may choose to delegate some of these responsibilities to local entities that can meet the applicable subpart M requirements.)

Section 422.562(b) explains the basic rights of M+C enrollees under subpart M and provides regulatory references to the sections that fully explain the relevant rights. This section does not establish any rights beyond those now available under the part 417 rules, but consolidates general information about enrollees' rights into a central location in the regulations.

Like the part 417 regulations, the general provisions section concludes with brief sections addressing the applicability of requirements in subpart M and the applicability of other regulations under title II of the Act.

3. Grievance Procedures (§ 422.564)

As noted above, section 1852(f) requires that each M+C organization provide ''meaningful procedures for hearing and resolving grievances.'' There is no explicit indication in the statute of what constitutes a grievance; however, given the provision in section 1856(b)(2) for basing Part C standards on standards under section 1876, we have retained the meaning of grievance used in part 417. We have defined this term in § 422.561 as any complaint or dispute other than one that involves an ''organization determination'' (as described under § 422.566(b)).

An enrollee might file a grievance if, for example, the enrollee received a service but believed that the demeanor of the person providing the service was insulting or otherwise inappropriate. Also, as specified under §§ 422.570(d)(2)(ii) and 422.584(d)(2)(ii), grievance procedures would apply when an enrollee disagrees with an M+C organization's decision not to comply with an enrollee's request to expedite an organization determination or a reconsideration. Under § 422.564(a), we are requiring that an M+C organization must resolve grievances in a timely manner and that procedures for doing so must comply with any guidelines established by HCFA. This guidance would include forthcoming instructions, rulemaking, and requirements built into HCFA's Quality Improvement System for Managed Care (QISMC). (See section II.D of this preamble for more information about QISMC.) Section 422.564(b) then clarifies that grievance procedures are separate and distinct from appeal procedures, which address organization determinations. We also clarify under § 422.564(c) that the PRO complaint process under section 1154(a)(14) addresses quality issues, but is separate and distinct from the M+C organization's grievance procedures.

Although we have not in the past outlined detailed requirements for a plan's grievance procedures, we considered doing so in this interim final rule as a means of implementing the requirement under section 1852(f) for meaningful grievance procedures. Accordingly, we consulted with the managed care industry as well as beneficiary advocacy groups, reviewed comments we received from the public, and looked to recent standards in this area, such as those developed by the National Association of Insurance Commissioners (NAIC). (NAIC has developed and adopted a Model Grievance Act setting forth standards for grievance procedures that include timeframes for the resolution of quality-related issues.) We also recognize that section 1852(c)(2)(C) requires organizations to provide data on the number of grievances and their disposition in the aggregate upon an enrollee's request, and we believe timely processing of grievances is necessary to assist in consistent data reporting. Thus, we considered requiring certain timeframes for

addressing grievances and contemplated further clarification of the definition of a grievance.

However, due to limited time for rulemaking, input we received from the public opposing mandated grievance procedures, and our understanding that extensive research is underway concerning State grievance requirements (the results of which should be available in the very near future), we have decided not to prescribe specific timeframes for grievances in this rule and instead to consider doing so through proposed rulemaking. We plan to address such issues through a future proposed rule. At this time, we welcome comments on the necessary elements of a meaningful grievance procedure, including recommended timeframes, the types of issues that should be considered grievances, an expedited grievance process, independent review of grievances, reconsideration of grievances, and the type of notification enrollees should receive concerning the outcome of their grievance.

4. Organization Determinations (§§ 422.566 Through 422.576)

Section 1852(g) requires an M+C organization to establish procedures for hearing and resolving disputes between the organization and its Medicare enrollees concerning organization determinations. These rights are similar to those available to beneficiaries under original Medicare, except that under the M+C program the initial level of review is typically conducted by the organization itself rather than by a PRO, intermediary, or carrier.

(For the convenience of the reader, we are presenting below a chart offering a sequential overview of the available procedures and related timeframes associated with service-related organization determinations and appeals. This chart is for illustrative purposes only, and certain details (such as when extensions are permissible and timeframes for requests for payment) have been omitted for ease of presentation. For a full description of the applicable requirements, please consult the preamble material that follows and the regulations set forth in subpart M of part 422. Although the chart reflects the maximum allowable timeframes available to an M+C organization under the M+C regulations (for service requests), we emphasize that the primary applicable requirement, as discussed in detail below, is that an M+C organization make a determination as expeditiously as the enrollee's health condition requires. In addition, note that maximum timeframes for an M+C organization to make a payment-related determination are somewhat longer than for service-related determinations, as is also discussed below.)

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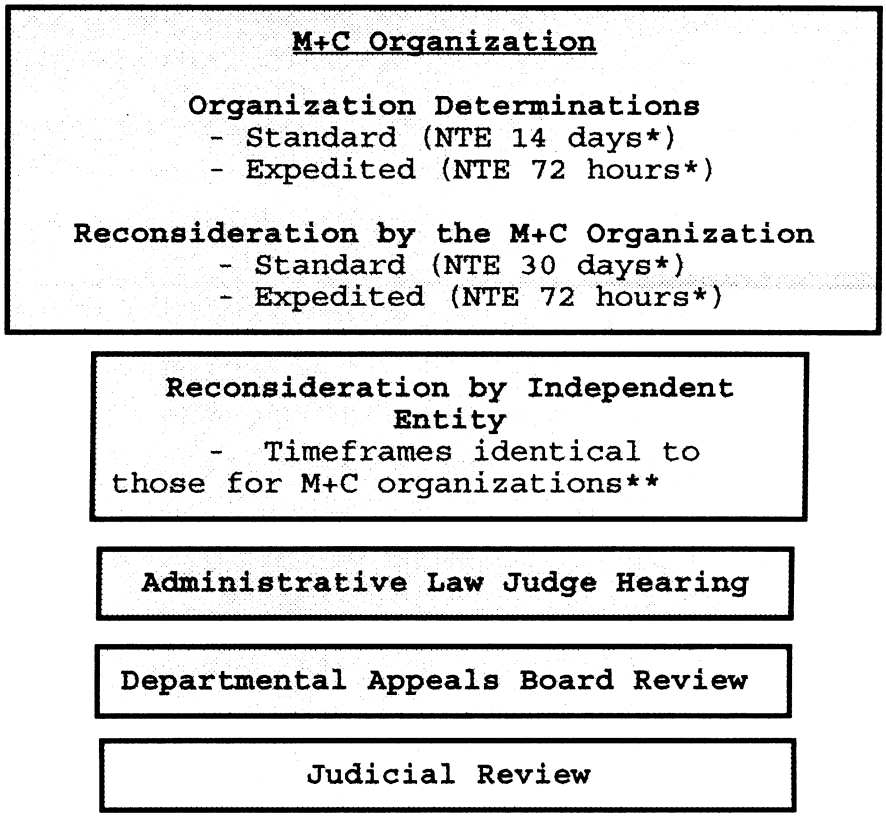
M+C ORGANIZATION DETERMINATION AND APPEAL PROCESS FOR SERVICE-RELATED REQUESTS



* For all service-related requests, an M+C organization must render determinations "as expeditiously as the enrollee's health condition requires," but not to exceed (NTE) the timeframes noted above.

** As discussed below, the timeframe requirements for standard and expedited reconsiderations by the independent entity will be established through contract.

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In accordance with section 1852(g)(1), § 422.566 begins by specifying that an M+C organization must have a procedure for making timely organization determinations regarding the benefits an enrollee is entitled to receive and the amount, if any, that an enrollee must pay for a health service. We note that under section 1852(g)(1), the issues that must be addressed through an organization determination include an enrollee's entitlement to ''receive a health service *under this section*.'' (Emphasis added.) Section 1852(a) describes basic benefits that M+C organizations must offer, as well as supplemental benefits that organizations may offer. Supplemental benefits may either be provided to all enrollees on a mandatory basis (with the Secretary's approval) or provided at the enrollee's option. In both cases, the enrollee pays for supplemental benefits. Disputes involving supplemental benefits that are mandatory for all enrollees in a plan will be organization determinations and subject to the appeal process, as similar benefits were under part 417. We believe, however, that optional supplemental benefits should also be included in the meaning of ''health services under [section 1852]'' and disputes involving these types of benefits should be the subject of organization determinations and the appeal process. This policy, which is incorporated into § 422.566(a), represents a departure from existing part 417 requirements, where disputes concerning optional supplemental benefits are not the subject of organization determinations and must be resolved only through grievance procedures. Section 422.566(b) then lists actions that are organization determinations, consistent with existing § 417.606(a) (except for new language to reflect the inclusion of optional supplemental benefits and the explicit mention of payment for post-stabilization care, along with payment for emergency or urgently needed services, which appear already in § 422.606(a)).

Section 422.568 includes the standard timeframe and notice requirements for organization determinations. Note that this section, in conjunction with §§ 422.570 and 422.572, reflect a major reorganization of the requirements in existing §§ 417.608 and 417.609. This reorganization was necessary both to help clarify the different timeframe and notice requirements that apply for expedited determinations as well as to facilitate the addition of several new BBA requirements (which are discussed below).

The primary substantive change in § 422.568 is the requirement under § 422.568(a) that an M+C organization must make a determination with respect to an enrollee's request for service as expeditiously as the enrollee's health status requires, and in no case later than 14 calendar days after the organization receives the request. As discussed in detail below in section II.M.6 of this preamble, this new requirement emphasizes making determinations consistent with an enrollee's health needs, while also providing for a reduction in the maximum time allowed to make a determination from 60 days, as reflected in § 417.608(a), to 14 days. In conjunction with the reduced timeframe for making an organization determination, we are also providing that the M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must include written justification for the extension in the case file. The length of the extension period is consistent with the extensions currently allowed under part 417 for expedited organization determinations.

We note that the maximum timeframes for both organization determinations and for reconsiderations are now reckoned in ''calendar days,'' as opposed to ''working days,'' in order to be unambiguous and consistent with the statute. In addition, under § 422.568(b), we have specified that timeframes for requests for organization determinations on payment issues are identical to the ''prompt payment'' requirements set forth under § 422.520. Thus, for issues relating to payment, the requirements are as follows: (1) For ''clean claims,'' an M+C organization must make a determination regarding the claim within HCFA's current ''clean claim'' rules, that is, 95 percent of clean claims must be paid within 30 calendar days after receipt of the request for payment. (As defined in § 422.500, ''clean claims'' are claims that have no defect, impropriety, lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payment.) (2) For all other claims, an M+C organization must make a determination regarding the claim within 60 calendar days after receipt of the request for payment.

Consistent with section 1852(g)(1)(B), § 422.568(c) and (d) require that an M+C organization issue written notification for all denials, including the specific reasons for the denial in understandable language, information regarding the enrollee's right to either an expedited or standard reconsideration, and a description of both the expedited and standard review processes, as well as the rest of the appeal process.

Sections 422.570 and 422.572 set forth the requirements for M+C organizations with respect to expedited determinations. Section 1852(g)(3)(A) specifically allows either an enrollee or a physician to request an expedited organization determination or reconsideration, regardless of whether the physician is affiliated with the M+C organization. We have reflected this provision in §§ 422.570(a) (for expedited organization determinations) and 422.584(a) (for expedited reconsiderations). We have also addressed the issue of the circumstances under which a physician can request expedited review for an enrollee. HCFA currently allows any physician to request an expedited organization determination without being appointed as an enrollee's authorized representative. In contrast, HCFA requires that a physician be an enrollee's authorized representative in order for the physician to request an expedited reconsideration on the enrollee's behalf. We have made this distinction because, in the context of an organization determination, we regard the physician as a provider who is requesting a service for his or her patient. In the context of a reconsideration, on the other hand, we believe the physician is serving as the enrollee's representative in the first level of the appeal process.

We have decided to continue this current policy, and have reflected in § 422.570(a) that any physician can request an expedited organization determination, while § 422.584(a) provides that a physician who requests an expedited reconsideration must be acting on behalf of the enrollee as an authorized representative. We would also like to make it clear that, in any case in which a physician is only supporting an enrollee's request for expedited review, the physician does not need to be the enrollee's authorized representative.

As mentioned above, the requirements for expedited organization determinations and the like requirements for expedited reconsiderations were the subject of HCFA's April 30, 1997 final rule. Section 1852(g)(3) is modeled to a large extent on our existing requirements. For example, section 1852(g)(3)(B)(ii)

explicitly states that an M+C organization must expedite its determination (or its reconsideration of a determination) if a physician has requested the expedited review and has indicated, either orally or in writing, that the application of a standard timeframe for a determination (or reconsideration) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. This new statutory provision reflects the current provisions in part 417. Sections 417.609(c)(4) and 417.617(c)(4) require that an HMO or CMP grant a physician's request for expedited review; however, they do not require that the physician make any statements about the enrollee's health, as the physician must under section 1852(g)(3)(B)(ii). In effect, the statute now requires that an M+C organization must expedite a determination at the physician's request, that is, providing that the physician's request indicates the possibility of serious jeopardy to the enrollee.

Section 422.570(b)(2) specifies that a physician may provide written or oral support for a request for expedition, and under § 422.570(c)(2)(ii), we clarify that when requests for expedited organization determinations are made or supported by a physician, the M+C organization must grant the request if the physician indicates that the enrollee's health could be jeopardized. In any case in which a physician has not initiated the request, but supports it, we regard the physician as having joined in the request and, in effect, as being a co-requestor. (We note that in a case when an enrollee submitted a request for an expedited organization determination but did not know that physician support could automatically expedite a determination, an enrollee or a physician may submit a subsequent request, including the physician's statement of support, for an expedited organization or reconsidered determination.)

These sections also incorporate several details necessary to clarify current policy, such as the provision in § 422.568(d)(1) that an M+C organization automatically transfer a denied request for an expedited organization determination to the standard 14-day timeframe described in § 422.568(a), and the requirement under § 422.570(d)(2)(ii) that an M+C organization inform the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision not to expedite. We also require under § 422.570(c)(1) that an organization establish an efficient and convenient means for individuals to submit oral or written requests for expedited organization determinations and document any oral requests. Generally, in accordance with the provisions of § 422.570(b)(1), we would expect that such requests would be submitted directly to the M+C organization. However, because we recognize that some organizations may already have established or may wish to establish other convenient procedures for accepting oral and written requests for expedited review, we clarify under § 422.570(b)(1) that procedures may involve submitting a request to another entity responsible for making the determination, as ''directed by the M+C organization.''

Under section 1852(g)(3)(B)(iii), an M+C organization must notify the enrollee (and the physician involved, as appropriate) of an expedited determination. The requirement to notify the physician is similar to one in § 417.609(c)(3), which requires of an HMO or CMP ''notification of the enrollee, and the physician as appropriate.'' This requirement is set forth in § 422.572(a). Section 1852(g)(3)(B)(iii) also requires that the M+C organization notify the enrollee and physician of an expedited determination under time limits established by the Secretary, but not later than 72 hours after receiving the request (or receiving the information necessary to make the determination), or such longer period as the Secretary may permit in specified cases. Under this authority, we are able to retain in § 422.572(a) the existing 72-hour timeframe for expedited review that appears in § 417.609(c)(3). Also, we have exercised our discretion to allow in § 422.572(b) an M+C organization to extend the 72-hour deadline for expedited review by up to 14 calendar days if the enrollee requests the extension or if the organization finds that additional information is needed and the delay is in the interest of the enrollee.

Thus, the authority in section 1852(g)(3)(B) has allowed us to retain the recently promulgated regulations on expedited determinations with only a few clarifications and minor technical changes (for example, we have changed the 10 working day extension in § 417.609(c)(3) to 14 calendar days, to be consistent with how we are counting days under the other section 1852 provisions). We have added to the regulation an example of the type of reason for which an extension may be granted, and we have specified that an M+C organization must notify an enrollee of a determination as expeditiously as the enrollee's health care needs require but no later than upon expiration of the extension.

We have also added a provision in both §§ 422.570(f) and 422.584(f) to prohibit an M+C organization from taking or threatening to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited organization determination or reconsideration. Since publication of our April 30, 1997 final rule, several national organizations (including the American Medical Association and the American Association of Retired Persons) have expressed strong support for a general prohibition that would prevent retaliation against physicians who act on behalf of or in support of enrollees to expedite reviews. Moreover, we believe that this prohibition complements the anti-gag rules incorporated into subpart E of this interim final rule.

Section 422.574 identifies the parties to an organization determination. The statute does not specify who can ask for an organization determination involving the rights of an M+C enrollee to certain health services. Section 1852(g) does specify that an M+C organization must reconsider a determination upon the request of the enrollee, and either the enrollee or a physician can request an expedited reconsideration. The enrollee specifically has the right to appeal a reconsidered determination under section 1852(g)(5), a provision that is almost identical to the appeal provision in section 1876(c)(5)(B) for HMO and CMP enrollees.

We are interpreting these provisions in the same manner as we interpreted them in part 417 to include not just the enrollee, but also to allow other parties to exercise those rights. Section 417.610 lists as parties to an organization determination not just the enrollee, but certain physicians and other providers who are assignees of the enrollee, legal representatives of a deceased enrollee's estate, and the broad category of any other entity determined to have an appealable interest in the proceeding. These parties can continue to have an interest in the proceedings throughout each level of an appeal. We have retained this provision in § 422.574, except that we have modified § 417.610(d) to include any *provider* or entity determined to have an appealable interest. We have also specifically excluded the M+C organization, since we believe that this entity constitutes the decision maker, and as such is not a party to an organization determination.

5. Reconsiderations by an M+C Organization (§§ 422.578 Through 422.590)

If a decision regarding a request for payment or service is unfavorable (in whole or in part) to the enrollee, the enrollee or any other party to an organization determination as listed in § 422.574 who is dissatisfied with the organization determination may request that the M+C organization reconsider the decision. Reconsiderations represent the first step in the appeal process. The reconsideration process encompasses both standard and expedited reconsiderations, as described under §§ 422.582 and 422.584. The timeframe and notice requirements for reconsiderations are set forth under § 422.590.

One important distinction between organization determinations and reconsiderations is that an M+C organization issues a reconsidered determination only if the reconsideration is entirely favorable to the enrollee. As discussed in detail below, § 422.590(a)(1) now requires that with respect to standard reconsiderations concerning requests for service, an M+C organization must issue any determination that is entirely favorable to the enrollee as expeditiously as the enrollee's health condition requires but no later than 30 calendar days after it receives the request for reconsideration. (As with organization determinations, we are also providing under § 422.590(a) that the M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee.) Under § 422.590(b)(1), for standard reconsiderations involving requests for payment, the M+C organization must issue any fully favorable determination no later than 60 calendar days from the date it receives the request for the reconsideration. In the case of expedited reconsiderations (which involve only requests for services), § 422.590(d)(1) requires that an M+C organization issue any determination that is entirely favorable to the enrollee as expeditiously as the enrollee's health condition requires but no later than 72 hours after it receives the request for expedited reconsideration, again with the possibility of a 14-day extension as described in § 422.590(d)(2). If, however, the M+C organization's reconsideration results in an affirmation, in whole or in part, of its original adverse organization determination, this decision is automatically subject to further review by an independent entity contracted by HCFA. (Again, the timeframe within which an M+C organization must reconsider a standard or expedited case has been tied to the enrollee's health needs for service requests, subject to either a 30-day or 72-hour maximum (with a possible 14-day extension), while the timeframe remains at 60 days for reconsideration requests involving payment.)

Section 1852(g)(4) of the Act requires HCFA to contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm, in whole or in part, an M+C organization's denial of coverage. Thus, unless an organization completely reverses its coverage denial, the M+C organization must prepare a written explanation and refer the case to the independent review entity for a new and impartial determination concerning the payment or service at issue. This requirement is consistent with existing policy. Under § 417.620, an HMO or CMP that recommends partial or complete affirmation of its adverse determination must prepare a written explanation and send the entire case to HCFA, so that HCFA can make the reconsidered determination. We have in the past contracted with an independent outside entity, the Center for Health Dispute Resolution (CHDR), to perform this function.

For standard requests for services, § 422.590(a)(2) requires that the M+C organization send the case to the independent review entity as expeditiously as the enrollee's health requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration (or the date of an expiration of an extension). For standard requests for payment, § 422.590(b)(2) allows the M+C organization 60 calendar days from the date it receives the request to send the case to the independent review entity. In instances involving expedited requests for reconsideration, § 422.590(d)(5) requires that the M+C organization forward its decision to the independent entity as expeditiously as the enrollee's health condition requires, but not later than within 24 hours of its affirmation of the adverse organization determination.

Section 1852(g)(2)(B) requires that any reconsideration that relates to a determination to deny coverage based on a lack of medical necessity must be made only by ''a physician with appropriate expertise in the field of medicine which necessitates treatment.'' We have interpreted this requirement in § 422.590(g)(2) to refer to a physician with an expertise in the field of medicine that is appropriate for the services at issue. The statute also requires that the physician be one other than the physician involved in the initial determination. We believe this requirement is implicit in the provision in § 422.590(g)(1) that the reconsideration be conducted by a person not involved in making the organization determination.

For the most part, the procedures outlined above are consistent with the existing part 417 requirements and are carried over into subpart M of part 422—all significant discretionary changes (such as the timeframe reductions) as well as statutory requirements (such as required physician review of certain coverage denials) are discussed in this preamble. We also are implementing several changes in the reconsideration requirements that are analogous to those described for organization determinations, such as the requirement under § 422.584(d)(1) that an M+C organization automatically transfer a denied request for an expedited reconsideration to the standard 30-day timeframe described in § 422.590(a). In addition, § 422.590(e) requires that if an M+C organization refers a case to the independent entity, it must concurrently notify the enrollee of that action.

6. Reduction of Timeframes for Standard Organization Determinations and Reconsidered Determinations

As noted above, section 1852(g)(1)(A) requires that M+C organizations make organization determinations ''on a timely basis.'' For standard (non-expedited) reconsiderations, section 1852(g)(2)(A) specifies that a decision must be made no later than 60 days after the enrollee's request, but the Act provides the Secretary with discretion to reduce the timeframe. Again, the BBA conference report (H.R. Rep. No. 105–217, at pg. 605 (1997)) indicates Congress' understanding that HCFA was developing proposed regulations that would reduce existing timeframes and that these efforts could instead be incorporated into the regulations implementing the M+C program. Consequently, we have decided to exercise such discretion and to reduce the timeframes within which M+C organizations must render both standard organization and reconsidered determinations involving requests for service.

In researching this issue, we found widespread support for reducing timeframes for standard determinations in both medical journals and reports

from other independent entities. For example, the Physician Payment Review Commission's (PPRC) 1996 Annual Report to Congress listed ''the timeliness of the process, especially for pre-service denials'' as one of the areas requiring improvement in the current appeal process. PPRC reported that ''[c]onsiderable delays are built into the [appeal] process.'' Likewise, the Medicare Rights Center (MRC) recently recommended that HCFA require health plans to make non-expedited organization determinations within 10 days of receiving the request. The MRC also recommended that HCFA require health plans to make non-expedited reconsiderations within 20 days.

The 60-day timeframes in part 417 for organization and reconsidered determinations were based on the original fee-for-service Medicare appeal process. However, this process is mostly retrospective. In coordinated care plans, preservice requests for organization determinations exceed the number of retrospective requests. Reduced timeframes often are of critical importance—particularly when an individual is awaiting prior authorization for a service. Therefore, we believe there is a compelling need to reduce the current timeframe of 60 days for determinations regarding the provision of services in M+C organizations.

Options Considered

In developing this rule, we consulted with beneficiary advocacy groups and the managed care industry concerning several policy options, and reviewed comments received from the public. The groups agreed that the current 60-day timeframe to issue organization and reconsidered determinations was too long. A representative of HCFA's independent contractor, the Center for Health Dispute Resolution (CHDR), also agreed that 60 days was too long for processing determinations.

Beneficiary advocacy groups indicated that the timeframe for rendering standard service-related organization determinations and reconsiderations should be no more than a total of 20–30 days. Advocates reported (and our research supports) that many States require determinations within 30 days. Additionally, beneficiary advocates indicated strong support for the judgment of the United States District Court for the District of Arizona in *Grijalva, et al.* v. *Shalala* (Civ. 93–711, 1997). That case involved the appeal rights of Medicare beneficiaries who were members of HMOs and had their requests for services denied. The court's judgement in *Grijalva* prescribes various procedures to be used for beneficiary appeals in Medicare managed care programs, including the requirement that the HMO make a decision within 5 days, with an opportunity for a 60-day extension if there are exceptional circumstances.

Representatives of the managed care industry recommended that we adopt the National Committee for Quality Assurance's (NCQA) standard of 10 working days (or 14 calendar days) for organization determinations—with an opportunity for an extension. It was also noted that decisions on reconsiderations often take more time than organization determinations. The industry representatives agreed that, in many cases, plans process reconsiderations in less than 30 days, but that often times, additional time is needed to gather information (e.g., medical records). The industry representatives noted that in some instances, allowing extra time to collect information is advantageous to the beneficiary.

Based on all of this information, we are implementing revised requirements from those in part 417 for an M+C organization when it issues standard organization determinations or reconsiderations. These revised requirements include a reduction in the maximum timeframes from 60 days to 14 days for standard organization determinations involving requests for service, and from 60 days to 30 days for standard reconsiderations involving requests for service. (In both cases, 14-day extensions would be permissible under certain circumstances, as discussed above.) More important, §§ 422.568 and 422.590 establish for the first time the requirement that M+C organizations make both their organization and reconsidered determinations as expeditiously as the enrollee's health condition requires. We believe that this emphasis on the health needs of the individual enrollee is consistent with the statutory requirement that determinations be made on a timely basis. Thus, the fact that an organization makes a determination on a service-related issue within 14 days does not necessarily constitute compliance with the regulations if there is evidence that an earlier determination was necessary to prevent harm to the enrollee's health.

7. Reconsiderations by an Independent Entity (§§ 422.592 and 422.594)

Section 1852(g)(4) requires the Secretary to contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. HCFA has held such a contract for services from an independent review entity for 9 years. Section 422.592 reiterates the statutory requirement. It also articulates the principle that the independent entity must conduct reviews as expeditiously as the enrollee's health requires, but not to exceed the deadlines specified in its contract with HCFA.

For standard reconsiderations, the contractor historically has been able to process most cases within 30 days. We will require the contractor to meet the standard articulated for M+C organizations at section 422.590; that is, subject to considerations of medical exigency, the contractor must process standard reconsiderations within 30 days, with the possibility of an extension. As part of our new requirement to collect and report information regarding beneficiary appeals, we will monitor all exceptions to deadlines and reasons for delay. In cases in which the delay is due to the failure of the M+C organization to supply the contractor with requested information in a timely manner, we will generally instruct the contractor to find in the beneficiary's favor on any issue that it cannot decide without the information in question. (When an M+C organization has conducted a reconsideration, it presumably will have already collected all the relevant documents and other information needed to make the decision. However, our experience demonstrates that the independent reviewer must sometimes request additional material in order to have a complete record of the dispute.)

For expedited cases, we will require the contractor to make a decision as quickly as the enrollee's condition requires, or within 72 hours (with the possibility of an extension under certain circumstances), in accordance with the expedited reconsideration requirements for M+C organizations under § 422.590(d). As with standard reconsiderations, we will monitor cases that exceed this deadline along with the reasons for the delay. If any delay is due to the failure of the M+C organization to supply the contractor with requested information in a timely manner, we will generally instruct the contractor to find in the beneficiary's favor on any issue that it cannot decide without the information in question.

In order to provide more guidance to both our contractor and the M+C organizations with which we will contract, we will work with them and other interested parties to develop common guidelines for identifying those cases that require immediate attention due to the enrollee's health condition.

These guidelines will build upon, but not be limited to, the criteria that M+C organizations must use to evaluate whether a case should be expedited, currently contained in § 422.570(c)(2). We will issue this information as part of forthcoming manual instructions.

8. Administrative Law Judge (ALJ) Hearings, Departmental Appeals Board (DAB) Hearings, and Judicial Review (§§ 422.600 Through 422.612)

If the independent reviewer's reconsidered determination is not fully favorable to the enrollee, any of the parties listed in § 422.574 has a right to request a hearing before an ALJ of the Social Security Administration if the amount remaining in controversy is $100 or more. (Note that the M+C organization does not have a right to request a hearing before the ALJ.) If the ALJ hearing does not result in a fully favorable determination, any party (including the M+C organization) may request that the Appeals Council of the DAB review the ALJ decision. Following the administrative review process, any party (including the M+C organization) is entitled to judicial review of the final determination if the amount remaining in controversy is $1,000 or more. In establishing the requirements for M+C organizations, we have clarified and adopted the existing requirements in part 417, with one exception. That is, consistent with section 1852(g)(5), we require under § 422.612(a) that a party who wishes to request judicial review of an ALJ's decision must notify the other parties involved.

9. Effectuation of a Reconsidered Determination or Decision (§ 422.618)

Based on public reaction to our April 30, 1997 final rule, we believe there may be a need for explicit regulatory requirements concerning an M+C organization's effectuation of (that is, an organization's compliance with) an appeal determination or decision. Therefore, we are including at § 422.618 (and referencing at § 422.590(a)(1) and (b)(1)) several requirements that constitute a restatement of HCFA's longstanding policy in this regard (with a corresponding timeframe reduction from 60 to 30 days in the case of service-related reconsiderations). (See sections 2405.4 and 2405.5 of the HMO/CMP Manual Transmittal 6, issued in March, 1991.) Specifically, § 422.618(a)(1) requires that if, on reconsideration of a request for service, an M+C organization reverses its adverse organization determination, the organization must authorize or provide the service under dispute as expeditiously as the enrollee's health requires, but no later than 30 calendar days after the date the M+C organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(a)(1)). For reconsideration of requests for payment, § 422.618(a)(2) requires that if an M+C organization reverses its adverse organization determination, the organization must pay for the service no later than 60 calendar days after the date the M+C organization receives the request for reconsideration. Similarly, under § 422.618(b), if an M+C organization's adverse organization determination is reversed in whole or in part by the independent entity's reconsideration or at a higher level of appeal, the M+C organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date the M+C organization receives notice reversing its organization determination. The M+C organization must also inform the independent, outside entity that it has effectuated the decision.

10. Noncoverage of Inpatient Hospital Care—Notice and PRO Review (§§ 422.620 and 422.622)

Under § 422.620, we are largely incorporating the existing requirements under § 417.440(f) concerning notice of noncoverage of inpatient hospital care. Section 417.440(f) requires that if an enrollee in an HMO or CMP is a hospital inpatient, the enrollee remains entitled to inpatient care until he or she receives notice that the care is no longer covered. We have revised this provision, however, to make it clear that inpatient services only continue to be covered until there is a notice of noncoverage in situations in which the hospital admission was authorized in the first instance by the M+C organization or in which the admission constituted emergency or urgently needed care, as described in §§ 422.2 and 422.112(b). This clarification is warranted in light of the fact that an M+C organization offering an M+C non-network MSA or private fee-for-service plan has the right to deny coverage retroactively for a hospital stay involving nonemergency or nonurgently needed care on the grounds that it was not medically necessary. Also, this would make it clear that an M+C organization does not have to make payment under an MSA plan if the deductible has not been satisfied.

Section 422.622 explains our requirements with respect to an enrollee's right to PRO review of a determination by an M+C organization or a hospital that inpatient care is no longer necessary.

Under existing § 417.605, Medicare managed care enrollees have two protections available to them when they believe they are being discharged prematurely from a hospital—immediate PRO Review or an HMO or CMP's internal expedited appeal process. Under § 417.604(b), enrollees may elect one appeal right or the other; exercising one right eliminates the right to the other.

We believe that the PRO review process offers significant advantages to enrollees, most significantly the protection from financial liability for a continued hospital stay until noon of the calendar day following the day the PRO notifies the enrollee of its review determination. Additionally, PROs generally communicate directly with the Medicare enrollee (or authorized representative) during the review, conduct their reviews of an alleged premature discharge within 3 days, and use nurses and physicians to conduct the reviews. In contrast, enrollees who file for an expedited review with the managed care organization are not protected from financial liability during an appeal. The HMO or CMP has 72 hours to conduct the review. If the organization is unable to issue a fully favorable decision to the enrollee, the case file will be forwarded to the independent contractor.

In developing the M+C requirements with respect to this issue, we considered whether the regulations should require enrollees of M+C organizations to exercise their right to immediate PRO review. We consulted with representatives of both the managed care industry and beneficiary advocates. The groups with which we consulted indicated that the immediate PRO review process appears to be a better option for the enrollee. As noted previously, PRO review provides financial protection, direct communication between the PRO and the enrollee, and a decision that is generally rendered more quickly than a managed care plan's determination. However, we were not certain whether we should limit beneficiaries to one option. Particularly in the event that an enrollee misses the deadline for filing with the PRO, we believe that the enrollee should retain the option of filing an expedited appeal with the M+C organization.

Based on this review, we have concluded that the appropriate course is to draft the M+C requirements so as to make it clear that it is in the best interest of an M+C enrollee to request PRO review if the individual believes that he

or she is being discharged from a hospital prematurely. Thus, § 422.622(a)(1) specifies that: ''An enrollee who wishes to appeal a determination by an M+C organization or hospital that inpatient care is no longer necessary must request immediate PRO review. * * * An enrollee who requests immediate PRO review may remain in the hospital without further financial liability [subject to the provisions of § 422.622(c)]'' (until PRO review is completed). Section 422.622(a)(2) then provides that an enrollee who fails to make a timely request for PRO review still has the option of requesting an expedited reconsideration from the M+C organization, although the financial liability protections associated with the PRO review process do not apply. We believe that this regulatory construction makes it clear that enrollees are expected, for their own benefit, to avail themselves of the PRO review process, but does not eliminate the fall-back option of the M+C organization's expedited review process for those enrollees who fail to request PRO review on a timely basis.

We have made further revisions to the language in § 417.605 to adapt this provision to the new M+C MSA and private fee-for-service plan options. As discussed above in connection with the notice of non-coverage requirement in § 422.620, under these plan options, an M+C organization may not be aware that an enrollee has been hospitalized, and has the right to deny coverage of such a hospitalization on the grounds that the stay was not medically necessary. Also, in the case of an enrollee in an M+C MSA plan, the individual may not have reached the deductible under the plan, and therefore payment for medically necessary hospital services shall be applied to the deductible. We thus have made it clear in § 422.622(c)(1) that if an M+C organization did not authorize coverage of a hospital admission, and notifies the enrollee that a continued stay is not covered, the organization is not required to pay for services while the enrollee pursues an appeal with a PRO (that is, unless and until it is determined on appeal that the hospital stay should have been covered under the M+C plan). We have qualified this statement to provide that the M+C organization is obligated to pay for continued services if the enrollee was hospitalized in order to receive emergency services or urgently needed care as described in §§ 422.2 and 422.112(b), since these services do not require prior authorization.

In cases in which the *hospital* makes a determination that hospital services are no longer needed, section 1154(e)(4)(B) of the Act expressly precludes the hospital from charging a Medicare beneficiary for services during the period that a PRO is reviewing an appeal under section 1154(e). We have reflected this statutory provision in § 422.622(c)(2).

11. Conclusion

In developing the organization determination, appeal and grievance requirements for M+C organizations, we have undertaken a broad review of the existing Medicare managed care requirements. We have consulted with representatives of beneficiary advocacy groups and the managed care industry concerning several policy options. We believe that we have included in this interim final rule those improvements that were practical within the short timeframe allotted for rulemaking. In addition to the changes made in this rule, we intend to publish a notice of proposed rulemaking in the near future to implement a variety of other improvements in the M+C dispute resolution process.

Therefore, we welcome comments, concerns, and ideas on all issues discussed in this interim final rule, as well as on the overall organizational changes incorporated into these regulations. In particular, as noted above, we would appreciate comments on whether HCFA should specify requirements (such as timeframes) for meaningful grievance procedures. We also are seeking additional comments on establishing effective and efficient parameters as to when a reduction in services (for example, a reduction in prescription dosage, skilled nursing facility coverage, home health care or outpatient visits) constitutes a denial that gives rise to an obligation to provide written notice. Comments are also welcome on whether notification requirements should apply in all instances of service discontinuations, as opposed to only when an enrollee indicates that he or she disagrees with such a discontinuation, as provided under § 422.566(b)(4). Finally, we would appreciate input on categories of meaningful data elements for reporting plan-level grievances and appeals. We believe such comments can assist with our data collection and reporting efforts (as required by the BBA) and in promoting consistency at the plan level in data collection and reporting. We welcome all suggestions for other improvements to the M+C grievance, organization determination and appeal processes.

N. Medicare Contract Appeals

Subpart N of this interim final rule sets forth procedures for making and reviewing the following contract determinations: (1) A determination that an entity is not qualified to enter into a contract with HCFA under Part C of title XVIII of the Act; (2) a determination to terminate a contract with an M+C organization; and (3) a determination not to authorize a renewal of a contract with an M+C organization. Pursuant to at section 1856(b)(2), which provides for the adoption of standards under section 1876 to implement analagous provisions in the new Part C, the procedures set forth in subpart N of part 422 are for the most part modeled after the contract appeal procedures currently in place with regard to HMO and CMP contracts under section 1876, which are set forth at 42 CFR part 417 subpart R. We describe below the provisions of new subpart N of part 422 that are not identical to 42 CFR part 417.

Section 422.641 sets forth the contract determinations that are subject to the reconsideration and appeals procedures in subpart N.

Section 422.644(a) specifies that when HCFA makes a contract determination, it provides the M+C organizations written notice specifying reasons for the determination and M+C organization rights pursuant to a reconsideration.

Under, § 422.644(d) a HCFA notice that it has decided not to authorize an M+C organization contract renewal is sent to the M+C organization by May 1 of the current contract year. (Note that while this notice informs an M+C organizations of its right to appeal a decision not to authorize a renewal, a contract will not be renewed unless an affirmative notice *authorizing* renewal is sent by HCFA. *See* § 422.506(b)(2).) The May 1 deadline specified above should afford HCFA enough time to consider any M+C organization's request for reconsideration and still afford adequate time for HCFA to ensure the accuracy of its printed and electronic material utilized in the annual health fair.

If HCFA decides to terminate a contract under § 422.644(c) for reasons other than those specified at 422.510(a)(5) it must provide notice to the M+C organization by mail at least 90 days before the intended date of the termination. Consistent with section 1857(h)(2), which provides for immediate termination where there is an ''imminent and serious risk'' to enrollee health and pursuant to our rulemaking authority at section 1856(b)(1), in § 422.644(c) we also provide a separate notice timeframe for immediate terminations discussed in

§ 422.510(a)(5). See section K of this preamble. Pursuant to violations described in § 422.510(a)(5), HCFA will notify the M+C organization in writing that its contract has been terminated effective the date of the termination decision by HCFA. We believe that in instances where the life and physical well being of beneficiaries is in jeopardy, HCFA must have the ability to immediately sever its relationship with an M+C organization in order to protect beneficiaries and to safeguard taxpayer confidence in HCFA's administration of the Medicare program.

Section 422.646 states that initial contract determinations are final and binding unless the determination is reconsidered in a manner consistent with applicable requirements described in § 422.648. In § 422.650(b) we have shortened the deadline for filing a request for reconsideration to 15 days from the sixty days allowed for HMOs and CMPs under § 417.650(b), and have eliminated the provision made in § 417.650(c) for a deadline extension for good cause. We believe the time frames afforded under § 422.650 still provide M+C organizations sufficient time to prepare a request for reconsideration of the contract determination at issue, should the organization decide to do so.

As in the case of the deadline for requesting reconsideration, and based on our rulemaking authority at section 1856(b)(1), in § 422.662(b), we have shortened the 60 day time period for requesting a hearing under § 417.662(b) to 15 days. We also have again eliminated ''good cause'' extension authority that was found in § 417.662(c).

Like § 417.664(a), § 422.664(a) provides that the effective date of a determination to terminate a contract will be postponed until after a final decision is rendered on any M+C organization appeal. Section 422.664(b) also follows § 417.664(b) in providing that a request for a hearing will *not* postpone a decision not to authorize a contract renewal unless HCFA finds an extension of the contract past its expiration date consistent with the purposes of Part C. There are two significant differences between § 417.664 and § 422.664, however. First, as discussed below, § 417.664 provides that in the case of a termination only, the general rule is that the termination will be postponed until after an additional post-hearing decision level of review required under section 1857(h)(1)(B). Second, § 422.664(c) implements the ''imminent and serious risk to health'' exception in section 1857(h)(2), under which a termination can take effect immediately, and will not be postponed while an appeal is pursued. Specifically, when a contract termination decision is based upon § 422.510(a)(5), discussed in section K above, the termination is effective immediately. While the M+C organization still has the right to appeal the termination, this appeal will not prevent the termination from taking effect.

In § 422.670, pursuant to our rulemaking authority at section 1856(b)(1), we have added a requirement that the hearing officer establish a time and place for the hearing within 30 days of the date of their receipt of the request for a hearing. Again, this time constraint has been added because we believe it is necessary to impose time-weighted discipline on the reconsideration process that strengthens HCFA's enforcement capabilities while simultaneously enhancing beneficiary protections. Changing the time frame from the open-ended language provided under § 417.670 to the 30-day time frame provided at § 422.670 accomplishes these goals.

In § 422.692, we provide in the case of termination decisions only for an appeal from the hearing decision, as required under section 1857(h)(2) before a termination can take effect. We have provided for review of a hearing officer's decision by the Administrator, under similar procedures to those used for the Administrator's review of decisions of the Provider Reimbursement Review Board pursuant to § 405.1875.

O. Intermediate Sanctions

The M+C organization actions subject to intermediate sanctions and civil money penalties are substantially the same as those established at § 417.500 for section 1876 contracting plans. However, there are some exceptions. Since the 50/50 enrollment requirement has been dropped, so have the accompanying intermediate sanctions.

The BBA also contains additional sanction authority not found in § 417.500, which we are implementing in subpart O. First, the BBA retains and modifies new section 1876 intermediate sanction and civil money penalty authority originally enacted in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This authority has not been implemented in § 417.500. Under this new authority (in section 1876(i)(1) for HMOs and CMPs and in section 1857(g)(3) for the M+C program), intermediate sanctions and civil money penalties can be imposed on the same grounds upon which a contract could be terminated. *See* discussion of contract termination in sections K. and N. above. Under the section 1876 provision, the procedures now found in section 1857(h)(1), discussed in section N. above, applied to the new HIPAA sanction authority, and had to be followed before sanctions based upon this new HIPAA authority could be imposed. Under the BBA, however, sanctions based on the grounds for termination in section 1857(c)(2) can be imposed on the same terms as the sanctions in § 417.500. *See* section 1857(g)(3). As discussed above in section K., in § 422.510(a)(4) through (a)(11), we have identified specific M+C organization behaviors that we believe meet one of the broad grounds for termination in section 1857(c)(2). Under the authority in section 1857(g)(3) to impose sanctions where the grounds in section 1857(c)(2) exist, intermediate sanctions can be imposed for any of the violations identified in § 422.510(a), and we so provide in § 422.752(b).

Finally, private fee for service plans are subject to intermediate sanctions if they fail to enforce the balance billing limit that applies to charges to plan members by contracting providers. See discussion of these provisions in section IV. of this preamble.

The process for imposing all of the M+C intermediate sanctions will largely be the same as established under § 417.500. Under this process, when HCFA determines that a sanctionable violation has occurred, it notifies the M+C organization that enrollment and marketing must be suspended (or, alternatively, in the case of some violations, payment for new enrollees will be suspended) in 15 days, unless the organization provides evidence that HCFA's determination is incorrect. There is an exception to this 15 day delay in the effective date of the sanctions if HCFA determines that the M+C organization's conduct poses a serious threat to an enrollee's health and safety. *See* § 422.756(d)(2). In addition to or in place of these intermediate sanctions, civil money penalties may be imposed for the same underlying violations. For any of the violations that were previously set forth in § 417.500, and are now in § 422.752(a), the Office of Inspector General imposes civil money penalties in accordance with 42 CFR part 1003. In the case of the new HIPAA sanction authority discussed above, HCFA imposes civil money penalties, with the exception of a determination under § 422.510(a)(4), based upon fraudulent behavior by an M+C organization. In this latter case, OIG imposes civil money penalties.

P. Technical and Conforming Changes

This interim final rule makes a number of technical and conforming changes to part 422 subpart H (which was established by an interim final rule published on April 14, 1998 (63 FR 18124) and amended by an interim final rule published on May 7, 1998 (63 FR 25360) For example, we remove the definition of ''health care provider'' from subpart H. We do this because this rule establishes a definition of ''provider'' in subpart A of part 422 for purposes of the entire part that is exactly the same as the definition of ''health care provider'' appearing in subpart H. Further, as a conforming change, we then change ''health care provider'' wherever it appears in subpart H to ''provider.''

In addition to the additions and revisions to part 422 of our regulations discussed throughout this document, this interim final rule also makes a number of technical and conforming changes to the following parts of 42 CFR: 400, 410, 411, and 417. These changes, which are generally in the form of redesignations and nomenclature changes, are made in order to bring our regulations into conformity with the provisions of the section 4001 through 4006 of the BBA.

We have also made a conforming change to 42 CFR part 403 ''Special Programs and Projects,'' with regard to Medicare supplemental policies. As Medicare does not cover the total cost of providing medical care, approximately 75 percent of Medicare beneficiaries purchase or have available through their own, or a spouse's employment or former employment, some type of private supplemental health insurance coverage. This kind of insurance helps to pay for expenses, services, and supplies that Medicare either does not cover or does not pay in full such as coinsurance or deductible charges, prescription drugs, and some long term care services. This coverage is ordinarily referred to as Medicare supplemental (Medigap) insurance. The BBA, in section 4003, provides that an M+C plan is not considered a Medicare supplementary policy. Therefore, we are revising § 403.205 to specify that a Medicare supplemental policy does not include a M+C plan. We are aware of other provisions in that statute affecting the Medigap area, but those are included or will be covered under the National Association of Insurance Commissioners (NAIC) Model Standards in line with existing § 403.210. NAIC works with us to annually update the Model Standards with regard to changes to the Medicare supplemental insurance area.

Q. Transition Information for Current Medicare Program

Section 4002 of the BBA included a number of provisions that were effective upon enactment for eligible organizations with section 1876 contracts or section 1833 agreements or that would alter the requirements for those contractors that remained in force following the implementation of the M+C program. The provisions that were effective upon enactment were conveyed to current contractors through operational policy letters (OPLs) numbered 61, 63, and 65 and available to the public on HCFA's Internet homepage. Most of the provisions convey automatically with the publication of the Part C regulations, either contained in the newly-established part 422 or contained in conforming changes to part 417, while others simply created operational impacts during the transition year of 1998.

The BBA in section 4002(a) immediately changed the required enrollment composition of 50 percent Medicare and Medicaid, and 50 percent commercial under section 1876 to: (1) Consider only Medicare members for 50 percent of the enrollment, and (2) permit waiver of the requirement when it is ''in the public interest.'' All enrollment composition requirements for Medicare contractors are eliminated beginning with contract periods on or after January 1, 1999.

The BBA in section 4002(j) changed the definition of a health care prepayment plan (HCPP) to mean: (1) An organization that is Union or Employer sponsored; or (2) an organization that does not provide, or arrange for the provision of any inpatient hospital services. Current HCPPs must meet this definition on January 1, 1999 and new 1998 applicants must meet the definition as of the effective date of the HCPP agreement. Also, as of January 1, 1999, HCPPs are not required to meet Medigap requirements.

The BBA also affected section 1876 cost contracts. Upon enactment of the BBA (August 5, 1997), the Secretary may not enter into new section 1876 cost contracts, except for current HCPPs that converted to section 1876 cost contracts. Also, 1876 cost contracts may not be extended or renewed beyond December 31, 2002.

III. Medicare+Choice MSA Plans

A. Background

As noted above, among the type of M+C options available under section 1851(a)(2) of the Act is an M+C MSA plan, that is, a combination of a high deductible M+C insurance plan and a contribution to an M+C MSA. Section 1859(b)(3)(A) of the Act defines an MSA plan as an M+C plan that:

- Provides reimbursement for at least all Medicare-covered items and services (except hospice services) after an enrollee incurs countable expenses equal to the amount of the plan's annual deductible.
- Counts for purposes of the annual deductible at least all amounts that would have been payable under original Medicare if the individual receiving the services in question was a Medicare beneficiary not enrolled in an M+C plan, including amounts that would be paid by the beneficiary in the form of deductibles or coinsurance.
- After the annual deductible is reached, provides a level of reimbursement equal to at least the lesser of actual expenses or the amount that would have been paid under original Medicare if the individual receiving the services in question was a Medicare beneficiary not enrolled in an M+C plan, including amounts that would be paid by the beneficiary in the form of deductibles or coinsurance.

Eligible individuals may enroll in M+C MSA plans effective January 1, 1999. Section 1859(b)(3)(B) sets the maximum annual deductible under an M+C MSA plan for 1999 at $6,000, with changes for future years to be based on the national per capita M+C growth percentage established under section 1853(c)(6). (See section II.F of this preamble.) In this interim final rule, we are seeking comment regarding establishing, pursuant to our general authority under section 1856(b)(1), a minimum deductible under an M+C MSA plan. As discussed below, one possibility would be to establish a minimum deductible equal to the projected actuarial value of the average per capita copayment under original Medicare, rounded to the nearest $50.

Section 4006 of the BBA adds new section 138 of the Internal Revenue Code of 1986 containing Internal Revenue Service (IRS) rules concerning M+C MSAs. In general, an M+C MSA is a tax-exempt trust created solely for the purpose of paying the qualified medical expenses of the account holder. The account may be established only in connection with an M+C MSA plan, and must consist only of contributions from HCFA under the M+C program or of

transfers from another M+C MSA, if an enrollee has set up more than one M+C MSA. Section 138 also sets forth IRS rules concerning the distribution of MSA funds and tax penalties associated with the distribution of funds from an M+C MSA for purposes other than paying the qualified medical expenses of the account holder. (These provisions are discussed below in section III.J of this preamble.)

In establishing the M+C MSA option, Congress specified under section 1851(b)(4) of the Act that the opportunity to enroll in an M+C MSA plan was available on a demonstration basis to up to 390,000 enrollees through December 31, 2002. The Secretary is charged with regularly evaluating the impact of permitting enrollment in M+C MSA plans and with submitting a report to Congress by March 1, 2002, concerning the effects of the M+C MSA program and whether it should be extended beyond 2002.

The introduction of M+C MSAs builds upon the private market MSA demonstration program now available to small employers and the self-employed under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Like the HIPAA demonstration, the BBA conference report (H.R. 105–217, pg. 585) indicates that the introduction of M+C MSAs is premised on the need for beneficiaries to play a greater role in the health care purchasing decision. M+C MSAs offer beneficiaries incentives to ensure that the health care resources they need are allocated in an efficient manner. This increased consumer control is believed to have potential for discouraging the overutilization of health services.

In implementing the BBA provisions concerning the M+C MSA demonstration, our primary objective is to allow a true test of the potential benefits of the MSA concept to the Medicare program and its beneficiaries. Thus, as with other parts of the M+C regulations, an underlying design principle has been to preserve as much flexibility as possible for organizations and providers in terms of service delivery arrangements, while still building in the protections intended under the BBA for M+C MSA enrollees and the Medicare trust fund. For the convenience of the reader, all portions of the M+C regulations that specifically concern M+C MSA plans and accounts are discussed below in this preamble; however, the M+C MSA regulations do not constitute a separate subpart of new part 422. This is because, except as noted below, the general M+C requirements throughout part 422 apply equally to M+C organizations that offer M+C MSA plans; thus it would be redundant to repeat all applicable requirements in a separate M+C MSA subpart.

B. General Provisions (Subpart A)

Sections 422.2 and 422.4 set forth several definitions for terms connected with M+C MSA plans, including ''M+C MSA,'' ''M+C MSA plan,'' and ''MSA trustee.'' As noted in section II.D of this preamble, we also distinguish between a ''network'' and a ''non-network'' M+C MSA plan. The definitions consist of general meanings for these terms as used in the BBA and do not impose specific requirements. Thus, the definition for an MSA references the applicable requirements of sections 138 and 220 of the Internal Revenue Code, and the M+C MSA plan definition references the applicable requirements of new part 422.

The theory behind the new M+C MSA option is that a beneficiary will pay a lower monthly premium for a ''catastrophic'' insurance policy with a high deductible, and use the money deposited in his or her M+C MSA account to cover expenses during the extended period prior to this high deductible being reached. This concept is reinforced by the fact that Congress excluded from eligibility for M+C MSA plans individuals with ''first dollar'' health care coverage (such as, Medicaid-eligible individuals'—see discussion below), who would not be required to incur expenses during the significant period of time expected to transpire before the high M+C MSA plan deductible is met. This is also the reason that Congress amended the Medigap statute to preclude insurers from selling policies to enrollees in M+C MSA plans that would cover costs incurred before the high deductible is met. Indeed, the legislative history expressly refers to ''[p]rohibit[ing] the sale of certain [Medigap] policies to a person electing a *high deductible* plan,'' meaning an MSA plan. (H.R. Rep. No. 105–217, pg. 654 (1997). Emphasis added).

Although Congress did not include a minimum deductible amount, we believe that the statutory scheme, and the above-quoted reference to a ''high deductible plan'' in the Conference report, clearly *imply* that MSA plans would have a higher deductible than other plans. As noted above, we are seeking comment on providing for a minimum deductible based on the actuarial value of the average per capita cost-sharing under original Medicare rounded to the nearest $50. For 1999, this amount is $1,000. (Clearly, any deductible *lower* than the actuarial value of what original Medicare beneficiaries pay is *not* a ''high'' deductible.) We believe that a minimum deductible amount could ensure that M+C MSA plans comport with the ''high deductible'' design envisioned by Congress, without inappropriately limiting organizations' flexibility in designing M+C MSA plans. Without such a deductible, however, we are concerned that an organization could purport to offer an ''M+C network MSA plan'' that had such a low deductible that it would be impossible to distinguish from a coordinated care plan, although the plan would not be subject to the rules that Congress intended be applied to coordinated care plans. Therefore, in deciding whether to institute a minimum deductible for M+C MSA plans, we intend to examine any evidence that such abuses may be taking place, in addition to our review of public comments on the issue.

The only other general requirement concerning M+C MSA plans is the incorporation under § 422.4(a)(2) of the statutory provision (section 1851(a)(2)(B)) that one of the available alternatives under the M+C program is the combination of an M+C MSA plan with a contribution into an M+C MSA. Consistent with the statute, any State-licensed risk-bearing entity could offer an M+C MSA plan, whether it is an HMO offering an ''M+C network MSA plan'' under which beneficiaries are limited to a limited network of providers for covered services after the deductible is met, or an indemnity plan covering services on a fee-for-service basis after the deductible is met.

C. Eligibility, Election and Enrollment Rules (Subpart B)

1. Eligibility and Enrollment (§ 422.56)

Any individual who is entitled to Medicare under Part A, is enrolled under Part B, and is not otherwise prohibited (such as an ESRD patient), is eligible to enroll in an M+C plan. However, the statute places several limitations on eligibility to enroll in an M+C MSA plan. These limitations are set forth at § 422.56 of the regulations. Section 422.56(a) indicates that M+C MSA plans are established on a demonstration basis and incorporates the statutory provisions of section 1851(b)(4), that is:

- No more than 390,000 individuals may enroll in M+C MSA plans.
- No individual may enroll on or after January 1, 2003, unless the enrollment is a continuation of an enrollment already in effect as of that date.
- No individual may enroll or continue enrollment for any year unless

he or she can provide assurances of residing in the United States for at least 183 days during that year.

The 390,000 limit represents approximately 1 percent of the Medicare population. We do not intend to apply any State or regional limits on enrollment in M+C MSA plans, although we will monitor the number of enrollees on an ongoing basis. We believe it is unlikely that the number of applications for M+C MSAs will reach 390,000 in the first enrollment period, November, 1998. If necessary, however, we will accept applications for enrollment in M+C MSA plans on a first-come, first-served basis, with the first 390,000 applicants being allowed to enroll. We will notify organizations offering M+C MSA plans directly should the enrollment cap be reached.

The only restrictions on enrollment in M+C MSA plans under § 422.56(b) and (c) are those directly contemplated under section 1851(b)(2) and (3) of the statute. Specifically, § 422.56(b) states that an individual who is enrolled in a Federal Employee Health Benefits Program (FEHBP) plan, or is eligible for health care benefits through the Veterans Administration (VA) or the Department of Defense (DoD), may not enroll in an M+C MSA plan. The statute provides that the restriction on FEHBP enrollment may be eliminated if the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies to ensure that the enrollment of FEHBP participants will not result in increased expenditures for health benefit plans. We intend to apply this same test for the enrollment restrictions that apply to VA and DoD-eligible individuals. In addition, § 422.56(c) incorporates the statutory prohibition under section 1851(b)(3) on enrollment in M+C MSA plans by individuals who are eligible for Medicare cost-sharing under Medicaid State plans.

Section 422.56(d) sets forth several additional restrictions on enrollment in M+C MSA plans that we believe are clearly consistent with statutory intent. These restrictions are discussed in detail below in section III.D.2 of this preamble, in the discussion of supplemental benefits under an M+C MSA plan.

2. Election (§ 422.62)

Section 1851(e) of the Act establishes general rules concerning the time periods when a beneficiary may elect to enroll in an M+C plan, with special rules for M+C MSA plans set forth at section 1851(e)(5). Based on these provisions, § 422.62(d) specifies that an individual may elect an MSA plan only during one of the following periods;

- An initial election period, that is, the 7-month period beginning 3 months before the individual is first entitled to parts A and B of Medicare.
- The annual coordinated election period in November of each year.

Unlike for other M+C plans, an individual may discontinue election of an M+C MSA plan only during the annual coordinated election period. Thus, effective January 1, 1999, enrollees in M+C MSA plans are ''locked in'' for 1 year, or for the remainder of the calendar year for elections during an initial election period that take effect other than on January 1. This lock-in rule contrasts sharply with the rules for other types of M+C plans, which provide for continuous open enrollment and disenrollment through December 31, 2001.

There are two exceptions to this lock-in rule. First, as specified under section 1851(e)(5)(C) and codified at § 422.62(d)(2)(ii), an individual who elects an M+C MSA plan during an annual election period in November of a given year, and has never before elected an M+C MSA plan, may revoke that election by submitting to the organization offering the plan a signed request or by filing the appropriate disenrollment form by December 15 of that year. In addition, we are providing at § 422.58(d)(2) that an individual may disenroll from an M+C MSA plan during the special election periods prompted by circumstances such as termination of the plan, change in the individual's place in residence, etc., as spelled out under § 422.62(b). As discussed in detail in section II.B of this preamble, section 1851(e)(4) provides that these special election periods are to take effect on January 1, 2002, in concert with the initial effective date for the lock-in rules for M+C plans other than MSA plans. Given that the lock-in rule for M+C MSA plans takes effect on January 1, 1999, we believe it is appropriate that the protections afforded by the special election period should be applicable at that time to individuals who elect M+C MSA plans.

3. Information About the M+C Program (§ 422.64)

Section 1851(d) and § 422.64 address the requirement that M+C organizations must provide the information that HCFA needs to help beneficiaries make informed decisions with respect to their available choices for Medicare coverage. The only M+C MSA-specific requirement involved here (also applicable for M+C private fee-for-service plans) is that the description of an M+C MSA plan's benefits should include differences in cost-sharing, premiums, and balance billing, as compared to other types of M+C plans (see § 422.64(c)(7)(iv)). We believe that the purpose of this requirement is to make sure that beneficiaries are aware of the fundamental differences between M+C MSA or private fee-for-service plans and other types of M+C plans, rather than to present detailed information concerning the benefits, premiums, and copayments for all other *specific* M+C plans in the area. For compliance purposes, then we intend to evaluate the information submitted by organizations for MSA plans in these terms. We note that we would apply the same standard in determining compliance with the requirement of § 422.110(b)(2)(ii) concerning an organization's responsibility to disclose to its enrollees a description of the benefits available under other types of plans.

D. Benefits (Subpart C)

1. Basic Benefits Under an M+C MSA Plan (§ 422.102)

Section 422.102 incorporates the statutory requirements for M+C MSA plans defined under section 1859(b)(3) of the Act, as outlined above. Thus, § 422.102(a) specifies that an MSA organization offering an MSA plan must make available to an enrollee, or provide reimbursement for, at least all Medicare-covered services (except for hospice services) after the enrollee's countable expenses reach the plan's annual deductible. We note that section 1859(b)(3)(A)(i) only uses the phrase ''provides reimbursement for'' the covered services, but the intent of the statute clearly includes situations where a network M+C MSA plan would either furnish the services directly or arrange for provision of the services. We believe that the phrase ''make available to the enrollee'' accounts for either of these situations.

Section 422.102(b) then indicates that countable expenses must include the lesser of actual costs or all the amounts that would have been paid under original Medicare if the services were received by a Medicare beneficiary not enrolled in an M+C plan, including the amount that would have been paid by the beneficiary under his or her deductible and coinsurance obligation. In accordance with section 1859(b)(3)(A)(ii) of the statute, under each MSA plan, an organization would have the discretion to define what it considers countable expenses, subject to the statutory threshold of the Medicare

payable amount. We would envision that M+C organizations offering MSA plans could provide that countable expenses would include a considerably broader range of services than does Medicare, including expenses for services that often would constitute supplemental health care benefits under other M+C plans, such as prescription drugs, dental services, or preventative care services. (As discussed below, section 1852(a)(3)(B)(ii) prohibits an M+C MSA plan from providing most supplemental health care benefits before an individual reaches the annual deductible. However, counting the expenses for such services towards the annual deductible is permissible.) An M+C organization could also choose to provide that countable expenses under an M+C MSA plan would include a provider's full charges, rather than just the amount payable under the Medicare payment rate schedules.

Section 422.102(c) provides that after the deductible is met, an M+C MSA plan pays the lesser of 100 percent of either the actual expense of the services or of the amounts that would have been paid under original Medicare if the services were received by a Medicare beneficiary not enrolled in an M+C plan, including the amount that would have been paid by the beneficiary under his or her deductible and coinsurance obligation. As discussed below in section III.F., M+C balance billing protections do not apply in this situation. Thus, unless explicitly included in the terms of the M+C MSA plan, any amounts billed in excess of 100 percent of this Medicare allowed amount would be the responsibility of the enrollee. In this provision, we have interpreted the language in section 1859(b)(3)(A)(iii)(II) referring to the ''amounts that would be paid (without regard to any deductibles and coinsurance) under parts A and B'' to mean the amount that would be paid if there *were no* beneficiary liability provided for in the form of deductibles and coinsurance—in other words, the full amount of the Medicare rate. We have put this a different way in § 422.102(c), providing that the amount in question *includes* the amounts that the beneficiary would pay in deductibles and coinsurance. We considered interpreting ''without regard to any deductibles and coinsurance amounts'' to mean without *counting* the amounts original Medicare beneficiaries would pay in deductibles and coinsurance. We decided, however, that after a deductible of up to $6000, and with balance billing permitted, M+C MSA plans should be required to pay the full Medicare payment rate once the deductible is met. Again, an organization would be free to offer expanded benefits under an M+C MSA plan beyond the minimum requirements after the deductible is met, including supplemental benefits that it could not offer before the deductible is met.

Section 422.103(d), concerning the annual deductible, is based on section 1859(b)(3)(B). As the statute specifies, the maximum annual deductible for an MSA plan for contract year 1999 is $6,000. In subsequent contract years, the maximum deductible may not exceed the maximum deductible for the previous contract year increased by the national per capita M+C growth percentage for the year. In calculating the maximum deductible for future years, HCFA will round the amount to the nearest multiple of $50.

Another issue we examined in developing the regulations concerning the annual deductible for M+C MSA plans was whether to establish specific requirements on deductibles for individuals who enroll in M+C MSA plans effective other than on January 1 of a given year, that is, individuals who turn 65 and make midyear elections of an M+C MSA plan within their initial enrollment periods. Our primary alternatives on this issue were to: (1) require all M+C MSA plans to ''prorate'' the deductible, that is, reduce the amount of the deductible for midyear enrollees in proportion to the amount of the calendar year remaining or (2) allow insurers the flexibility to decide for themselves how to deal with partial year enrollees. Although the prorating alternative would reduce the cost-sharing burden on beneficiaries during the first partial year, and thus possibly make it more likely that an individual whose initial election period occurs late in the year would choose an M+C MSA plan, this option has several drawbacks. Few if any insurance carriers now prorate their deductibles for midyear enrollees, and we are reluctant to implement such an approach unilaterally, particularly since we have no evidence that the costs of implementing a prorated system would be exceeded by the benefits to beneficiaries in terms of reduced risk. Such a requirement could limit interest in establishing M+C MSA plans, if insurers believed that they could be placed at risk of the enrollment of individuals with low prorated deductibles who anticipate high cost short-term health care needs.

Instead, we decided to allow insurers to decide for their M+C MSA plans how to deal with partial year enrollees. This should foster flexible approaches to this situation, with organizations making decisions based on their perceptions of the cost of implementation and the benefits to them in terms of attracting prospective enrollees. For example, an organization's plans could include a ''carry-over'' procedure. Under such a procedure, bills incurred during a specified period of one calendar year could be carried over to the following year and applied to the next year's deductible.

2. Supplemental Benefits (§§ 422.102 and 422.103)

Section 422.102 addresses the general M+C rules on supplemental benefits. Unlike other M+C plans, MSA plans are not permitted to include any mandatory supplemental benefits and are limited in terms of the optional supplementary benefits that can be offered. In accordance with section 1852(a)(3)(B)(ii), § 422.103(a) specifies that an M+C MSA plan generally may not provide supplemental benefits that cover expenses that count toward the annual deductible. In addition, section 4003(b) of the BBA added new section 1882 to the Act to prohibit the sale of most supplementary health insurance policies to individuals enrolled in M+C MSA plans. The only exceptions to this rule are spelled out in section 1882(u)(2)(B). These exceptions apply both for purposes of the prohibition on selling freestanding supplementary health insurance (or ''Medigap'' insurance), and for purposes of ''optional supplemental benefits'' offered under M+C MSA plans. These exceptions are reflected in § 422.103(a)(2). Under § 422.103(a)(2), the only types of policies that an enrollee in an M+C MSA plan may purchase that cover expenses that may count toward the annual deductible are as follows:

- A policy that provides coverage for accidents, disability, dental care, vision care, or long-term care.
- A policy in which substantially all coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, or liabilities relating to use or ownership of property.
- A policy that provides coverage for a specified disease or illness or pays a fixed amount per day (or other period) for hospitalization. (Note that the fact that an organization offering an M+C MSA plan permits a particular expense to count toward the plan's annual deductible does not necessarily mean that such expenses are considered ''qualified medical expenses'' by the IRS.)

The above restrictions on optional supplemental benefits and Medigap

coverage under section 1882, combined with Congress' explicit exclusion of individuals with ''first dollar'' health coverage under government programs (Medicaid, VA benefits, and FEHBP benefits—see section 1851(b)(2) and (3) and discussion above), make it clear that Congress intended that individuals enrolled in M+C MSA plans would be required to use the money in their M+C MSA accounts to pay for services until the ''high deductible'' under the plan is met. While Congress addressed government programs under which expenses during the deductible would be covered, and prohibited the *sale* of *new* private supplemental insurance that would cover such deductible amounts (whether an optional supplemental benefit offered under an M+C MSA plan, or a freestanding ''Medigap'' policy), some categories of individuals with first dollar coverage that would cover expenses that would count toward an M+C MSA plan deductible would remain eligible to enroll in M+C MSA plans absent a regulatory prohibition.

We believe that it would give effect to clear congressional intent to expand the categories of individuals ineligible to enroll in M+C MSA plans to include the additional categories that Congress neglected to include. For example, while Congress prohibited the *sale* of private insurance covering expenses that count toward an M+C MSA deductible, it did not address individuals who may already *have* such coverage, including those who have first dollar Medigap coverage through their employer. In addition, individuals who have elected hospice coverage are also eligible for first dollar Medicare payment, without any qualification in the case of MSA plans. (See section 1853(h)(2)(A).) This is also inconsistent with Congress' intended design for the M+C MSA option. Pursuant to our authority under section 1856(b)(1) to establish M+C standards by regulation, we accordingly are providing in § 422.56(d) that individuals with such health benefits are ineligible to elect an MSA plan.

As mentioned above, M+C MSA plans may not provide any supplemental benefits, except those exempted, covering expenses that count towards the annual deductible. Once the deductible is reached, however, there are no limitations on the supplemental benefits a plan may offer, as long as the plan satisfies the requirements concerning making available basic part A and B Medicare services. We believe that a market may emerge for supplemental insurance policies in connection with M+C MSA high deductible insurance policies. We considered the possibility of establishing one or more sample benefit plans for use in conjunction with M+C MSA plans, similar to the limited number of standardized Medigap plans that are now offered. Although we are not doing so at this time, we welcome comments on the need for such uniform plans.

E. Quality Assurance (Subpart D)

Like for other M+C plans, an organization offering an MSA plan must have an ongoing quality assessment and performance improvement program for the services furnished to M+C enrollees under the plan. As discussed in detail above, the quality assurance requirements that apply to an M+C MSA plan depend on whether the plan is a network model plan, that is, a plan that provides benefits either through contracting providers or under arrangements made by the plan, or a non-network plan. Consistent with section 1852(e)(2) of the Act, a network model M+C MSA plan must meet requirements similar to those that apply to all other M+C coordinated care plans (with the exception of the achievement of minimum performance levels); the statute and regulations establish different requirements for non-network M+C MSA plans. See section II.D of this preamble, and § 422.152 of the regulations, for more information on this subject. Also, see section II.D. of the preamble and § 422.154 for information on the external review requirements that apply to network M+C MSA plans. Under § 422.154(b)(1), the external review requirements do not apply to non-network M+C MSA plans.

F. Relationships Between Plans and Participating Physicians (Subpart E)

For the most part, subpart E of new part 422 does not establish any requirements that are specific to MSA plans. However, § 422.214, ''Special rules for services furnished by noncontract providers,'' does have implications for enrollees in MSA plans. The provisions of this section are based on section 1852(k) of the Act, beginning with the requirement under section 1852(k)(1) that for enrollees in M+C coordinated care plans, a physician that does not have a contract with the plan must accept as payment in full an amount no greater than the amount the physician could collect if the individual were under the fee-for-service Medicare program, including any applicable deductibles, coinsurance, or balance billing permitted by the plan. (See section 1848(g) concerning the Medicare fee-for-service rules on limiting charges.) Section 1852(k)(2) then establishes balance billing limits for M+C private fee-for-service plans, as discussed in detail in section IV of this preamble and § 422.216; however, the statute contains no balance billing protections for enrollees in M+C MSA plans.

It is clear from the legislative history of the provisions imposing balance billing limits that the omission of any limits under M+C MSA plans was not inadvertent. Page 609 of the Conference Report (H.R. Rep. No. 105–217) refers to the House bill, which included across the board limits on what could be collected. The Senate amendment is described as including a ''[similar provision except that it *excepts from the requirement* * * * a[ ] fee-for-service plan as well as *an MSA plan*.'' The ''conference agreement'' is then described as ''including] the Senate provision with an amendment to provide for application of the provision to Medicare+Choice *fee for service plans*. * * *'' Thus, Congress clearly indicates that it provided for a balance billing limit for M+C coordinated care plans and private fee-for-service plans (albeit a different limit), but *not* for M+C MSA plans. On page 611, the Conference Report expressly states that the House bill provided that an ''MSA plan * * * would not be subject to the * * * limitations on balance billing.'' The conference agreement indicates that it ''includes'' this ''House bill'' position. In light of the absence of any statutory provision for a limit on balance billing under M+C MSA plans, and these clear statements of congressional intent that there be no such limits, we have not provided for any limits on balance billing under M+C MSA plans in these regulations.

G. Payments Under MSA Plans (Subpart F)

Section 1853 describes the method to be used to calculate the annual M+C capitation rate for a given payment area (see section II.F of this preamble and § 422.254). We apply the same methodology in determining the annual capitated rate associated with each M+C MSA plan enrollee. Thus, for calendar year 1999, the capitated rate will continue to be adjusted for the age, gender, Medicaid-eligibility, disability, institutional status, and employment of the individual beneficiary, with risk adjustment scheduled to begin on January 1, 2000, as also discussed in detail in section II.F of this preamble.

The special rules concerning the allocation of the M+C capitated amount for individuals enrolled in M+C MSA plans are set forth at section 1853. In

general, HCFA will allocate the capitated amount associated with each M+C MSA enrollee as follows:

- On a lump-sum basis at the beginning of the calendar year, pay into a beneficiary's M+C MSA an amount equal to the difference between the annual M+C capitation rate for the county in which the beneficiary resides and the M+C MSA premium filed by the organization offering the MSA plan (this premium is uniform for all enrollees under a single M+C MSA plan.) This results in a uniform amount being deposited in an M+C MSA plan enrollee's M+C medical savings account(s) in a given county, since the uniform premium amount will be subtracted from the uniform county-wide capitation rate for every enrollee in that county.
- On a monthly basis, pay to the M+C organization an amount equal to one-twelfth of the difference, either positive or negative, between the annual M+C capitation payment for the individual and the amount deposited in the individual's M+C MSA.

Section 422.262 contains the regulations concerning the allocation of Medicare trust funds for enrollees in M+C MSA plans. First, under § 422.262(a), an enrollee must establish an M+C MSA with a qualified trustee or custodian. An enrollee may establish more than one account, consistent with section 1853(e)(2)(B) of the Act, but must designate the particular account to which payments by HCFA are to be made. As specified under § 422.262(b), a trustee can be a bank, insurance company, or anyone approved by the IRS to be a trustee of Individual Retirement Accounts. Section 422.262(b) also requires that M+C MSA trustees must register with HCFA, agree to comply with IRS rules concerning MSAs, and provide organizational information that HCFA may require.

The specific requirements concerning the amount that HCFA pays into an individual's M+C MSA are spelled out at § 422.262(c). We calculate the payment by first comparing the monthly premium for the M+C MSA plan to the county-wide capitation rate under § 422.252 that is used in making payments to M+C organizations under other types of M+C plans (final payment to M+C organizations is based on this county-wide capitation rate, adjusted by demographic factors). If the monthly premium is less than the monthly capitation rate for the county, HCFA deposits into the individual's M+C MSA a lump sum equal to the annual difference between these two amounts, that is, the monthly difference multiplied by 12, or by the number of months remaining in the calendar year when the individual becomes covered under the M+C MSA plan.

The lump-sum payment is made in the first month of coverage under the M+C MSA plan, but HCFA makes no payment until the individual has not established an M+C MSA before the beginning of the month. Should an individual's coverage under an M+C MSA plan end before the end of a calendar year, HCFA will recover the excess portion of the lump-sum deposit attributable to the remaining months of that year.

In summary, Medicare's contributions to an individual's M+C MSA are equal to the difference between the unadjusted county-wide capitation rate for the county in which the enrollee lives and the premium filed by the individual's high deductible M+C MSA plan. For example, if the annual Medicare payment rate for a county is $6,000 ($500 per month), and the annual premium for an M+C MSA insurance plan is $4800 ($400 multiplied by 12), HCFA would deposit $1,200, in January, into the M+C MSA of each plan enrollee residing in that county. It would pay to the insurer (generally divided into 12 equal monthly payments) the difference between the demographically adjusted M+C payment amount for that individual and the MSA contribution. (See the example below.) The annual payment by HCFA represents the only permissible deposit into the individuals's M+C MSA, with the exceptions of transfers from another M+C MSA established by the same individual or interest or income that accrues to the account.

Example of Payments Under an M+C MSA Plan

Monthly premium for an M+C MSA plan	$400
Monthly M+C county-wide capitation rate	500
Monthly demographically adjusted M+C payment for an individual beneficiary:	
Individual A (65-year old beneficiary)	450
Individual B (85-year old beneficiary)	700

A. Annual contribution to enrollee's M+C MSA =
(M+C county-wide capitation rate − M+C MSA plan monthly premium) × 12. ($500 − $400) × 12 = $1,200

B. Monthly payment to an M+C organization under an M+C MSA plan for an enrollee =
Demographically adjusted M+C payment rate for an enrollee − Monthly contribution to the enrollee's M+C MSA plan
Individual A: $450 − $100 = $300
Individual B: $700 − $100 = $600

In theory, payments to the plan for an individual enrollee could be positive or negative, depending on the relationship between a plan's premium and the capitation rate for a given county. If, in the example above, the M+C MSA plan premium were only $25 (rather than $400), the monthly contribution to an enrollee's M+C MSA would be $475 ($500 − $25 = $475). For the 65-year old beneficiary (Individual A), the resultant payment to the plan would be a negative $25 ($450 − $475 = (−$25)). Given that organizations offering M+C MSA plans likely will carefully assess payment ranges and demographic factors within their market areas before proposing a premium, we believe that a negative payment would be rare, but not impossible.)

H. Premiums (Subpart G)

Section 1854 establishes the requirements for determination of the premiums charged to enrollees by M+C organizations. Like other M+C organizations, organizations offering M+C MSA plans in general must submit by May 1 of each year information concerning enrollment capacity and premiums. For M+C MSA plans, the information to be submitted includes the monthly M+C MSA plan premium for basic benefits and the amount of any beneficiary premium for supplementary benefits. These requirements are set forth under section 1854(a)(3) of the act and § 422.306(c) of the regulations.

Unlike for M+C coordinated care plans, section 1854(a)(5) Act expressly exempts M+C MSA plan premiums from review and approval by the Secretary. Section 1854(b)(1)(B) merely states that for M+C MSA plans, the monthly amount of the premium charged to an enrollee equals the M+C monthly supplemental beneficiary premium, if any. Although this provision effectively

precludes an organization offering an M+C MSA plan from charging an additional premium to an enrollee for basic Medicare benefits paid for through the capitated payment made by HCFA, the plan is free to set the basic and supplemental premium at whatever levels the market place will bear.

The only statutory limitation placed on an M+C MSA plan's ability to establish premiums is the ''uniform premium'' requirement of section 1854(c). The effect of this provision is that the monthly basic and supplementary premiums may not vary among individuals enrolled in an M+C MSA plan. (See the discussion of service area in section II.A. of this preamble.) Thus, insurers that want to charge different amounts for different benefits, according to geographic areas for example, could do so only by establishing multiple M+C MSA plans. Within a plan, however, payments into the M+C MSAs of individuals residing in the same county will be uniform; payments to the plans will vary for each individual.

I. Other M+C Requirements

The remaining requirements under subpart 422 have few if any implications specific to M+C MSA plans. For example, the organizational and financial requirements, provisions on compliance with State law, contracting rules, and grievance and appeal requirements generally apply in equal measure to MSA plans as to other types of plans. More accurately, perhaps, these requirements primarily apply to the M+C organization, rather than the plan; thus, an organization offering any type of M+C plan must meet the applicable requirements.

One issue that may require clarification, however, involves the provision of section 1856(b)(3)(B)(i) (and § 422.402(b)) that any State standards relating to benefit requirements are superseded. We recognize that this provision means that State benefit rules will not apply (such as State laws that mandate first dollar coverage for particular benefits such as mammograms or other preventative services). Some States may not license entities to offer catastrophic coverage, and it is possible that M+C MSA plans could not be offered in that State. We welcome public comment on this issue.

The only other sections of these regulations that contain requirements that are specific to M+C MSA plans are found in Subpart K—Contracts with M+C Organizations. First, in accordance with section 1857(c)(3), § 422.504(a) specifies that the effective date for a contract providing coverage under an M+C MSA plan may be no earlier than January 1, 1999.

We note that § 422.500(b)(2) authorizes HCFA to include in a contract any requirements that we find ''necessary and appropriate'' that are not inconsistent with the M+C statute and regulations. Given the demonstration basis of M+C MSA plans under section 1851(b)(4), and the corollary requirements for an evaluation and a report to Congress, we believe it may be necessary and appropriate to require that organizations offering M+C MSA plans provide HCFA with data that will enable us to evaluate M+C MSA plans in terms of selection, use of preventive care, access, and impact on the Medicare trust fund. We are now in the process of determining what, if any, specific data will be required with respect to M+C MSA plans (beyond the encounter data to be collected with respect to all M+C plans) to facilitate HCFA's evaluation. In § 422.502(f)(2)(vii), we provide authority for HCFA to request data from M+C organizations offering MSA plans related to selection, use of preventive care, and access to services.

J. Tax Rules

As mentioned earlier, section 4006 of the BBA added new section 138 to the Internal Revenue Code (IRC) of 1986 concerning M+C MSAs. The regulations set forth in this interim final rule do not incorporate the IRC provisions on M+C MSAs. However, for the convenience of the reader, we are presenting here a brief summary of the tax rules associated with M+C MSAs. For a full explanation of the tax consequences of establishing a M+C MSA, we refer readers to sections 138 and 220 of the IRC and to the relevant IRS publications. (For more information, contact the IRS at (888) 477–2778 or through its website at www.irs.ustreas.gov.)

When an individual joins an M+C MSA plan, HCFA makes a specified contribution, as explained above, into the M+C MSA designated by the individual. No other contribution may be made into the M+C MSA, and the contribution is not included in the taxable income of the account holder. Any income earned on amounts held in the M+C MSA are not currently included in taxable income, similar to an individual retirement account.

Withdrawals from an M+C MSA are not considered taxable income if used for the ''qualified medical expenses'' of the account holder, regardless of whether the account holder is still enrolled in an M+C MSA plan at the time of the distribution. In general, ''qualified medical expenses'' are defined the same as under the IRS rules relating to itemized deductions for medical expenses. (See sections 213(d) and 220(d)(2)(A) of the IRC and IRS publication 502, Medical and Dental Expenses.) For M+C MSA purposes, however, most health-related insurance premiums do not constitute qualified medical expenses, nor do amounts paid for the medical expenses of any individual other than the account holder. Also, keep in mind that the IRS definition of qualified medical expenses encompasses a broader range of items and services than are covered by Medicare, including for example prescription drugs and dental services. Thus, items that are considered qualified medical expenses by the IRS do not necessarily constitute countable expenses toward an M+C MSA plan's annual deductible.

An enrollee in an M+C MSA plan may make withdrawals from an M+C MSA that are not used to pay for the qualified medical expenses of the account holder, but these withdrawals are included in the account holder's taxable income and may be subject to additional tax penalties under section 138(c)(2) of the IRC. The additional tax provisions do not apply to distributions following the disability (as defined in section 72(m)(7) of the IRC) or death of the account holder. Finally, under section 138(d) of the IRC a surviving spouse of an M+C MSA holder may continue the M+C MSA upon the death of the account holder, including making nontaxable withdrawals for the qualified medical expenses of the spouse or the spouse's dependents, but may not make new contributions to the M+C MSA. Again, we recommend contacting the IRS for further details.

K. Letters of Intent

In closing, we wish to solicit letters of intent from organizations that intend to offer high deductible M+C MSA insurance plans to Medicare beneficiaries and/or to serve as M+C MSA trustees or custodians. A letter of intent to offer an M+C MSA plan should include basic information about the plan, the geographic area in which the plan intends to operate, the name, address, and telephone number of a contact person, so that beneficiaries can call the plan to verify whether the plan did, in fact, submit an application and receive our approval. This letter of intent must be received no later than July 31, 1998.

For prospective M+C MSA trustees, the letter of intent must include the name of the organization, the address, a contact person and telephone number,

funds routing number, Federal tax identification number, the geographic area the trustee will serve, a public information number for publication, and attestation that the organization is a chartered bank, licensed insurance company, or other entity qualified under section 408(a)(2) or section 408(h) of the Internal Revenue Code to act as a trustee or custodian of an individual retirement account. For trustees, no further application to us will be required if the organization appears to be qualified based upon submitted information. Trustees that decide at a later date to participate will have to notify us before offering M+C MSAs.

Statements of intent should be submitted to—Health Care Financing Administration, CHPP, Attn: Cynthia Mason, Room C4–17–27, 7500 Security Boulevard, Baltimore, Maryland 21244.

A letter of intent in no way commits an organization to submit an application to offer an M+C MSA plan or serve as an M+C MSA trustee, nor does it preclude the submission of an application if a letter of intent is not submitted to us. As part of our information campaign, we plan to publish and disseminate the information we receive to inform beneficiaries of the plans that may be participating in the M+C MSA plan demonstration project.

IV. M+C Private Fee-for-Service Plans

1. Background and Definition of M+C Private Fee for Service Plans (§ 422.4(a)(3))

As noted above, among the type of M+C options available under section 1851(a)(2) is an M+C private fee for service plan. An M+C private fee for service plan is an M+C plan like any other except where there are special rules and exceptions that apply to them. The effect of these special rules and exceptions is that we believe that M+C plans will function much like a traditional health insurance plan rather than a coordinated care plan nor a medical savings account. The law provides considerable flexibility in the creation of this M+C option and therefore, it is likely that M+C private fee for service plans will vary widely in how they function. Moreover, the law does not limit the premiums that an M+C organization may charge for an M+C private fee for service plan, thus making it very sensitive to market forces in its pricing, its benefits and its function.

We propose to define an M+C private fee-for-service plan as being an M+C plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk, does not vary the rates for a provider based on the utilization of that provider's services, and does not restrict enrollees' choice among providers who are lawfully authorized to provide the services and agree to accept the plan's terms and conditions of payment. This is the statutory definition of M+C private fee-for-service plan at 1859(b)(2)(A). The requirements these plans must meet to contract with HCFA as an M+C private fee-for-service plan are incorporated into the relevant sections of this regulation. An M+C private fee-for-service plan must meet all of the requirements for any other M+C plan, except to the extent that there are special rules for M+C private fee-for-service plans.

2. Quality Assurance (§§ 422.152 and 422.154)

The law exempts M+C private fee for service plans and non-network MSAs from some of the quality assurance requirements of the law. Moreover, the law exempts M+C private fee for service plans and non-network MSAs from external quality review if they do not have written utilization review protocols. Specific discussion of the statute and the regulations that implement these provisions that apply to both M+C private fee for service plans and non-network MSAs are found in subpart D at sections 422.152 and 422.154. As with all other requirements for M+C organizations and M+C plans, those provisions of regulations that are not specific to coordinated care plans and MSAs also apply to M+C private fee for service plans.

3. Access to Services (§ 422.214)

In § 422.214 we implement the special requirements for access to health services that are contained in section 1852(d)(4). The law requires that the Secretary must assure that the M+C private fee-for-service plan offers sufficient access to health care. Specifically, in § 422.114(a) we require that an M+C organization that offers an M+C private fee-for-service plan must demonstrate to HCFA that it has sufficient number and range of health care providers willing to furnish services under the plan. Pursuant to the specific instructions of the law, under § 422.114(a) HCFA will find that an M+C organization meets this requirement if, with respect to a particular category of provider, the plan has—

- Payment rates that are not less than the rates that apply under original Medicare for the provider in question;
- Contracts or agreements with a sufficient number and range of providers to furnish the services covered under the plan; or
- A combination of the above.

Hence, an M+C private fee-for-service plan will be found to have met the access requirements for a category of services if it has sufficient numbers of providers under direct contract in its service area or, if not, it has payment rates that are equal to or higher than the original Medicare payment for the service. This access test must be met for each category of service established by HCFA on the M+C organization application. Clearly, if an M+C private fee-for-service plan has payment rates that are no lower than Medicare, it need not address if it has a sufficient number of providers of services. However, where the plan has payment rates that are less than the Medicare payment for that type of provider, the plan must demonstrate that it has sufficient number of providers of that type under direct contract. For purposes of making this judgement of sufficiency, HCFA will use the same standards for M+C private fee-for-service plans as for coordinated care plans. We see no basis to use different standards.

In § 422.114(b) we specify that the plan must permit the enrollees to receive services from any provider that is authorized to provide the service under original Medicare. This implements that part of section 1852(d)(4) that says that the access requirements cannot be construed as restricting the persons from whom enrollees of the M+C private fee-for-service plan may obtain covered services.

4. Physician Incentive Plans (§§ 422.208 and 422.210)

In § 422.208(e) we specify that an M+C private fee-for-service plan may not use capitated payment, bonuses, or withholds in the establishment of the terms and conditions of payment. This is necessary to implement that part of the definition of an M+C private fee-for-service plan that specifies that the plan must pay without placing the provider at financial risk. We believe that these physician incentives place the physician at financial risk and thus are not permitted by the law for M+C private fee-for-service plan payments. Capitation places physicians at risk because of the uncertainty of the extent to which the beneficiary will require the physician's time and services to provide an adequate level of service. Withholds from payment place the physicians at financial risk because of the uncertainty of what the ultimate payment for the

services furnished will be. Bonuses are essentially the same as withholds. In both the case of bonuses and withholds, the physicians knows the least amount that could be paid but in both cases, they face uncertainty about what the total payment from the plan would be for the services furnished.

5. Special Rules for M+C Private Fee-for-Service Plans (§ 422.216)

In § 422.216(a) we address payment to providers. Specifically in 422.216(a)(1) we state that the M+C organization offering an M+C private-fee-for-service plan pays contract providers (including those that are deemed to have contract under § 422.216(f)) on a fee-for-service basis at a rate, determined under the plan, that does not place the provider at financial risk. This reflects the statutory definition of an M+C private fee-for-service plan.

We also specify in § 422.216(a)(1) that the payment rate includes any deductibles, coinsurance, and copayment imposed under the plan and must be the same for all providers paid pursuant to a contract whether or not the contract is signed or deemed to be in place as discussed below. This reflects our understanding of the meaning and use of these terms in common insurance use. It also reflects our belief that the plan rate (on which balance billing discussed below is based) is intended to be analogous to the Medicare allowed amount for a service, of which the deductible, coinsurance or copayment is a part. We think the deductible, and coinsurance or copayment is a part of the plan payment rate because deductibles have to be subtracted from that plan payment and because coinsurance is a percentage of the plan payment rate, thus being included within the rate by definition. We believe that the payment rate does not include balance billing because the common definition of balance billing under both original Medicare and common insurance is an amount above and beyond the payment rate established for the service. Balance billing is discussed in more detail below in (c) as a provider charge to enrollees.

As noted above, we specify in § 422.216(a)(1)(i) that a uniform payment rate must be established for a given item or service furnished under a contract, whether the contract is signed or deemed to exist (*see* discussion of deemed contracts below). In § 422.216(b)(1)(i), we also require that the plan deductible, coinsurance or copayments and other beneficiary liability be uniform for services furnished by all contracting providers, whether contracts are signed or deemed to be in place. These two requirements are closely related, since permissible enrollee liability is linked by statute to the plan's payment rate. The balance billing limitation in section 1852(k)(2)(A) that applies to M+C private fee-for-service plans is based on the plan payment rate, which has deductible, copayment and coinsurance amounts built into it. In our view, therefore, the uniform cost-sharing rule in § 422.216(b)(1)(i) follows from the uniform payment rate rule in § 422.216(a)(1)(i).

We believe that the uniform rate requirement in § 422.216(a)(1)(i) is implicit in the definition of private fee-for-service plans in section 1859(b)(2), which refers in the singular to reimbursing, hospitals physicians and other providers at ''a rate'' determined under the plan. The balance billing limit in section 1852(k)(2)(A) even more explicitly supports a uniformity rule, in referring in the singular to ''a'' prepayment ''rate'' that is established under ''a contract (including [a deemed contract]). * * *'' Section 1852(k)(2)(A) thus makes clear that Congress contemplated that a *single* ''rate'' would be established for a given service, or for a service in a given area, under ''a contract,'' and that this rate would apply under the contract, ''including'' a contract deemed ''through the operation of subsection (j)(6)'' of section 1852 (discussed below).

Even if the statute did not refer to a single rate that applies under a contract, and expressly include a deemed contract in this statement, we would exercise our authority under section 1852(b)(1) to impose a uniform rate and cost-sharing requirement. We understand from oral presentations and written comments received in response to the January 20, 1998 **Federal Register** notice (63 FR 2920), that some entities would like to establish different payment rates and enrollee cost-sharing for providers that sign contracts than those which would apply to providers deemed to have a contract. These entities indicated that they wanted to establish incentives to use the network of providers with signed contracts. We believe that it would be inconsistent with the scheme established by Congress to permit this.

Under such an approach, the M+C organization would in essence be establishing a defined and limited network of preferred providers. Congress has applied a different set of rules to plans that employ provider networks, and exempted M+C private fee-for-service plans from these requirements. Indeed, a ''preferred provider organization'' (PPO) plan and ''point of service'' option are each expressly mentioned as examples of ''coordinated care plans'' subject to the quality assurance rules that apply to network plans, including network MSA plans. We believe that permitting private fee-for-service plans to have different cost-sharing amounts for providers with signed contracts would create a ''loophole'' permitting organizations from offering network type PPO plans without complying with the quality assurance requirement that Congress intended to apply to network plans.

In § 422.216(a)(1)(ii) we specify that contracting providers must be paid on a fee-for-service basis. This is required by the definition of M+C private fee-for-service plans contained in 1859(b)(2)(A).

In § 422.216(a)(1)(iii) we specify that the M+C organization must make the payment rate available to providers that furnish items or services that may be covered under the M+C private fee-for-service plan offered by the organization. We require this to ensure that the contracting providers will be advised or be able to acquire the amount of payment for the services they furnish to plan enrollees. This is particularly important given the plan's flexibility to set and change payment rates.

In § 422.216(a)(2) we specify that the M+C organization must pay a contract provider (including one deemed to have a contract) an amount that is equal to the payment rate described above less any applicable deductible, coinsurance or copayment. The M+C plan's share of the payment is the payment rate (which includes deductible, coinsurance and copayment as discussed above) less that enrollee's cost-sharing.

In § 422.216(a)(3) we also specify that the plan pays for services of noncontract providers in accordance with § 422.100(b)(2).

Section 1852(k)(2)(B)(i) specifies that the minimum payment rate for noncontracting providers of M+C private fee-for-service plans must be the payment rate set in 1852(a)(2)(A), the same payment rate that applies when coordinated care plans pay noncontracting providers for approved services. The provisions of 1852(a)(2)(A) are set in regulations at § 422.100(b)(2) and thus that provision applies to the payment to noncontracting providers by M+C private fee-for-service plans. Thus, the plan must pay the provider at least the amount that the provider would have received under original Medicare, including any allowed balance billing amounts. The provider must accept this amount, together with allowable cost

sharing paid by the enrollee, as payment in full.

In § 422.216(b) we address provider charges to enrollees. Specifically in § 422.216(b)(1) we state that a contract provider (including one that is deemed to have a contract under paragraph (f) (discussed below) may charge the enrollee no more than the deductible, coinsurance, copayment, and balance billing amounts permitted under the plan, that the plan must have the same cost-sharing for deemed contract providers as for contract providers and that the plan may permit balance billing no greater than 15 percent of the payment rate for the service.

The provisions regarding what enrollees may be charged are based on our interpretation of section 1852(k)(2)(A)(i) that says that a provider shall accept as payment in full ''* * * an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.'' We believe that the intent of this provision is that the plan may, but is not required to, permit the provider to collect balance billing equal to but not in excess of 15 percent of the plan payment rate. We believe that the intent of the section was to permit a balance billing provision that mirrors that which currently exists section 1848(g) with respect to services paid under the Medicare fee schedule for physician services for beneficiaries who are enrolled in original Medicare.

We recognize, however, that the inclusion of the words ''balance billing otherwise permitted under the plan'' in the second parentheses in section 1852(k)(2)(A)(i) could be construed, if read literally, to permit the 115 percent limit on enrollee liability for balance billing to be applied to a payment ''rate'' that already included balance billing ''otherwise provided for'' in the plan.

This interpretation would in effect have created two balance billing amounts: one balance billing amount within the payment rate (that would be above and beyond the deductible, coinsurance and copayment) and another balance billing amount based upon the payment rate (effectively a balance billing amount as a percentage of another balance billing amount). This is a convoluted result that we do not believe was intended. In addition to producing a convoluted result, the above reading of the reference to balance billing in the second parenthetical in section 1852(k)(2)(A)(i) would permit M+C organizations to avoid the limitation on enrollee liability in section 1854(e)(4), which applies only to deductibles, coinsurance, and copayments. *See* section G. below. If an M+C organization offering a private fee-for-service plan could ''provide for'' balance billing amounts in its payment rate, such amounts would not count towards the overall limit on enrollee liability in section 1854(e)(4). This could result in unlimited enrollee liability if such unlimited ''plan'' balance billing amounts were coupled with balance billing of 115 percent of rates that include the plan balance billing.

The provision that requires that the plan establish the same cost-sharing for the services of deemed contract providers as for contract providers is discussed above in its relationship to § 422.216(a)(1).

In § 422.216(b)(1)(iii) we specify that the M+C organization must specify in the contract the deductible, coinsurance, copayment, and balance billing permitted under the plan for services furnished by a contracting provider (including a deemed contract under paragraph (f)). We believe it is important to ensure that the providers who furnish services are explicitly aware of the amounts they can collect from enrollees since there are potential penalties for violation of these limits.

In § 422.216(b)(1)(iv) we specify that an M+C organization is subject to intermediate sanctions under § 422.752(a)(7), under the rules in subpart O of part 422, for failing to enforce limits on beneficiary liability that apply to contract (including deemed contract) providers. This implements section 1852(k)(2)(A)(i).

In § 422.216(b)(2) we specify that a noncontract provider may charge the enrollee no more than the cost-sharing established under the M+C private fee-for-service plan limited as specified in § 422.308(b). This requirement implements section 1852(a)(2), which applies to all M+C plans other than MSA plans, and which is referenced in section 1852(k)(2)(B)(i), which applies specifically to payments to non-contract providers under M+C private fee-for-service plans. Section 1852(a)(2) requires that M+C organizations provide for payment to non-contracting providers of an amount, representing the sum of payment from the organization and any cost-sharing provided for under the M+C plan, that is at least equal to the total dollar amount of payment that would be authorized to be paid under parts A and B, including any balance billing permitted under such parts. We have defined ''cost-sharing'' in section 422.2 as including only deductibles, copayments and coinsurance, and not balance billing amounts. Because section 1852(a)(2)(A)(i) uses the term cost-sharing, we believe that it requires that M+C organizations make payment in an amount that, when combined with deductible amounts, coinsurance or copayments provided for under the M+C plan, at least equals the amount the individual or entity would be able to collect under original Medicare, as we have provided in section § 422.216(b)(3). This means that enrollees must be held harmless against any balance billing by non-contracting providers.

While § 1852(a)(2) thus limits enrollee liability to deductible, coinsurance, and copayment amounts (and does not permit enrollee liability for balance billing in the case of non-contracting individuals or entities), it does not contain any limit on the *amount* of enrollee liability that can be imposed under a M+C private fee-for-service plan for services furnished by a non-contracting provider. While section 1854(e)(4) limits the actuarial value of cost-sharing overall, it does not limit the amount that can be charged for a particular service, except as specified elsewhere in this rule, for example limits for emergency services as established in section 422.112(b). Hence, except for limits specified elswhere in this rule, M+C organizations that offer M+C private fee-for-service plans will be able to establish cost-sharing for services of non-contracting providers without regard to a specific limit per service.

In § 422.216(c)(1) we specify that an M+C organization that offers an M+C private fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section. We also specify in § 422.216(b)(1)(iv) that if the M+C organization fails to enforce the limit as required by paragraph (c)(1) of this section, the organization is subject to intermediate sanctions under subpart O of this part. We intend to leave to the organization's discretion the means by which it will enforce the limits on charges to enrollees. However, through the ongoing monitoring of the M+C private fee-for-service plan, HCFA will review the means by which the plan is enforcing the limits on charges to enrollees by looking at the extent of complaints from enrollees and the action the M+C organization takes to resolve them, both systematically and individually.

In § 422.216(c)(2) we specify that an M+C organization that offers an M+C private fee for service plan must monitor the amount collected by non-contract providers to ensure that those amounts do not exceed the amounts

permitted to be collected under paragraph (b)(2) of this section. The M+C organization must develop and document violations specified in instructions and must forward documented cases to HCFA. HCFA may impose the sanctions provided in section 1848(g)(1)(B). These are the penalties that apply to nonparticipating physicians who fail to abide by the limiting charge under original Medicare.

In § 422.216(d) we specify that the M+C organization that offers an M+C private fee-for-service plan must provide to plan enrollees an appropriate explanation of benefits that includes a clear statement of the enrollee's liability, including any liability for balance billing consistent with this section. Section 1852(k)(2)(C)(i) requires that the plan must notify the enrollee of balance billing that can be collected by the provider. We believe that it would be misleading for this notice to be limited to the balance billing that can be collected by the provider since the provider may also be able to collect deductible, coinsurance and or a copayment from the enrollee (depending upon the plan's policy) and that therefore the plan should notify the enrollee of all cost-sharing and balance billing that can be collected by the provider so that there is no confusion.

We also specify that, in its terms and conditions of payment to hospitals, the M+C organization must require a hospital, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to $500 or more, notice that balance billing is permitted for those services and a good faith estimate of the likely amount of balance billing, based on the enrollee's presenting condition. Section 1852(k)(2)(C)(ii) requires that such a notice be furnished by a hospital for inpatient services and permits the Secretary to require such a notice for other hospital services at a tolerance to be set by the Secretary. We believe that this requirement was included in the law because of the potential for the balance billing provisions that apply to contracting providers to create quite large liability for enrollees of these plans. For example, if an M+C private fee-for-service plan permits a hospital to balance bill up to the 115 percent of plan payment rate that the law would permit, and the plan payment is $10,000 for the hospital stay, the enrollee would be liable for $1500 in balance billing in addition to the deductible, coinsurance and copayment the plan permits the hospital to collect.

We specify that the advance notice requirements applies to all services furnished by a hospital because of the trend towards furnishing services on an outpatient basis that would previously have been furnished on an inpatient basis. These services can be very expensive and we believe that the enrollee has a need to know the cost-sharing for these services in advance of receiving the services as for inpatient hospital services.

We have set the tolerance at which the hospital must provide this advance notice at $500, which is the tolerance for nonparticipating physicians to provide advance notice of the nonparticipating physician's actual charge under section 1842(m)(1) for purposes of Part B of original Medicare.

In § 422.216(e) we specify that the M+C organization must comply with the coverage decisions, appeals, and grievances procedures of subpart M. This requires that the M+C organization, offering the M+C private fee-for-service plan, make coverage determinations on all services and that it must make a determination before the service is furnished if the enrollee or provider requests it. We believe that this requirement is necessary to enforce the provisions contained in section 1852(g)(1)(A), which apply to all M+C organizations. Specifically, section 1852(g)(1)(A) requires that ''A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such services. Subject to paragraph (3), such procedures shall provide for such determinations to be made on a timely basis.'' Paragraph (3) is the expedited decision process.

We recognize that providing advance determinations of coverage has not been a common feature of commercial fee-for-service plans in the past. However, the law's use of the present tense with regard to the requirement for coverage determinations and its reference to the expedited appeals process (which is intended to obtain a quick appeal of a denial of a service not yet furnished) clearly anticipates that there will be the opportunity for an advance determination of coverage for all M+C plans. Moreover, the opportunity to acquire an advance determination of coverage is particularly important since there is no protection from retroactive denial for enrollees in an M+C private fee-for-service plan. This is a source of great risk for enrollees in M+C private fee-for service plans, who, unlike enrollees in coordinated care plans, may seek treatment from any licensed provider that agrees to accept the terms and conditions of the plan.

While the opportunity for advance determinations of coverage presents the opportunity to minimize the risk by giving the enrollee and provider the opportunity to determine whether the plan will pay for the service and the amount for which the enrollee will be liable, it does not provide protection to the enrollee that is comparable to the protection provided by original Medicare under the provisions of section 1879 (which apply to assigned claims) and under 1842(l) (which apply to unassigned physician claims). These provisions hold the beneficiary without fault when a services is denied as not medically necessary to treat illness or injury unless the beneficiary was advised by the provider in advance of the service that Medicare would not pay and the beneficiary accepted liability if Medicare did not cover the service. These provisions also permit a physician to take assignment on a claim for Medicare services to be found to be not at fault and to be paid by Medicare for the noncovered service if he can demonstrate that he did not know and could not reasonably have known that the service was not covered.

We considered and rejected imposing several requirements that would have provided Medicare beneficiaries with protection like that available under original Medicare. Specifically, we considered requiring that the M+C organization must require that contracting providers (including deemed contractors) submit claims for the services they furnish to enrollees. We also considered but rejected requiring the M+C organization to require that contracting providers (including deemed contractors) assume the responsibility for acquiring an advance determination of coverage from the plan or risk being unable to charge the enrollee if they did not notify the enrollee in advance of the service if the plan does not cover the care. This approach would have provided enrollees protection from the liability of full payment in the case of retroactive denials and would have given providers an opportunity to minimize their risk by acquiring advance approval of coverage.

However, we decided that it would be contrary to the spirit and intent of the M+C fee-for-service legislation to impose these requirements on providers and plans, since they would make the plan much more like a coordinated care plan than like a traditional fee-for-service plan. Moreover, such a construction would place the provider at financial risk, contrary to the

definition of an M+C private fee-for-service plan.

Our silence in regulations on the claims filing requirements of M+C private fee-for-service plans and the absence of any explicit mechanism for providing protection to enrollees from retroactive denials of coverage does not foreclose the possibility that an M+C private fee-for-service plan may choose to address these issues. For example, the M+C private fee-for-service plan may choose to include in its terms and conditions of payment a requirement that the provider must bill the plan for payment. Similarly, the M+C private fee-for-service plan may choose to provide some level of payment for services subject to retroactive denials as an additional benefit or as a supplemental benefit under the plan. This could be an attractive feature of the plan and a valuable benefit to enrollees.

Although we are silent on these issues, we remain concerned about the absence of protections for beneficiaries who enroll in private-fee-for-service plans. We are soliciting comments on these issues, and we are particularly interested in comments on whether to apply the protections discussed above as a requirement or how otherwise to protect the beneficiary from being financially at risk, while not creating undue burdens on providers and insurers.

In § 422.216(f) we specify that any provider that does not have a contract will be treated as having a contract in effect with the M+C organization offering the M+C private fee-for-service plan if the provider furnishing services (1) is aware that the beneficiary receiving the services is enrolled in the plan, and (2) before furnishing the services, has a reasonable opportunity to be informed about the terms and conditions of payment and coverage under the plan. Section 1852(j)(6) requires that we deem a noncontracting provider to be a contracting provider when these criteria are met. In § 422.216(f) we further specify three general criteria, each of which must be met for a provider to be deemed to have a contract with the plan and which are discussed further in § 422.216(g) and (h).

In § 422.216(f) we specify that for the deemed contract provision to apply the services must be covered under the plan and must be furnished to an enrollee of an M+C private fee-for-service plan, by a provider that does not have in effect a signed contract with the M+C organization. We also specify in § 422.216(f)(2) that the provider must have been informed of the individual's enrollment in the plan and must have been informed or given a reasonable opportunity to obtain information about the terms and conditions of payment under the plan in a manner reasonably designed to effect informed agreement. The information must include the information described in § 422.202(a)(1).

In § 422.216(g) and (h) we further clarify that the requirements of paragraph (f) of this section are met (and the noncontract provider is subject to the provisions for contracting entities) if the following conditions are met.

Enrollment information must be provided by one of the following methods or a similar method:

- Presentation of an enrollment card or other document attesting to enrollment.
- Notice of enrollment from HCFA, a Medicare intermediary or carrier, or the M+C plan itself.

We considered how best to ensure that the noncontracting provider would be advised that the enrollee is enrolled in the M+C private fee-for-service plan. However, since there is no direct contract between the provider and the M+C private fee-for-service plan, it becomes incumbent upon the enrollee to advise the provider of the enrollment. Even where the provider had previously been notified of the beneficiary's enrollment in the M+C private fee-for-service plan (e.g. at the time of a previous service), the provider cannot automatically assume that the beneficiary is enrolled in the plan and may not be able to learn the beneficiary's enrollment status prior to providing services. This occurs because, before 2002, beneficiaries can disenroll from M+C plans at any time, either voluntarily or involuntarily by moving out of the service area. After that date, the beneficiary can disenroll within the first 3 months of the year or at any time if they move out of the service area. Hence, there are very few times that a noncontracting provider can know with certainty that the beneficiary remains enrolled in the M+C private fee-for-service plan based on previous knowledge of enrollment. If the provider fails to acquire current enrollment information from the enrollee or the plan at the time of each service, we do not see how he or she can be held to have met the first test of ''deemed contract status'': knowing that the beneficiary is enrolled in the plan.

To be a deemed contractor, the provider or supplier who knows that the patient is enrolled in the plan must either have been given information on payment terms and conditions or must have had a reasonable opportunity to learn such terms and conditions of plan payment. Under that circumstance, treatment of the patient implies consent to the terms and conditions of plan payment.

To meet the requirement of having been given information on payment terms and conditions, we specify in paragraph (h)(1) that the information must have been communicated to one of the following:

- The provider of the services.
- The provider's employer or billing agent.
- A partnership of which the provider is a member.
- Any party to which the provider makes assignment or reassigns benefits.

We expanded the list of parties to whom the information must be provided beyond those of providers themselves in recognition that providers, and in particular, individual physicians and practitioners, seldom receive the insurance information that is sent to them and seldom complete and submit their own claims. By reassigning insurance benefits to other parties and by delegating the responsibility to complete and submit claims to other parties, they are, effectively, also delegating the authority to make decisions governing their payment for which they remain responsible.

We also specify in paragraph (h)(1) that the information must have been transmitted via mail, FAX, electronic mail or telephone. Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment. We specify how the information must have been provided because we have been asked if general distribution of information to the public (e.g. annual newspaper notice) is an acceptable notice to bind the provider to being considered to be a deemed contractor. We do not believe that it is reasonable for a plan to do a general public notice since the provider may not see it and has no way of relating that information to itself. However, where the plan has transmitted the information directly to the provider by mail, FAX, electronic mail or telephone, the statute's test of having been furnished the information to the provider has clearly been met.

However, the law also provides that a provider that has a reasonable opportunity to acquire the terms and conditions of plan payment must be treated as if it were a contract provider. To implement this provision of the law, we further specify in paragraph (h)(2) that a provider that does not have a contract with the plan is deemed to have a contract with the plan if the plan has an acceptable procedure under which the provider could acquire the

terms and conditions of plan payment before providing services to the enrollee. Specifically, we say that this test is met where the M+C plan has in effect a procedure under which noncontract providers are advised how to request the payment information and the plan responds to the request before the provider furnishes the service. This procedure could be the inclusion of a toll free telephone number or E-mail address on the enrollment card for the provider's use in acquiring the terms and conditions of payment. Where the plan responds to the provider's request before the service is furnished, the provider would be treated as a contract provider if the provider subsequently furnishes the service to the enrollee, regardless of whether the provider agrees to accept the terms and conditions of the plan.

The effect of these statutory provisions is that there are very few circumstances in which a provider would not be treated as if it had a contract with the plan. These would include but not be limited to the following:

- Where the beneficiary did not notify the provider of enrollment in the plan.
- Where the provider requested but was not furnished terms and conditions of payment in advance of the provision of services to a known enrollee.
- Where the plan did not have a process that provided terms and conditions of payment.

We think that in most cases, plans will ensure that there is a procedure in place for providing this information before services are furnished. We think that the most likely circumstances in which a provider will be considered to be a noncontracting provider will be in cases of emergency where the provider has not previously been mailed the terms and conditions of payment under the plan or where the provider does not know that the beneficiary is enrolled in the plan.

In § 422.216(h)(2)(iii) we specify that the plan must include the following in the terms and conditions of plan payment that it must furnish to providers of services:

- Billing procedures.
- The amount the plan will pay towards the service.
- The amount the provider is permitted to collect from the enrollee.
- The information described in § 422.202(a)(1).

V. Regulatory Impact Statement

A. Introduction

We have examined the impact of this rule as required by Executive Order 12866 and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). The RFA requires agencies to analyze options for regulatory relief of small businesses. For purposes of the RFA, small entities include small businesses, non-profit organizations and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually.

Section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 50 beds.

The Unfunded Mandates Reform Act (Public Law 104–4) requires that agencies prepare an assessment of anticipated costs and benefits before proposing any rule that may result in an annual expenditure by State, local and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation). This rule does not impose any mandates on State, local, or tribal governments, or the private sector that will result in an annual expenditure of $100,000,000 or more.

Summary of the Interim Final Rule

As discussed in detail above, this rule implements the M+C program as directed by the BBA of 1997. The primary objective of the M+C program is to increase the number and types of health plan choices available to Medicare beneficiaries.

Since the implementation of section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA 82) (Public law 97–248), the Medicare program has offered beneficiaries a prepaid capitated option through HMOs and CMPs paid on a full risk basis. Enrollment by Medicare beneficiaries in Medicare managed care risk plans has grown to over 4.5 million enrollees. The number of plans increased 31 percent in CY 1995, 36 percent in CY 1996, and 31 percent in CY 1997. With the implementation of the M+C program, we expect that the rate of growth of beneficiaries enrolling in capitated plans will continue.

The M+C program authorizes HCFA to contract with several new types of entities not previously available to Medicare beneficiaries such as provider sponsored organizations, preferred provider organizations, entities offering an ''MSA plan'' and a contribution into an M+C medical savings account (MSA), and M+C private fee-for-service plans. These new options will provide Medicare beneficiaries with a broad range of health insurance alternatives like those available in the private sector. Based on current growth rates and other information discussed later, we estimate that anywhere from 160 to 800 new entities may apply to contract with HCFA as M+C organizations.

By expanding choices and providing extensive educational materials through a coordinated open enrollment period, it is expected that beneficiaries will choose plans and health delivery systems that will maximize the benefits to these individuals.

The BBA also revamped the payment methodology for entities receiving capitated payments from Medicare. These payment changes were intended primarily to insure that the amounts paid to M+C organizations were fair and equitable to both the Medicare Trust Funds and to the participating organizations. Although Medicare's capitation rates had been set at 95 percent of expected costs based on actual fee-for-service costs, there is significant evidence that Medicare has paid more for enrollees in the managed care program than it would have paid in the fee-for-service program. This is due primarily to the favorable selection that these plans have experienced. The new payment rules slow the annual increase M+C organizations would have received under the old payment methodology. In addition, there has long been concern regarding the regional variation in payment rates, particularly between urban and rural counties. Because the capitated payment rates had been based upon the fee-for-service payments, the capitated rates not only included the variation in local prices, they also reflected different fee-for-service practice patterns in each region. To level out the variation in payment rates, the new methodology uses a blend of local and national rates and input price adjustments to insure the payments more closely reflect the different prices in the region while giving less weight to the different utilization rates. Finally, to insure that the new options would be

viable in all parts of the country a floor on capitated payments was introduced.

Summary of Discussion of Impact

We believe that the overall impact of this regulation should be beneficial to Medicare beneficiaries by providing them with more options to receive health care. However, although many of the provisions in this regulation are intended to assist beneficiaries by providing them with comparative information, we are concerned that the many new choices and types of plans may prove confusing even for the most knowledgeable consumers. Reductions in capitated payment amounts in what are now relatively higher payment areas may result in reduced benefits for beneficiaries. Providers (especially rural providers) should benefit from this regulation because they can contract directly with HCFA under the PSO provisions. New contracting entities will benefit as the Medicare statute has not previously permitted entities that were not state licensed HMOs or CMPs to participate in the Medicare managed care program. Providers could be negatively impacted if they contract with M+C organizations by the degree that any reduction in the rate of growth in payments to M+C organizations will be passed on to them. We also recognize that existing contractors and States may be adversely affected but cannot quantify to what degree. This impact analysis will focus on the provisions of the BBA and this regulation that significantly alter the risk program we have been administering since 1985. The major differences between the section 1876 risk program and the M+C program are:

The coordinated open enrollment and public education campaign:

New payment methodology for contracting plans

Introduction of New Contracting Entities

Provider Sponsored Organizations

Medicare Savings Account Plans

Private Fee-for-Service Plans

New Quality Standards

Our analysis will assess the impact these changes will have on Medicare beneficiaries, the Medicare Trust Funds, providers, managed care entities, and States. Whenever possible, we will use appropriate methods for assessing the impact quantitatively. However, because of the large number of unknowns—such as the prospective number of contracting organizations—this analysis relies upon many simplifying assumptions.

B. Coordinated Open Enrollment and Public Education Campaign

Section 1851 directs HCFA to hold annual coordinated open enrollment periods beginning in November 1999 (all plans will also be open to enrollment in November 1998) to allow eligible beneficiaries the opportunity to enroll in M+C organizations. It also directs HCFA to broadly disseminate information to current and prospective Medicare beneficiaries on the coverage options available in order to promote an active, informed selection among such options. At least 15 days before each annual, coordinated election period, HCFA will send to each eligible individual a notice containing information in order to assist the individual in making an election. This information describes M+C options as well as original Medicare. In addition, M+C organizations are directed to provide plan-specific information.

The public education campaign will include information on covered benefits, cost sharing and balance billing liability under the original Medicare program; election procedures; grievance and appeals rights under the original Medicare fee-for-service program and the new M+C program; information on Medigap and Medicare SELECT; and the beneficiary's right to be protected against discrimination based on health status.

The costs of the coordinated open enrollment and public education campaign will be borne primarily by the participating M+C plans. Section 4001 of the BBA added a new section 1857(e)(2) to the Social Security Act that establishes a fee requirement under which M+C organizations and section 1876 contractors must contribute their pro rata share, as determined by the HCFA, of costs related to enrollment, dissemination of information, and the counseling and assistance programs.

The annual fee will be assessed by HCFA on all participating organizations. The amount of the user fee will vary year to year as determined through the appropriations process. The BBA authorized ceiling amounts of $200 million in FY 98, $150 million in FY 99, and $100 million annually in FY 2000 and beyond. However, in FY 1998 HCFA was authorized to collect only $95 million through the appropriations process.

On December 2, 1997 HCFA gave notice of our methodology of assessing current contractors for their pro rata share of the expenses associated with the CY 1998 information campaign. To determine each organization's share, we divided the total amount appropriated for the information campaign by the total projected revenues for the first 9 months of CY 98. The resulting percentage was deducted from the payments to contracting organizations.

We explored several alternatives to this methodology. One option was to assess each organization on a per capita basis (by number of Medicare enrollees). Another option was to assess each organization on the percentage of revenue they received from capitated Medicare payments, but have a cap on the highest amount any organization would pay.

We rejected both of these methodologies as not consistent with the goals of the BBA. One of the primary effects of the reformed payment methodology of the BBA was to even out variation between high and low payment areas. By charging a per capita amount, those organizations that are located in areas that have a high payment rate would pay a reduced percentage of their revenue. Or put another way, we deemed that if an organization received a higher payment per person, it should pay a correspondingly higher user fee for its share of the education campaign. We also decided not to put a cap on the assessment any organization would receive based on the premise that only large organizations would receive the benefit of a cap and smaller organizations would have to pay more to make up the difference. This did not seem fair or consistent with our intention of encouraging the creation of new contracting entities and spurring competition in areas with lower payment rates.

As stated in the interim final rule (M+C Program: Collection of User Fees from M+C Plan and Risk-Sharing Contractors (42 CFR 417.470–417.472)), we will establish a fee percentage rate and collect the fees over nine consecutive months beginning with January until the assessment limit has been reached. The following table illustrates the method by which we will calculate the fee percentage rate, provides the rate for FY 1998, and sets forth projections for FY 1999–2002.

TABLE 1.—COLLECTION OF CONTRIBUTIONS FROM ORGANIZATIONS FOR COSTS RELATING TO INFORMATION DISSEMINATION

	Projected fiscal year total medicare payment to organizations (in millions of dollars) [1]	Projected medicare payment to organizations per month (in millions of dollars) [2]	Projected medicare payment to organizations over 9 months (in millions of dollars) [3]	Authorized assessment amount (in millions of dollars) [4]	Fee amount secretary is directed to collect (in millions of dollars) [5]	percentage of projected 9-month payment
FY 1998	30,000	2,465	22,181	200	95	.428
FY 1999	38,000	3,167	28,500	150	150	.526
FY 2000	47,000	3,917	35,250	100	100	.284
FY 2001	63,000	5,250	47,250	100	100	.212
FY 2002	64,000	5,333	48,000	100	100	.208

[1] Source: Congressional Budget Office, The Economic and Budget Outlook: Fiscal Year 1999–2008. January 1998.
[2] Projected total fiscal year payment divided by 12 (months).
[3] Projected monthly payment amount multiplied by 9 (months).
[4] New Section 1857(e)(2)(D) of the Social Security Act, as added by the BBA (Public Law 105–33).
[5] For purposes of these projections, we have assumed that Congress will include the full amount authorized under the BBA.

As noted in the interim final rule published on December 2, 1997, we believe that assessing the fees to reflect an organization's pro rata share of the expenses associated with the information campaign will require the deduction of only a very small percentage of any organization's total annual Medicare payments. For example, in FY 1998 the percentage fee assessment is 0.428 percent—less than one-half of one percent. In subsequent fiscal years the fees as a percentage of Medicare payments will likely represent an even smaller percentage of the Medicare payments as the number of eligible organizations increase and the existing organizations experience enrollment growth.

Information Campaign

In general, we believe that this investment in new forms of information dissemination should be beneficial to Medicare beneficiaries, contracting organizations, and the Medicare program. By providing extensive educational materials, it is expected that beneficiaries will choose organizations and health delivery systems that will maximize the benefits for them. Finally, while organizations face an assessment fee to support information campaign activities, it comprises a very small proportion of their revenue from the Medicare program and could serve to enhance their marketing efforts and to save marketing expenditures.

HCFA's information dissemination activities provided for under this regulation encompass a variety of interventions, including mailings of standardized, comparative information about coverage options, an Internet web site with such information, and a toll-free telephone line for beneficiary inquiries. In addition, the regulation provides for information dissemination activities to be undertaken by M+C organizations, including mailings to Medicare enrollees of plan-specific information and the provision of additional information upon request by Medicare eligible individuals.

In order for market competition to work effectively, consumers must have information about their choices in order to make good decisions. The information dissemination efforts provided for under this regulation will give Medicare beneficiaries information about the Medicare market, enabling them to compare fee-for-service coverage to managed care coverage, as well as coverage under different M+C organizations.

The Medicare program and managed care arrangements are inherently complex subjects, and it is challenging to communicate information that is meaningful and accurate. Many studies have shown that Medicare beneficiaries' level of understanding of how the Medicare program works today is very low (GAO, 1996) and this lack of understanding could be compounded by the introduction of a new array of choices if beneficiaries lack sufficient information or lack the skills or understanding necessary to use available information.

For example, studies have found that many individuals who disenrolled from Medicare risk HMOs misunderstood the nature of the plan, such as the lock-in feature. (OIG, 1997; GAO, 1996; IOM, 1996). As Medicare beneficiaries become better informed about the Medicare program generally and their options under M+C specifically, they will be able to make more informed decisions about meeting their health care needs, leading to fewer disenrollments based on misunderstandings. Disenrollment can be costly for plans. In 1996, a GHAA study estimated that disenrollment costs plans close to $1,300 per Medicare disenrollee. (GHAA, 1996)

While enhancing beneficiary choice is positive and providing beneficiaries with information on their choices is necessary, we are concerned that Medicare beneficiaries, especially in areas where several M+C organizations are operating, may experience information overload. Beneficiaries may have great difficulty in understanding the different types of plans available to them in their area or understanding the different benefit packages plans may offer. Beneficiaries will be required to assess their health needs in relation to the benefits being offered and they may well have to choose among a wide array of different benefit packages. These will be difficult choices and some beneficiaries may not choose the option best suited to their individual needs.

We believe important secondary effects may ensue as well. To date, plans have competed primarily on the basis of price and benefits. Broad dissemination of plan-specific information, including quality measures, should encourage competition among organizations based on quality factors, in addition to price and benefits. As Medicare beneficiaries become more familiar with health plans, their expectations of plan performance and quality services will increase. Enhanced beneficiary awareness will provide an incentive to plans to improve in areas that beneficiaries demonstrate are important to their decision making, such as the availability of certain providers and positive customer service experiences.

Moreover, beneficiaries will be better health care consumers in general if they understand their rights under managed

care and how to make a plan work for them. As Medicare enrollees receive more information and become more active decision makers on plan options, we believe they will also become more informed and active decision makers with respect to meeting their personal medical needs. More informed and active decision making on the part of enrollees will, in turn, facilitate plans' efforts to manage the delivery of appropriate, high quality health care services.

In addition, it should be noted that the information campaign is designed to reach all Medicare beneficiaries, and it is likely that, to the extent that this encourages growth in the M+C program, organizations will be well positioned to take advantage of the expanding market. Since the number of organizations and total revenues over which the BBA fee collections will be spread is likely to continue to rise with increased participation in the M+C program in future years, we believe the regulatory impact of the selected option for imposition of fees on M+C organizations will not be significant. Moreover, M+C organizations will benefit from the increased visibility they will receive through the focused information campaign each open enrollment season.

Aside from the benefits of the public education campaign there are benefits derived from the coordinated open enrollment for contracting organizations, beneficiaries, and to a lesser degree the Medicare Trust Funds, as discussed below.

Coordinated Open Enrollment and Beneficiary Lock-In

We anticipate that the transition into a coordinated open enrollment period and the beneficiary lock-in will be beneficial to M+C organizations in their efforts to attract and retain Medicare enrollees. It also will allow them to maximize their visibility as beneficiaries focus on information about plans during a single, coordinated period. An annual open enrollment period may present a challenge for start-up organizations that did not have the benefit of adding enrollment during continuous open enrollment periods available before 2002. However, the M+C beneficiary lock-in will provide a more stable enrollment base for all participating organizations.

Current contractors have conveyed that continuous open enrollment, which was prevalent prior to passage of the BBA, provided an incentive for beneficiaries that exhaust extra benefits offered by one HMO/CMP to switch to another HMO/CMP or back to traditional fee-for-service Medicare. This behavior provides a disincentive for M+C organizations to offer extra benefits, and we anticipate that M+C organizations will be more likely to offer extra benefits if concerns about enrollees disenrolling upon exhausting a benefit are diminished.

Moreover, as the lock-in is phased in, organizations offering M+C plans will operate within a framework that supports their efforts to manage the delivery of health care services. For example, if beneficiaries are not moving in and out of a plan, the M+C organization offering the plan will be better able to track a beneficiary's utilization of services over time. The lock-in will encourage plans to invest more in preventive health services or screening of new enrollees, because it increases the likelihood that the plan will retain its members long enough to benefit from eventual savings due to reduced morbidity. (PPRC, 1996)

We also note that M+C organizations will have to address the potential staffing and administrative requirements associated with a lock-in and a compressed enrollment period, such as how to staff appropriately to handle inquiries during the open enrollment period, how to process new enrollees when enrollment begins, and how to conduct initial physical histories and review medications for new enrollees. Therefore, there will be added burdens on the M+C organizations as they experience administrative and clinical burdens in implementing the lock-in. M+C organizations may have to hire temporary staff and this would be a cost to them (PPRC, 1996)

Although beneficiaries will have less flexibility with a lock-in period, they will also benefit from a coordinated open enrollment period because it provides a framework conducive to informed decision making. Similar to the experience of many individuals in the private sector, beneficiaries will receive extensive information each year, allowing them to compare all options simultaneously. By receiving standardized, comparative information during an annual, coordinated period, beneficiaries will find it easier to make appropriate choices among competing plans and between these plans and traditional Medicare fee-for-service. An annual coordinated open enrollment period will maximize the opportunity for all beneficiaries to make decisions that best meet their own needs.

Some beneficiaries may be more reluctant to enroll in an M+C organization if they must remain enrolled for extended length of time. The Office of Inspector General surveyed a two-stage random sample of 4,065 enrollees and disenrollees from 40 Medicare risk HMOs to compare their responses and to gain greater insight into HMO issues. The majority of beneficiaries surveyed stated that their most important reason for joining an HMO was their desire for more affordable health care. Only 17 percent of beneficiaries said they would be more hesitant to join an HMO if they did not have the option to disenroll at will. (OIG 1998) (see Table 2).

TABLE 2.—EFFECT OF MANDATORY ONE-YEAR ENROLLMENT—1996

[In percent]

	All	Enrollees	Disenrollees
If beneficiary had to stay in HMO for one year, the effect on the enrollment decision would be:			
—more likely to join	34	34	22
—less likely to join	17	16	33
—no effect on decision	49	49	45

Source: U.S. Department of Health and Human Services, Office of the Inspector General, Beneficiary Perspectives of Risk HMOs 1996, OEI–06–95–00430 (March 1998).

Beneficiaries retain the protection of the right to disenroll where the M+C organization's misrepresentation or the beneficiary's misunderstanding results in an enrollment that should not have occurred. In addition, the year-long opportunity for newly eligible aged individuals to disenroll and return to original Medicare is a particularly valuable protection for many beneficiaries who may be just beginning to understand the implications of new

options. (Newly eligible disabled beneficiaries are not afforded this option.) Beneficiary protections are enhanced by guaranteed issue of Medigap policies for first-time M+C enrollees who gave up supplemental coverage upon enrolling in an M+C organization and disenroll within 12 months, and for newly eligible aged beneficiaries who enroll in an M+C organization at age 65 and disenroll within twelve months of becoming eligible for Medicare.

Finally, we believe the lock-in will benefit the Medicare Trust Funds. The General Accounting Office found that the flexibility for beneficiaries to disenroll at will can cause problems for the Medicare program. (GAO, 1997) For example, beneficiaries could decide to use an M+C plan or other private plans while in relatively good health but disenroll to fee-for-service when their health care needs increased. The result could be a disproportionate number of less healthy beneficiaries in the fee-for-service sector, excess payments to HMOs, and unnecessary Medicare spending. We believe that the nine-month lock-in period will help reduce risk selection and, consequently, reduce the current problem of paying monthly premiums for beneficiaries while they are healthy but paying traditional claims when they become ill and disenroll from a managed care plan.

C. New Payment Methodology for M+C Plans

Section 1853 directs HCFA to modify the payment methodology for entities receiving capitated payments from Medicare. These payment changes are intended to: promote savings, reduce geographic variation in the rates, and stimulate the growth of new entities to serve Medicare beneficiaries in historically underserved areas. As described above, beginning in 1998, monthly county rates are the greatest of: (1) a minimum payment amount (of $367 in 1998); (2) a minimum percentage increase of 2 percent over the preceding year's payment for the area; and (3) a blend of the area-specific rate and an input-price adjusted national rate, further adjusted by a budget neutrality adjustment. The area-specific portion of the blended rates and the minimum payment amount are updated each year by the national average per capita Medicare growth rate (with specified reductions from 1998–2002).

Payment changes to M+C organizations figure prominently in reducing overall Medicare spending and postponing the depletion of the Medicare Trust Fund from 2001 to 2010. The CBO estimates that the BBA reduces Medicare spending by $116.4 billion dollars between 1998 and 2002. An estimated $22.5 billion, or almost 20 percent of total Medicare savings under the BBA, is attributable to payments to M+C organizations. Much of the savings is attributable to lower payment rates in the original Medicare program. Additionally, removal of GME and IME from the capitated payments to M+C organizations represents a redirection of $4 billion, which would be paid directly to providers. All told, the BBA payment changes are estimated to reduce annual spending increases for both the M+C program and original Medicare from 8.5 percent to about 5 percent a year between 1997 and 2002.

The new payment methodology will lessen the significant geographic variation in payments by reducing the influence of factors that cannot be explained by geographic differences in medical input prices. Under the pre-BBA methodology, capitation amounts were based on actual per capita costs for original Medicare in each enrolled's county of residence. Under the BBA formula, adjustments for input prices is specifically included in the computation of blended rates, but the influence of practice pattern differences is gradually minimized through the payment blending. Over the period 1998–2002, each county's blended payment amount is increasingly based upon a standardized rate that reflects practice patterns across the country. In this way, the new methodology attempts to achieve a more equitable distribution of payments, and will hopefully encourage plans to focus on implementation of quality-based, cost-effective treatment methods.

One of the chief considerations in restructuring the payment methodology was evidence that Medicare managed care organizations have attracted healthier and therefore less expensive enrollees than fee-for-service organizations. In its 1996 Annual Report to Congress the PPRC reported on a study of enrollees in Medicare risk plans between 1989 and 1994. This study showed that those enrolled in managed care plans cost the Medicare program only 63 percent as much as the average Medicare beneficiary during the six months preceding enrollment when both groups were enrolled in traditional Medicare. In contrast, persons who disenrolled and returned to traditional fee-for-service Medicare cost the program 160 percent as much as the average beneficiary in the six months following disenrollment. In its December, 1997 study, the Congressional Budget Office estimated that Medicare paid 6–8 percent more for enrollees in risk-based HMOs than it would have paid for those enrollees under fee-for-service Medicare. Although prior law did set Medicare capitation rates 5 percent below fee-for-service payments under original Medicare, this reduction was not enough to compensate for favorable risk selection. The new methodology mandated by the BBA requires risk adjustment beginning in the year 2000.

Medicare managed care enrollment has grown steadily in recent years. However, most of the growth has been concentrated in urban areas. Between December of 1990 and December of 1997, enrollment in risk contracts grew from 3.3 percent of Medicare beneficiaries to 14.0 percent. Twenty-four percent of beneficiaries residing in large urban areas with a population of 1 million or more were enrolled in a Medicare risk plan in June of 1997. Twelve percent of beneficiaries residing in areas adjacent to large urban areas and smaller metropolitan areas, and less than 3 percent of Medicare beneficiaries residing in rural areas, were enrolled in a Medicare risk plan. Approximately thirty-three percent of Medicare beneficiaries reside in an area that is not served by any Medicare managed care organization.

We assessed the impact of the payment methodology by first considering the overall impact and then considering the impact of changes in payment on specific entities. The potential overall impacts of changes in payment are: reductions in spending; redistribution of payments; increases in enrollment in M+C plans; changes in the distribution of enrollment in M+C plans; and the creation of a more competitive market offering a wider range of choices for Medicare beneficiaries.

We have identified the types of entities and individuals that will be directly affected by changes in payment. They include: beneficiaries, M+C organizations offering coordinated care plans (including current Medicare managed care contractors), and M+C organizations offering private fee-for-service plans or MSA plans, States, providers, and the Medicare Trust Funds.

One clear impact of the revised payment methodology is decreased spending relative to estimates of spending under prior law. In its BBA analysis, CBO estimated that changes in payments to managed care plans save $22.5 billion between 1998–2002. As stated earlier, these savings contribute significantly toward efforts to extend the long-term solvency of the Medicare Part

A Trust Fund. Table 3 provides more recent alternative projections of $30 billion in savings between 1998–2003. (HCFA Office of the Actuary, 3/98.)

TABLE 3.—PROJECTED IMPACT DUE TO CHANGES IN PAYMENT METHODOLOGY

Fiscal year	Savings (in billions of dollars)
1998	0.3
1999	0.7
2000	4.4
2001	6.6
2002	8.1
2003	9.2

*Includes risk adjustment.
Source: HCFA Office of the Actuary, 3/98.

As noted above, projected savings due to the change in the M+C payment methodology are also tied in part to the overall savings in Medicare created by BBA changes in payments to Medicare fee-for-service providers. Specifically, since the National Per Capita M+C growth factor (NGP) is defined as the ''projected per capita rate of growth in Medicare expenditures'' reduced by the BBA's specified percentage reduction, the NGP will include the impact of reductions and/or slower increases to provider payments in the original Medicare program.

Another factor that affects the amount of savings is the minimum payment amount and the minimum percentage increase. Because the payment methodology does not allow for reduction of the floor and minimum payment increases, budget neutrality, which is achieved by reducing or increasing the blended rates, may not be achieved in all years where the computation requires a reduction in the blended rates. This situation occurred in the calculation of the 1998 and 1999 rates, when no county received the blended rate because the budget neutrality adjustment brought all rates to an amount below the amount of the minimum 2 percent increase. See discussion in Section II.F. above.

It is clear that one aspect of the new payment methodology, the floor, actually increases spending compared to prior law. CBO estimates that increasing payments to the floor counties will cost $2.2 billion more than expected under previous law over the 5-year period of 1998–2002. However, increasing payment to floor counties meets important policy objectives in that by reducing payment disparities it is hoped that more choices will become available in under-penetrated areas.

The payment methodology has removed some of the variation in payment rates by increasing payment rates in lower payment counties through use of a minimum payment amount. In the future, blending will further reduce variation by reducing the influence of local fee-for-service costs in the blended rates. Table 4 shows the impact of the payment methodology by location. The floor rate increased payments significantly in rural areas and in some urban counties as well.

TABLE 4.—AVERAGE AND RANGE OF MEDICARE COUNTY PAYMENT RATES, BY LOCATION, 1997–1998

	1997 Average	1998 Average	1997 Range (Low:High)	1998 Range (Low:High)
All Counties	470	484	221:767	367:783
Central Urban	546	557	349:767	367:783
Other Urban	440	452	256:728	367:742
Urban Fringe	394	413	231:693	367:707
Other Rural	371	397	221:647	367:660

Source: MEDPAC, March 1998 Report to Congress: Medicare Payment Policy.

A further change in the methodology is the graduate medical education (GME) carve-out. While the removal of GME does not generate savings for the Medicare trust fund or Medicare GME, it does reduce capitation rates in counties that historically received GME payments (except in counties where the minimum payment amounts apply). In general, GME carve-outs disproportionately affect urban managed care organizations because urban counties house more teaching hospitals. Table 5 shows the 1995 GME percentages in urban and rural counties.

TABLE 5.—ESTIMATED GRADUATE MEDICAL EDUCATION PAYMENT REDUCTIONS AS A PROPORTION OF MEDICARE RISK PAYMENT RATES BY URBAN AND RURAL LOCATION (PERCENTAGE), 1995

Location	GME percentage
All Counties	3.4
Urban Counties	3.8
Central Urban	5.3
Other Urban	3.1
Rural Counties	2.1
Urban Fringe	2.2
Other Rural	1.9

Source: PPRC, 1997 Annual Report to Congress, Chapter 3, p. 62.

We anticipate that these changes to the variations payment will affect the enrollment distribution of M+C enrollees.

The methodology has already increased capitation levels in rural areas now receiving the payment floor, in some counties significantly. HCFA's Office of the Actuary currently predicts that the blended rates will begin in CY 2000, which should increase rates in some rural areas that received the 2 percent increase in 1998 and 1999. In fact, to the extent that blended rates are eventually applied under the budget neutrality rules, the blended rate will gradually elevate payments to counties that have an area-specific payment that is below the national average as adjusted for input prices.

The improved incentives in rural counties should prompt M+C organizations to contract in these areas. Greater participation of managed care plans in rural counties should spur increases in M+C enrollment in the long run. CBO expects an incremental gain of 3 percent market share for coordinated care plans by 2002. This growth occurs, for the most part, in non-urban areas. It

is expected that higher payments in rural areas will encourage M+C organizations to offer plans in these areas. In particular, PSOs were included as an M+C option in part because of the belief that rural providers might organize M+C organizations in their areas which, because of their smaller population bases, generally have not been as attractive to managed care plans for commercial or Medicare business.

Table 6 provides a profile of the distribution of risk contractors and enrollment prior to passage of the BBA.

TABLE 6.—DISTRIBUTION OF MEDICARE RISK ENROLLMENT, AND RISK CONTRACTORS

Location	Percent of beneficiaries in risk plans (6/97)	Percent of counties offering 0 risk plans (6/97)	Percent of counties offering 1 risk plan (6/97)	Percent of counties offering 2–4 risk plans (6/97)	Percent of counties offering more than 5 risk plans (6/97)
Urban (MSA of 1 million or more)	24	0	2	19	79
Other Urban (surrounding counties or smaller MSA)	11.8	27	12	34	27
Fringe Urban (rural areas bordering MSA)	2.6	71	18	11	1
Other rural areas	1.1	91	6	3	0

Source: MEDPAC 1997 Chartbook.

It is expected that as more M+C organizations enter the Medicare market, competitive pressures will increase. As the payment changes are implemented and geographic variation in payment levels is reduced, the profitability of M+C organizations will be driven less by where they deliver services, and more by how well they deliver services. An organization's success will depend on the quality of services offered, the extent and clarity of an organization's communications with beneficiaries, the ability of a plan to effectively manage the provision of care to Medicare beneficiaries, and the satisfaction levels of Medicare enrollees in a plan, as well as the benefits offered and the premiums charged. These competitive forces should provide increased access to high quality services under capitated plans for Medicare beneficiaries.

For beneficiaries in rural areas we believe the overall impact of these changes should make participation in the M+C program a more viable option. Conversely, as payment rates become less robust in urban areas and margins decrease, some coordinated care plans may choose to reduce benefits, or increase premiums. Reductions in benefits or increases in premiums would have a negative impact on beneficiaries.

We should also note here that oftentimes we look at payment as a driving force in the Medicare program as a whole. While the increased payment to rural counties should on its face provide an incentive for organizations to offer their services and products in rural areas, that may not always be the case. That is, some may assume that when Medicare pays coordinated care plans considerably more than the average per capita fee-for-service cost in a geographic area, as it does in many of the payment floor counties, this would cause organizations to rush to enter into contracts in these areas. However, plans may decide that the smaller pool of potential enrollees (and hence the smaller pool over which to spread risk) do not justify either their added financial risk or the proportionally larger start up and marketing costs associated with launching a plan in a rural area.

We believe and Congress intended that these increases for rural counties would stimulate the growth of capitated plans in these areas. However, there still is a large degree of uncertainty over the actual effects of the BBA changes for rural areas. In the end only M+C organizations can really determine if the payment levels justify their costs.

D. Introduction of New Contracting Entities

In general, we believe that new entities will be formed to serve the Medicare market. As discussed above, the new payment methodology and the availability of PSO and MSA plans should stimulate the private sector's development of entities to compete for Medicare beneficiaries. While estimates of the development of new entities are somewhat speculative, the following are our best estimates based on currently available information, enrollment projections, informal surveys and discussions with industry representatives.

Provider Sponsored Organizations: The Congressional Budget Office projects that PSO enrollment will reach a 3 percent share of Medicare beneficiaries, or about 1 million beneficiaries, by 2002 and that a significant portion of the PSO enrollment will be in rural areas (CBO, 1997).

Currently, there are approximately 5.5 million beneficiaries enrolled in 307 Medicare risk products, which is an average of approximately 8,000 enrollees per Medicare risk plan. We believe that CBO's projections, presented in the following table, represent a good estimate of the approximate number of new PSO plans that will be established. Some industry analysts have projected a higher level of certified PSOs than projected by CBO. While we believe it is highly unlikely that as many as 25 PSOs will be certified by the end of 1998, we believe that CBO's projections for 1999 and thereafter are reasonable.

Enrollment estimate	Year	New PSOs
100,000	1998	25
400,000	1999	50
600,000	2000	75
800,000	2001	100
1,000,000	2002	125

Source of enrollment estimate: CBO, 1997.

As a secondary impact, the M+C program could result in expanded availability of PSOs, particularly in rural areas. That is, PSOs that are successful in their Medicare contracts may decide to expand into the commercial market. In turn, if commercial payers learn of their success in serving the Medicare population, they may have more confidence in the ability of PSOs to assume and manage risk and may, therefore, be more interested in contracting with them.

Private Fee-For-Service Plans: The Congressional Budget Office projected that no Medicare beneficiaries will enroll in private fee-for-service plans, and no reliable estimates for the number of likely private fee-for-service market entrants are available. However, we have received some expressions of

interest from insurance carriers and others regarding how these plans will work and whether there is an opportunity to serve Medicare beneficiaries. If offered, we would expect them to be most attractive to wealthier beneficiaries because of their anticipated higher premiums and other out-of-pocket costs. While private fee-for-service plan providers are allowed to engage in limited balance billing, there is no statutory limit on premiums that a plan may charge beneficiaries.

Medical Savings Account Plans: The Congressional Budget Office estimated that 390,000 Medicare beneficiaries will enroll in M+C MSA plans by 2000. This is the statutory limit for the total number of beneficiaries that can enroll in the MSA demonstration. While there are no reliable estimates on the number of organizations that will offer M+C MSAs, we expect that many organizations offering MSA plans in the commercial marketplace will offer MSA plans in the Medicare market as well.

According to a recent General Accounting Office study, 57 carriers, including three HMOs, offered MSA plans in the commercial market as of the summer of 1997. Blue Cross & Blue Shield plans represented almost one-third of the plans offered in the market. At that time, an additional fifteen carriers and eight HMOs indicated an interest in offering MSA plans. However, commercial enrollment in MSA plans has been considerably lower than had been anticipated. While the demonstration project under the Health Insurance Portability and Accountability Act allowed for 750,000 MSAs to be sold, as of June 30, 1997, only 17,145 individuals had enrolled in these new products, according to the Internal Revenue Service.

The GAO found that the complexities surrounding the tax implications of an MSA product, increased time necessary to explain the product to customers, and lower commissions to brokers/agents for selling a high deductible product have contributed to the low number of plans sold. However, some of these complexities may be mitigated under the BBA, as beneficiaries are barred from contributing their own money to the medical savings account, and they will receive extensive information about MSA plans as part of the annual information campaign on their M+C options.

Impact of New Contracting Entities

Beneficiaries may benefit from competitive pressures on M+C organizations to compete on such factors as reduced premiums, extra benefits, and quality. However, the difference between out-of-pocket costs under managed care plans and the traditional fee-for-service program may decrease as M+C payments moderate. Under the Medicare risk program, beneficiaries enrolled in risk HMOs generally have had lower out-of-pocket costs than beneficiaries in the traditional Medicare fee-for-service sector. For example, a recent study by the American Association of Retired Persons projected that beneficiaries enrolled in a Medicare managed care plan will spend an average of 16 percent of their annual income, or $1,775, on out-of-pocket health care costs, in 1997. This is compared to the estimated out-of-pocket expenses for Medicare fee-for-service beneficiaries, which were projected on average to be 21 percent of their annual income, or $2,454, on out-of-pocket costs. (AARP, 1997).

We also anticipate that many providers will have new opportunities to serve Medicare beneficiaries, such as through provider sponsored organizations or through strategic partnerships with other coordinated care plans seeking to enter new markets. As M+C enrollment grows, providers will find it increasingly important to their business to participate in an M+C network as many of their patients will be locked into these networks. In turn, we believe M+C organizations will seek to contract with providers that are capable of serving both their commercial and Medicare populations.

Finally, the M+C program will most affect those states in which the greatest market opportunities for newly created M+C organizations exist. Oversight and licensing responsibilities will likely increase for such states as newly created M+C organizations, such as PSOs, seek to serve the Medicare market. The BBA increases the workload for States only to the extent that new organizations will begin operating in the State. It is likely that States will also have to monitor the compliance of PSOs that have a waiver of State licensure in the case of quality and consumer protection standards. This constitutes an additional workload of partial monitoring of plans that are not subject to State solvency requirements.

Many states will be confronted with issues on licensing of PSOs, whether by bringing such entities under existing HMO laws and regulations or establishing separate PSO licensing provisions. In a recent report, the National Association of Insurance Commissioners reported that ten states have already enacted state-level PSO regulation (NAIC, 1997), and the National Council for State Legislatures reports that thirteen states currently are considering PSO legislation.

States will also have to integrate PSOs into their state guaranty fund or other mechanism for protecting beneficiaries against insolvent plans. While this will not be a new function, it is expected to increase the amount of regulatory oversight necessary due to new market entrants and could place burdens on a state's ability to protect consumers if PSOs become insolvent.

Finally, the preemption of state mandated benefit and provider participation laws will lead to mandated benefits being applied to a smaller number of State residents. However, states may still enforce any laws relating to cost-sharing for a benefit included in an M+C contract as well as any laws restricting balance billing practices by providers. Moreover, we believe that few states will be impacted by the BBA's prohibition on state imposition of premium taxes on payments to Medicare risk contracts/M+C organizations. While almost all states impose premium taxes on insurers generally (and nineteen states have specific premium tax schedules for HMOs), it is our understanding that most states have not subjected Medicare revenue to a premium tax and that many states specifically exempt Medicare payments to HMOs from any premium tax.

E. New Quality Standards

Each M+C organization must have arrangements for an ongoing quality assessment and performance improvement program for health care services it provides to Medicare beneficiaries enrolled in the M+C plans. The quality assurance program for an M+C organization must, among other things: (1) stress health outcomes and provide for the collection, analysis, and reporting of data to permit measurement of outcomes and other indices of the quality of M+C organizations and organizations; (2) include measures of consumer satisfaction; (3) provide the Secretary with such access to information collected as appropriate to monitor and ensure the quality of care; (3) provide review by physicians and other health care professionals of the process followed in the provision of health care services; (4) provide for the establishment of written protocols for utilization review, based on current standards of medical practice; (5) have mechanisms to detect both underutilization and overutilization of services; (6) take action to improve quality and assess the effectiveness of that action through systematic follow-up; and (7) make available information

on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options.

An M+C organization is deemed to have met the quality assessment and performance improvement requirements if the organization is accredited (and periodically reaccredited) at a level acceptable to the Secretary by a national, private accrediting organization approved by the Secretary. Deemed M+C organizations must meet certain requirements, including submitting to surveys to validate its accreditation organization's process and authorizing its accreditation organization to release to HCFA a copy of its most current accreditation survey and any information related to the survey as required by HCFA.

Accrediting organizations will have to meet certain requirements in order to receive approval as well as ongoing requirements to maintain its approved status.

The quality assurance and performance improvement requirements under this regulation provide that each M+C organization achieve minimum performance levels on standardized quality measures. They also require that organizations conduct performance improvement projects that achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and non-clinical services that can be expected to affect health outcomes and member satisfaction. This approach to ensuring quality reflects the expansion in recent years of the problem-focused approach that was prevalent in the past to include a focus on systematic quality improvement as well.

We believe that the quality assessment and performance improvement requirements under this regulation will not impose significantly new burdens on most M+C organizations.

First, as discussed in detail in section III D of this preamble, requirements under this regulation build on a variety of HCFA and State Medicaid agency efforts to promote the assessment and improvement of quality in plans contracting with Medicare and Medicaid, including:

- The Quality Improvement System for Managed Care (QISMC), an initiative with state and federal officials, beneficiary advocates, and the managed care industry to develop a coordinated quality oversight system to reduce duplicative or conflicting efforts and that has an emphasis on demonstrable and measurable improvement.
- Initiatives to improve accountability by requiring uniform collection and reporting of data to allow assessment of plan performance and to facilitate comparisons among plans, such as the Health Plan Employer Data and Information Set (HEDIS 3.0).
- Projects to enhance the role of Medicare Peer Review Organizations (PROs) in evaluating and improving managed care plan quality, including the development and testing of a minimum set of performance evaluation measures and quality improvement projects developed through collaboration between PROs and the managed care industry.

Second, we anticipate that many new M+C organizations will be offered by organizations currently participating as Medicare risk contractors. While we acknowledge that many organizations have not developed the capacity to fully meet the pre-BBA requirements, we believe that this regulation does not create substantially new demands for building new administrative and information systems necessary to meet the quality assessment and performance improvement requirements for M+C products, as such organizations already are subject to similar requirements as section 1857 contractors. Moreover, we will build into the contract process a gradual phase-in of the number of focus areas for which a plan must demonstrate improvement to allow sufficient time for a plan to implement and conduct well-designed improvement projects.

Third, we anticipate that many organizations seeking to offer M+C products will have had to invest in administrative and information systems to meet the requirements of other purchasers and State regulators, diminishing burdens this regulation might otherwise have imposed. This is true even for provider-sponsored organizations that seek a federal waiver from state solvency requirements, as such entities are still subject to other state requirements, including a state's quality assessment and improvement requirements.

We have built on efforts in other sectors in developing these quality assessment and performance improvement requirements in order to minimize the burden that these activities place on plans. (GAO, September 1996; NCQA, 1997), such as:

- Many employers and cooperative group purchasing groups and some States already require that organizations be accredited by the National Committee on Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, the American Healthcare Accreditational Commission, or other independent bodies.
- Many also require that organizations report their performance on HEDIS, FACCT, or other measures and conduct enrolled surveys using the CAHPS or other instruments. For example, NCQA estimates that more than 90 percent of plans are collecting some or all of HEDIS data for their commercial population. (NCQA, 1997)
- States have heightened their regulatory efforts through insurance or licensing requirements, and the National Association of Insurance Commissioners has developed model acts on network adequacy, quality assessment and improvement, and utilization review.

Another important mechanism in avoiding duplication of effort and unnecessary administrative burdens with respect to internal quality assurance requirements is the ''deemed'' status afforded organizations for each standard that is accredited by a national, private accrediting organization.

Fourth, we have worked closely with private-sector leaders in health plan performance and quality measurement to avoid duplication of effort and promote standardization in measurement approaches. (GAO, September 1996) For example, we convened advisory groups of managed care organizations, State and Federal purchasers and regulators, beneficiary advocates, and experts in mental health and substance abuse services and relied heavily on the insight and expertise of these groups in refining standards and guidelines.

Fifth, measuring and reporting plan- and provider-specific information will allow plans and networks to compare themselves to competitors, track their own performance over time, and so drive their own internal quality improvement programs. (Palmer, 1997). Moreover, plans will have added incentives to initiate performance improvement projects that will lead to more cost-effective delivery of health care services, such as influenza immunization outreach efforts which lead to lower complications and treatment of influenza-related conditions or improving access to primary care to reduce inappropriately frequent use of the emergency room by enrollees. This regulation allows plans the freedom to select its own particular topics for measurement and improvement so that each plan can conduct projects relating to aspects of care and services that are significant for its own population.

Although the quality standards under this regulation are not substantially

different from requirements already in place, we recognize that some M+C organizations may need to invest in administrative and/or information systems necessary to comply with the existing as well as the M+C standards. Additionally, while some plans may be tempted to invest their resources into the areas in which they must measure and demonstrate improved performance at the expense of other parallel quality initiatives, we have designed the quality assessment and performance improvement requirements under this regulation to be as flexible as possible and encourage plans to work with HCFA in developing long-range goals for projects.

Our role in overseeing compliance with the quality standards interrelates with our efforts to sponsor an annual information campaign that coincides with the open enrollment period for M+C organizations and is an important augmentation to those efforts. These efforts are designed to ensure that all organizations in the M+C program have the organizational structure and operational capacity to provide quality health care to Medicare beneficiaries and to ensure that beneficiaries have accurate information on quality to guide their health plan selections.

F. Conclusion

We expect that this rule overall will have a positive impact on the Medicare program, Medicare beneficiaries, providers, rural providers and suppliers, and entities that have not previously contracted with us. However, some current managed care contractors will experience a decrease in the capitated payments they otherwise would have received without passage of the BBA, possibly resulting in reduced benefits for Medicare enrollees. States will also have to develop mechanisms to license new risk bearing entities known as provider sponsored organizations after 3-year waivers.

VI. Collection of Information Requirements

Emergency Clearance: Public Information Collection Requirements Submitted to the Office of Management and Budget (OMB)

In compliance with the requirement of section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995, the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), has submitted to the Office of Management and Budget (OMB) the following request for emergency review. We are requesting an emergency review because the collection of this information is needed prior to the expiration of the normal time limits under OMB's regulations at 5 CFR, Part 1320. The Agency cannot reasonably comply with the normal clearance procedures because of the statutory requirement, as set forth in section 1856 of Balanced Budget Act of 1997, to implement these requirements on June 1, 1998.

HCFA is requesting OMB review and approval of this collection within 11 working days, with a 180-day approval period. Written comments and recommendations will be accepted from the public if received by the individual designated below, within 10 working days of publication of this document in the **Federal Register**.

During this 180-day period HCFA will pursue OMB clearance of this collection as stipulated by 5 CFR 1320.5.

In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

Therefore, we are soliciting public comment on each of these issues for the information collection requirements summarized and discussed below.

Application Requirements (§ 422.6)

In order to obtain a determination on whether it meets the requirements to become an M+C organization and is qualified to provide a particular type of M+C plan, an entity, or an individual authorized to act for the entity (the applicant) must complete an application, in the form and manner required by HCFA, including all of the requirements set forth in § 422.6.

In order to contract with us under the M+C program, organizations are required to complete an application to demonstrate their capability of carrying out the requirements of the Medicare program. Completing an application requires the capability of organizations to adhere to Medicare program guidelines and demonstrate to HCFA by in-house documentation that such capability exists. In prior years, applicants were required to complete applications forms (HCFA 901–903) to obtain a Medicare contract under section 1876 of the program. The application having OMB clearance #0938–0470 estimated that approximately 100 hours would be required to complete an application. We believe the new applications are quite similar and therefore estimate that 100 hours will be required to complete an application under the Medicare + Choice program. We project approximately 100 applications a year requiring 10,000 hours of time by all applicants on an annual basis.

Eligibility To Elect an M+C Plan (§ 422.50)

A beneficiary must complete and sign an election form and gives information required for enrollment.

The burden associated with this requirement is the time it takes for a beneficiary to complete an enrollment form. The enrollment form varies for each organization, but similar identifying information is collected. It is estimated that it will take 2,000,000 beneficiaries (based on 2,012,025 enrollments in calendar year 1997) 10 minutes for an annual burden of 20,000,000 minutes = 333,000 hours.

Continuation of Enrollment (§ 422.54)

An M+C organization that wishes to offer a continuation of enrollment option must submit their marketing materials to HCFA for approval, which meet the requirements set forth in this section, that describe the option and the M+C organization's assurances of access to services as set forth in this section and, an M+C organization that offers a continuation of enrollment option must convey all enrollee rights conferred under this rule.

The burden associated with this requirement is captured below in § 422.64.

Election Process (§ 422.60)

The election form must be completed and signed by the M+C eligible individual beneficiary (or the individual who will soon become entitled to Medicare benefits) and include authorization for disclosure and exchange of necessary information between HCFA and the M+C organization.

The burden associated with this requirement is captured above in the § 422.50 discussion.

The M+C organization must file and retain M+C plan election forms for the period specified in HCFA instructions, and submit beneficiary M+C plan and optional supplemental benefit elections to HCFA.

The burden associated with this requirement is the time required for each organization to perform record

keeping on each application filed. It is estimated that it will take each organization 5 minutes for each of 2,000,000 beneficiaries (based on 2,012,025 enrollments in calendar year 1997). The total annual burden is estimated at 10,000,000 minutes = 167,000 hours. On average, M+C organizational level burden is 167,000/450 (100 new/350 current) = 371 annual hours. In addition, it is estimated to take each M+C organization 4 hours per month to electronically submit a subset of beneficiary M+C plan and optional supplemental benefit election information to HCFA, for a total annual burden of 21,600 hours.

The M+C organization must give the beneficiary prompt written notice of acceptance or denial in a format specified by HCFA that meets the requirements set forth in this section.

The burden associated with each organization providing the beneficiary prompt written notice, performed by an automated system, is estimated at 1 minute per application processed. The annual total burden is estimated at 2,000,000 minutes = 33,000 hours. On average, M+C organizational level burden is 33,000/450 (100 new/350 current) = 73 annual hours.

Within 30 days from receipt of the election form (or from the date a vacancy occurs for an individual who was accepted for future enrollment), the M+C organization must transmit the information necessary for HCFA to add the beneficiary to its records as an enrollee of the M+C organization.

The burden associated with electronic submission of information to HCFA is estimated at 1 second per application processed, for an annual burden of 2,000,000 minutes = 33,000 hours. On average, M+C organizational level burden is 33,000/450 (100 new/350 current) = 73 annual hours.

Election of Coverage Under an M+C Plan (§ 422.62)

Except as provided in paragraph (d)(2)(ii) of § 422.62, an individual may disenroll from an M+C MSA plan only during an annual election period or the special election period described in paragraph (b) of this section. However, an individual who elects an M+C MSA plan during an annual election period and had never before elected an M+C MSA plan may revoke that election, no later than December 15 of that same year, by submitting to the organization that offers the M+C plan a signed and dated request in the form and manner prescribed by HCFA or by filing the appropriate disenrollment form through other mechanisms as determined by HCFA.

The burden associated with this requirement is the time required for each beneficiary to complete a disenrollment form. It is estimated that about 5 percent of the maximum number of beneficiaries permitted to choose an MSA (390,000) would disenroll (19,500) and each disenrollment form would take 4 minutes to complete, for an annual burden of 78,000 minutes = 1,300 hours.

Information About the M+C Program (§ 422.64)

Each M+C organization must provide, on an annual basis and in a format and using standard terminology that may be specified by HCFA, the information necessary that meets the general and content requirements set forth in § 422.6, to enable HCFA to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

The burden associated with this requirement is the time required for the organization to provide the information to HCFA. It is estimated that it will take 450 (100 new/350 current) organizations 12 hours for an annual burden of 5,400 hours. In addition, it is estimated that on an annual basis it will take 4 hours for an estimated 50 organizations to modify and submit their revised materials to HCFA for review for a annual burden of 200 hours.

Coordination of Enrollment and Disenrollment Through M+C Organizations (§ 422.66)

An individual who wishes to elect an M+C plan offered by an M+C organization may make or change his or her election during the election periods specified in § 422.62 by filing the appropriate election form with the organization or through other mechanisms as determined by HCFA.

An individual who wishes to disenroll from an M+C plan may do so by (1) electing a different M+C plan by filing the appropriate election form with the M+C organization or through other mechanisms as determined by HCFA, (2) submitting a signed and dated request for disenrollment to the M+C organization in the form and manner prescribed by HCFA or, (3) filing the appropriate disenrollment form through other mechanisms as determined by HCFA.

The burden associated with electing a different plan is included in 422.50. The burden associated with disenrolling is the time to complete a disenrollment form. It is estimated that 720,000 disenrollments (based on the number of disenrollments in calendar 1997) will take 2 minutes each for an annual burden of 1,440,000 minutes = 2,400 hours. On average, M+C organizational level burden is 2,400/450 (100 new/350 current) = 5 annual hours.

The M+C organization must submit each disenrollment notice to HCFA promptly.

The burden associated with electronic submission of information to HCFA is estimated at 1 second per disenrollment processed, for an annual burden of 1,200 minutes = 20 hours.

On average, M+C organizational level burden is 1,200/450 (100 new/350 current) = 3 annual hours.

In the case of a plan where lock-in applies, the M+C organization must provide the enrollee with a statement explaining that he or she remains enrolled until the effective date of disenrollments, and until that date, neither the M+C organization nor HCFA pays for services not provided or arranged for by the M+C plan in which the enrollee is enrolled.

The burden associated with each organization providing the beneficiary prompt written notice of disenrollment and lock-in, produced by an automated system, is estimated at 1 minute per disenrollment processed, for an annual burden of 720,000 minutes = 1,200 hours. On average, M+C organizational level burden is 1,200/450 (100 new/350 current) = 3 annual hours.

The M+C organization must file and retain disenrollment requests for the period specified in HCFA instructions.

The burden associated for each disenrollment request is the time required for each organization to perform recordkeeping on each disenrollment request filed. It is estimated that it will take 5 minutes for 720,000 disenrollments processed for an annual burden of 3,600,0000 minutes = 60,000 hours. On average, M+C organizational level burden is 6,000/450 (100 new/350 current) = 13 annual hours.

Disenrollment by the M+C Organization (§ 422.74)

If the disenrollment is for any of the reasons specified in paragraphs (b)(1) through (b)(2)(i) and (b)(3) of § 422.74, that is, other than death or loss of entitlement to Part A or Part B, the M+C organization must give the individual a written notice of the disenrollment with an explanation of why the M+C organization is planning to disenroll the individual. The notice must be mailed to the individual before submission of the disenrollment notice to HCFA and include an explanation of the individual's right to a hearing under the

M+C organization's grievance procedures.

There is a burden associated with the requirement for the organization to notify the beneficiary about an involuntary disenrollment, and to separately notify the beneficiary of the effective date of the disenrollment. It is estimated that less than 100 such notices will be issued and that each notice will take 1 minute for an annual burden of less than 100 minutes = or less than 1.5 hours.

A M+C organization may disenroll an individual from the M+C plan for failure to pay any basic and supplementary premiums if the M+C organization sends a written notice of nonpayment to the enrollee within 20 days of the date that the delinquent charges were due stating that nonpayment of premiums will not automatically result in disenrollment and information about the lock-in requirements of the M+C plan.

There is a burden associated with the requirement for the organization to notify the beneficiary and it is estimated that less than 500 of these requests occur annually at 1 minute per notification, resulting in an estimated burden of 500 minutes, or approximately 80 hours.

A M+C organization may disenroll an individual from the M+C plan if the individual's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continued enrollment in the plan seriously impairs the M+C plan's ability to furnish services to either the particular individual or other individuals enrolled in the plan. The M+C organization must document the enrollee's behavior, its own efforts to resolve any problems, and any extenuating circumstances, as described in paragraphs (d)(2)(i) through (d)(2)(iii) of this section. And, a M+C organization must submit documentation related to the proposed disenrollment and any information submitted by the beneficiary, to HCFA for review to determine whether the M+C organization has met the disenrollment requirements.

The burden associated with this requirement is the time for the organization to document the behavior of the beneficiary and document the efforts of the organization to resolve any problems and provide information to HCFA concerning the involuntary disenrollment request. The burden reflects documentation and transmission of documentation to HCFA by the managed care plans. It is estimated that less than 100 such requests occur annually (based on estimate of regional office collection of such information), and it is estimated that each request will take 1 hour to manually collect the data and 15 minutes to transmit the data to HCFA, for a burden of 125 hours.

A M+C organization must report to the Office of the Inspector General of the DHHS any disenrollment based on fraud or abuse by the individual.

There is a burden associated with the requirement for the organization to report to the Office of the Inspector General any disenrollment based on fraud or abuse by the individual. It is estimated that only 1% of all involuntary disenrollments, or 10 involve fraud or abuse, and the reporting burden would be 1 minute each, for a total burden of less than 1 hour.

If a M+C organization terminates or is terminated or the service area or continuation area are reduced with respect to all M+C enrollees in the area in which they reside, the M+C organization must give each Medicare enrollee a written notice of the effective date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the M+C program. The notice must be sent before the effective date of the plan termination or area reduction.

The burden associated with this requirement is captured below in § 422.506.

Approval of Marketing Materials and Election Forms (§ 422.80)

At least 45 days before the date of distribution the M+C organization must submit any marketing material or election form to HCFA for review. The materials must be in a format and using standard terminology specified by HCFA, that meet the requirements specified in this section.

The burden associated with this requirement is captured above in § 422.64.

A M+C organization must notify the general public of its enrollment period (whether time-limited or continuous) in an appropriate manner, through appropriate media, throughout its enrollment area.

We anticipate notification to the general public would be through a general circulation newspaper and would require 8 hours of burden per organization to modify their enrollment period bulletin and seek publication in a local newspaper, for an annual burden of 3,600 hours.

Special Rules for Point of Service Option (§ 422.105)

M+C organizations must maintain written rules on how to obtain health benefits through the POS benefit. While the maintenance of written rules is a recordkeeping requirement subject to the PRA, the burden associated with this requirement is exempt from the PRA, as defined in 5 CFR 1320.3(b)(2) and (b)(3).

The M+C organization must provide to beneficiaries enrolling in a plan with a POS benefit an ''evidence of coverage'' document, or otherwise provide written documentation, that specifies all costs and possible financial risks to the enrollee, including the requirements set forth in (d)(2)(i) through (d)(2)(iv) of this section.

The burden associated with this requirement is captured above in § 422.64.

An M+C organization that offers a POS benefit must report data on the POS benefit in the form and manner prescribed by HCFA.

The special rules for M+C organizations offering a POS benefit as stipulated in § 422.105 requires that M+C organizations provide to HCFA POS data relating to the utilization of the POS benefit by plan members. This is not a new data requirement since M+C organizations that offer a POS benefit would need to have this data in the normal course of business in order to pay POS claims. We estimate that providing this data to HCFA would require 1 hour per quarterly submission. Thus, the annual burden would be 1 hour $\times$ 4 = 4 hours per MCO in providing the required POS data.

Disclosure Requirements (§ 422.111)

An M+C organization must disclose the information specified in § 422.64 and in paragraph (b) of § 422.111 to each enrollee eligible for or electing an M+C plan it offers. The information must be in clear, accurate, and standardized form, and provided at the time of enrollment and at least annually thereafter. The burden associated with this requirement is captured above in § 422.64.

If an M+C organization intends to change its rules for an M+C plan, it must submit the changes for HCFA review under the procedures of § 422.80. The burden associated with this requirement is reflected in § 422.80 above.

The plan must also give notice to all enrollees 30 days before the intended effective date of the changes. The burden associated with this requirement is reflected above in § 422.80.

The M+C organization must make a good faith effort to provide written notice of a termination of a contracted provider within 15 working days of receipt or issuance of a notice of termination, as described in

§ 422.204(c)(4), to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must also be notified.

HCFA has no basis to calculate the burden impact imposed by these requirements. Therefore, we explicitly seek comment on the impact of this notification requirement.

Access to Services (§ 422.112)

In the case of involuntary termination of an M+C plan or specialist(s) for a reason other than for cause, the M+C organization must inform beneficiaries of their right to maintain access to specialists and provide the names of other M+C plans in the area that contract with specialists of the beneficiary's choice, as well as an explanation of the process the beneficiary would need to follow should he or she decide to return to original Medicare.

The requirements imposed by this section would be pursuant to an administrative action and therefore are exempt from the PRA as defined in 5 CFR 1320.4.

An M+C plan seeking a service area expansion must demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served. The burden associated with meeting this requirement is captured above in 422.6.

An M+C plan must demonstrate to HCFA that its providers are credentialed through the process set forth at § 422.204(a). The burden associated with meeting this requirement is captured above in 422.6.

Plans must have procedures approved by HCFA for (1) identification of individuals with complex or serious medical conditions; (2) assessment of those conditions, including medical procedures to diagnose and/or monitor them on an ongoing basis; and (3) establishment of a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. Treatment plans must be time-specific and updated periodically by the PCP.

Plans must also; (1) establish written standards for the timeliness of access to care and member services that meet or exceed standards established by HCFA, (2) continuously monitor and document the timely access to care and member services within a plan's provider network to ensure compliance with these standards, and take corrective action as necessary, (3) establish written policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations, and (4) ensure that providers consider and document beneficiary input into the provider's proposed treatment plan.

Plans must maintain written procedures to ensure that; (1) the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that, each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; appropriate and confidential exchange of information among provider network components, (2) written procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and (4) documentation demonstrating that systems to address barriers to enrollee compliance with prescribed treatments or regimens.

HCFA's believes these requirements are reasonable and customary business practices and the burden associated with these requirements is exempt from the PRA as defined in 5 CFR 1320.3(b)(2). Therefore, we are assigning one token hour of burden for these requirements. HCFA invites comment on the burden estimate associated with these requirements.

Confidentiality and Accuracy of Enrollee Records (§ 422.118)

For any medical records or other health and enrollment information it maintains with respect to enrollees, an M+C organization must establish and maintain procedures set forth in (a) through (c) of this section.

While the maintenance of health records is a recordkeeping requirement subject to the PRA, we believe the burden associated with this requirement is exempt from the PRA, as defined in 5 CFR 1320.3(b)(2) and (b)(3), and assigning 1 token hour of burden for this requirement. We solicit comment on the burden associated with this requirement.

Information on Advance Directives (§ 422.128)

Each M+C organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in 43 CFR part 489 subpart I.

An M+C organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the M+C organization.

An M+C organization must provide written information to those individuals with respect to the requirement set forth in this section.

These requirements are identical to the requirements currently approved under OMB# 0938–0610, with an expiration date of July, 31, 1999. Since the currently approved requirements encompass a larger universe of provider types then just managed care organizations it is difficult to estimate the burden on the M+C organizational level. However, the per beneficiary encounter burden is estimated to be 3 minutes. In the near future, HCFA will revise this collection to capture this new provider type and resubmit the collection to OMB for approval.

Protection Against Liability and Loss of Benefits (§ 422.132)

Each M+C organization must adopt and maintain arrangements satisfactory to HCFA to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the M+C organization. The burden associated with demonstrating this requirement is captured below under § 422.306.

Each M+C organization must have an insolvency protection plan that provides for continuation of benefits. Each plan must submit a insolvency plan to HCFA for approval. The reporting requirements are similar to the insolvency plan reporting requirements submitted by 1876 plans. The burden associated with completing and submitting an insolvency plan is estimated to be 40 hours per plan on an annual basis. Therefore, the total annual burden associated with this requirement is 18,000 hours (40 hours x 450 plans (100 new/350 current)). In the near future, HCFA will revise this collection to capture this new provider type and resubmit the collection to OMB for approval.

Quality Assessment and Performance Improvement Program (§ 422.152)

The organization offering the plan must measure performance under the

plan, using standard measures required by HCFA, and report its performance to HCFA.

All Medicare+Choice organizations and an organization offering an M+C non-network MSA plan or an M+C private fee-for-service plan will be required to measure performance under their plans, using standard measures required by HCFA, and report their performance to HCFA. Reporting will be required annually. The standard measures that will be required will most likely be those already captured in HEDIS and CAHPS, approved under OMB # 0938–0701. The currently approved annual per plan burden is estimated to be 400.53 hours. Therefore, the total burden associated with this requirement is 180,239 hours (400.53 hours × 450 plans (100 new/350 current)). In the near future HCFA will resubmit this collection to OMB for approval for use by M+C organizations.

The organization must report the status and results of each performance improvement project to HCFA as requested.

All Medicare+Choice organizations offering coordinated care plans will be required to undertake performance improvement projects relative to those plans. Each organization must report the status and results of each project to HCFA as requested. We expect that, in any given year, each organization will complete two projects, and will have two others underway, relative to each plan. We expect that we will request the status and results of each organization's projects annually. We estimate that it will take an organization 5 hours to prepare its report for each project. Therefore, we estimate that the total annual hours involved per plan to be 20 and an overall annual burden for all plans of 9,000 hours.

For all types of plans that it offers, an organization must: (1) Maintain a health information system that collects, analyzes, and integrates the data necessary to implement its quality assessment and performance improvement program, (2) Ensure that the information it receives from providers of services is reliable and complete, and (3) Make all collected information available to HCFA.

All M+C organizations must maintain a health information system, and must make all collected information available to HCFA. The requirement guarantees our access to organization information: it does not impose an obligation for routine organization submission of information. At this time, we do not anticipate requesting information other than that relating to the standard measures and performance improvement projects discussed above.

External Review (§ 422.154)

Except as provided in paragraph (c) of § 422.154, each M+C organization must, for each M+C plan it operates, have an agreement that meets the provisions of this section, with an independent quality review and improvement organization (review organization) approved by HCFA to perform functions of the type described in 42 CFR part 466 of this chapter.

Most M+C organizations must have an agreement with a review organization approved by HCFA to perform functions of the type described in 42 CFR part 466. A similar requirement already exists for Medicare contracting HMOs, at § 466.72. The burden estimate prepared for OMB submission #0938–0445 would also apply to the new requirement. The currently approved burden associated with this requirement on the organizational level is 10 hours every three years.

In the near future HCFA will resubmit this collection to OMB for approval for use by M+C organizations.

Compliance Deemed on the Basis of Accreditation (§ 422.156)

An M+C organization deemed to meet Medicare requirements must: (1) Submit to surveys by HCFA to validate its accreditation organization's accreditation process, and (2) authorize its accreditation organization to release to HCFA a copy of its most recent accreditation survey, together with any survey-related information that HCFA may require (including corrective action plans and summaries of unmet HCFA requirements).

The burden associated with this requirement is captured below in § 422.158.

Accreditation Organizations (§ 422.157)

An accreditation organization approved by HCFA must undertake the following activities on an ongoing basis: (1) Provide to HCFA in written form and on a monthly basis all of the information required in paragraphs (c)(1)(i) through (c)(1)(v) of § 422.157, (2) Within 30 days of a change in HCFA requirements, submit to HCFA all of the information required in paragraphs (c)(2)(i) through (c)(2)(iii) of § 422.157, (4) Within 3 days of identifying, in an accredited M+C organization, a deficiency that poses immediate jeopardy to the organization's enrollees or to the general public, give HCFA written notice of the deficiency, and (5) Within 10 days of HCFA's notice of withdrawal of approval, give written notice of the withdrawal to all accredited M+C organizations. The burden associated with this requirement is captured below in § 422.158.

Procedures for Approval of Accreditation as a Basis for Deeming Compliance (§ 422.158)

A private, national accreditation organization applying for approval must furnish to HCFA all of the information and materials referenced in this section. However, when reapplying for approval, the organization need furnish only the particular information and materials requested by HCFA.

The BBA allows HCFA to deem that a M+C organization meets certain Medicare requirements if that organization is accredited by an accreditation organization approved by HCFA. We expect that four national accreditation organizations will eventually be approved. The application and oversight procedures that we have developed for deeming in the managed care arena mirror those already in place in the fee-for-service arena as currently approved under OMB # 0938–0690. Therefore, much of the burden estimate prepared for the fee-for-service deeming regulations in 42 CFR part 488, Subpart A, would also apply here. The initial application burden associated with obtaining deeming authority is 96 hours every six years. Since we anticipate that four organizations will apply, the total burden is 386 hours over a six year period. The ongoing burden of supplying HCFA with data on the status of its deemed facilities is estimated to be 48 annual hours per deeming organization for a total annual burden of 192 hours. In the near future HCFA will resubmit this collection to OMB for approval of deeming in the managed care arena use.

Participation Procedures (§ 422.202)

An M+C organization that operates a coordinated care plan or network MSA must provide for the participation of individual health care professionals and of the management and members of groups through reasonable written procedures that include the following; (1) written notice of rules of participation such as terms for payment, utilization review, quality improvement programs, credentialing, data reporting, confidentiality, guidelines or criteria for the furnishing of particular services, and other rules related to administrative policy, (2) written notice of material changes in participation rules before the changes are put into effect, (3) written notice of participation decisions that are adverse to health care professionals, (4) a process for appealing adverse

decisions, including the right of physicians and other health care professionals to present information and their views on the decision.

The M+C organization must maintain documentation demonstrating that: (1) practice guidelines and utilization management guidelines meet the requirements of (1)(i) through (iv) of this section, (2) the guidelines have been communicated to providers and, as appropriate, to enrollees, (3) decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines, and (4) an M+C organization that operates an M+C plan through subcontracted physician groups or other subcontracted networks of health care professionals provided that the participation procedures in this section apply equally to physicians and other health care professionals within those subcontracted groups.

The burden associated with these requirements is the time required to maintain documentation demonstrating that the requirements have been met and, as necessary, the time necessary to communicate the guidelines to providers and enrollees. HCFA believes that these requirements are reasonable and customary business practices and the burden of meeting these requirements is exempt from the PRA as stipulated under 5 CFR 1320.3(b)(2). Therefore, we are assigning one token hour of burden to these requirements. We explicitly solicit comments on the burden associated with meeting these requirements.

Participation Contracts: Requirements and Prohibitions (§ 422.204)

An M+C organization that operates a coordinated care plan or network MSA plan that provides benefits through contracting health care professionals must provide notice to contracting professionals when the organization denies, suspends, or terminates their agreement with the professional and include (1) the reason for the action, (2) the standards and the profiling data the organization used to evaluate the professionals, (3) the numbers and mix of health care professionals needed for the organization to provide adequate access to services, and (4) the professional's right to appeal the action and the timing for requesting a hearing. This is a new requirement.

The burden associated with this requirement is the time required for organization to prepare a written notification of the denial, suspension, or termination of their agreement with the organization. In discussions with HCFA plan managers, it was predicted that .5 percent of all organizations (approximately 2 organizations) would find it necessary to take such action for about 1 percent of their contracted professionals within a single year and if the organization was already established and doing business. The range of number of contracted professionals extends from 3 contracted professionals to 67,000. Excluding outliers on both ends of the range, we estimate that an organization contracts with an average of 3,000 health care professionals. Using an estimate of 10 minutes per instance to generate and furnish a notice of such action, the total burden on known contractors (350) would be 2 organizations * 30 * 10 minutes = 600 minutes or 10 hours annually.

In addition, HCFA expects to receive approximately 100 additional applications for contracts with new entities to be processed in 1998 for 1999. For organizations creating new networks, they would probably all have at least one instance of denial the first year affecting approximately 1 percent of the number of contracting professionals. Using an estimate of 10 minutes per instance to generate and furnish a notice of such action, the total burden on new contractors would be 100 organizations * 30 * 10 minutes = 30,000 minutes or 500 hours. The total burden with current applications and expected applications for contracts would be 510 hours annually.

The number of new organizations is expected to increase by 100, on an annual basis creating an expected burden for current contracts [350(*.005(organization-rounded to the nearest whole number) *30*10)/60 =]10 hours + new contracts [100*30*10 /60 =]500 hours = 510 hours.

An M+C organization is required to notify any licensing or disciplinary bodies or other appropriate authorities when it suspends or terminates a contract with a health care professional because of deficiencies in the quality of care provided by the professional.

The burden associated with this requirement is the time required for the organization to prepare a written notification to the appropriate authorities. No exact data is available to estimate how often this situation might occur. HCFA estimates that this situation might occur in 3 percent of the M+C organizations once during an annual period. The amount of time estimated to prepare the written notification is 10 minutes. The annual burden associated with this requirement is estimated to be [450 * .03 * 1 *10/ 60] = 2.25 hours.

Interference With Health Care Professionals' Advice to Enrollees Prohibited (§ 422.206)

Section 422.206 prohibits the M+C organization from restricting the provision of treatment advice by health care professionals to enrollees. However, the prohibition against interference is not construed as requiring counseling by a professional or a referral to a service by that professional, if there is an objection based on moral and religious grounds. Section 422.206 implements a new disclosure requirement and requires M+C organizations to notify HCFA during the application process, and later to all current and prospective enrollees, through appropriate written means, if the organization has such a conscience protection policy regarding counseling in effect or if the policy is changed subsequent to the application. The expected number of M+C organizations exercising this option is not expected to exceed 10 in any given year. The amount of burden imposed in the application process, which is captured in the application burden and in the preparation of the contents of the subscriber agreement or member handbook or a subsequent written notice to enrollees is reflected above in § 422.6 and § 422.64.

Physician Incentive Plans: Requirements and Limitations (§ 422.208)

An M+C organization must conduct periodic surveys of current and former enrollees where substantial financial risk exists.

The burden associated with this requirement is captured below in § 422.210.

Disclosure of Physician Incentive Plans (§ 422.210)

Each M+C organization must provide to HCFA descriptive information about its physician incentive plan in sufficient detail to enable HCFA to determine whether that plan complies with the requirements of § 422.208. Reporting should be on the HCFA PIP Disclosure Form (OMB No. 0938–0700). An M+C organization must disclose annually to HCFA the physician incentive arrangements that are effective at the start of each year.

Sections 422.208 and 422.210 require disclosure of physician incentive plan information to HCFA or to States and to Medicare beneficiaries and the enrollee surveys required when plans put providers at substantial risk. This collection of information, Incentive Arrangement Form HCFA–R–201 and supporting regulations, used to monitor

physician incentive plans on an annual basis, is approved under OMB # 0938–0700. In the near future HCFA will resubmit this collection to OMB for approval for use by M+C organizations.

Special Rules for M+C Private Fee-for-Service Plans (§ 422.216)

The M+C organization must make information on its payment rates available to providers that furnish services that may be covered under the M+C private fee-for-service plan.

We expect the M+CPFFS plan to provide written information to contracting providers and to make the information available via a website or toll free number to noncontracting providers who inquire. 50 M+CPFFS plans (estimate of M+CPFFS plans in out years; in first year we may have none) will be required to provide 20,000 annual responses (about 1 million providers nationwide divided by 50 M+CPFFS plans) at an estimated 5 minutes per disclosure (average of phone calls, website time, mailing time for hard copies to contracting providers) for a total annual burden of 1,667 hours per provider and an overall annual burden of 83,350 hours.

An M+C organization that offers an M+C fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section. Specifically, an M+C organization that offers an M+C private fee-for-service plan must monitor the amount collected by non-contract providers to ensure that those amounts do not exceed the amounts permitted to be collected under paragraph (b)(2) of this section. The M+C organization must develop and document violations specified in instructions and must forward documented cases to HCFA.

M+C private fee-for-service plans must investigate and send to HCFA documentation of excessive charges by providers. It is estimated that 50 M+C private fee-for-service plans will have 10 cases per year, at 20 hours per case (to contact the enrollee who complained, acquire and review documents, contact the provider, prepare report to HCFA). Therefore, the total burden associated with this requirement is 10 cases × 20 hours = 200 annual hours per plan, for a total annual burden of 10,000 hours.

An M+C organization that offers an M+C private fee-for-service plan must provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explanation of benefits. The explanation must include a clear statement of the enrollee's liability for deductibles, coinsurance, copayment, and balance billing.

This requirement is akin to the Medicare EOMB or summary statement and must be furnished on a regular basis for every claim paid or denied by the M+C private fee-for-service plan. It is estimated that 3 million notices will be disseminated by M+C private fee-for-service plans. This estimate is determined by; multiply 5000 enrollees per plan by 12 (one notice per month) or 60,000, multiplied by an estimated 50 plans for a total of 3 million notices. At an estimated 3 minutes of burden per notice, the total burden is 9 million minutes or 150,000 burden hours. On a plan level the average annual burden is estimated to be 3,000 hours.

In its terms and conditions of payment to hospitals, organization the hospital is required, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to not less than $500: (1) Notice that balance billing is permitted for those services; (2) a good faith estimate of the likely amount of balance billing, based on the enrollees presenting condition; and (3) the amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

It is estimated that 20,000 of 25,000 estimated hospitalizations will require these notices. The $500 tolerance will be exceeded each time the plan payment rate for the inpatient stay would exceed $3333.33—which is probably almost all of them—if the plan lets the hospital balance bill. At 5 minutes of burden per notice times 20,000 annual notices, the total burden is 100,000 minutes or 1,667 hours of burden.

Encounter Data (§ 422.257)

Each M+C organization must submit to HCFA (in accordance with HCFA instructions) all data necessary and as stipulated under this section to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

The Act requires that the collection of inpatient hospital data for discharges beginning on or after July 1, 1997 and allows the collection of other data no earlier than July 1, 1998. The statutory language is clearly tied to the creation of risk-adjusted payment rates, as defined at § 422.256 (c) and (d) of this rule. Requirements concerning collection of encounter data apply to M+C organizations with respect to all their M+C plans, including medical savings accounts (MSAs) and private fee-for-service plans.

M+C organizations must submit data as follows: (1) Beginning on a date determined by HCFA, inpatient hospital care data for all discharges that occur on or after July 1, 1997.

These requirements are approved under OMB # 0938–0711, with an expiration date of July 31, 1998. The burden associated with submitting data for inpatient hospital care data for all discharges that occur on or after July 1, 1997, is currently .5 minutes per EMC bill and 1 minute per hard copy bill. Although there are currently three options for submitting bills, on average the total annual burden per plan is 46.5 hours, with an overall burden of annual 32,833 hours.

HCFA will provide advance notice to M+C organizations to collect and submit: (1) Physician, outpatient hospital, SNF, and HHA data beginning no earlier than October 1, 1999; and (2) all other data HCFA deems necessary beginning no earlier than October 1, 2000. We estimate the following burden for each category based on a projection of 15 seconds per claim: Physician: 72 million claims = 300,000 hours Outpatient hospital: 12 million claims = 50,000 hours HHA, Hospice, SNF: 2.4 million claims = 10,000 hours All other: 24 million claims = 100,000 hours

We will implement this provision by providing for direct transmission from the provider to HCFA with common PC-based technology. It should be noted that prior to implementing the requirement for M+C organizations to collect and submit physician, outpatient hospital, SNF, and HHA data HCFA will amend OMB # 0938–0711 and seek OMB PRA approval. As part of the PRA process the public will be given several opportunities to comment, via **Federal Register** notification, on the proposed collection prior to OMB approval and implementation.

M+C organizations and their providers and practitioners will be required to submit medical records for the validation of encounter data, as prescribed by HCFA.

Currently HCFA plans on implementing this requirement pursuant to an administrative action or audit, based on data submitted to HCFA or one of its agents. Therefore, these requirements are currently not subject to the PRA as defined in 5 CFR 1320.4.

However, if HCFA were to implement these requirements on a prospective basis, as part of a program oversight activity, we will amend OMB # 0938–0711 and seek OMB PRA approval. As part of the PRA process the public will be given several opportunities to comment, via **Federal Register** notification, on the proposed collection prior to OMB approval and implementation.

Special Rules for Beneficiaries Enrolled in M+C MSA Plans (§ 422.262)

An entity that acts as a trustee for an M+C MSA must: (1) Register with HCFA, (2) certify that it is a licensed bank, insurance company, or securities broker, or other entity qualified, under sections 408(a)(2) or 408(h) of the IRS Code, to act as a trustee, (3) agree to comply with the M+C MSA provisions of section 138 of the IRS Code of 1986; and (4) Provide any other information that HCFA may require.

An M+C organization offering an M+C MSA plan will have to register with HCFA for each beneficiary enrolled. This will require a short form that would take no more than five minutes to fill out. The Act limits the number of MSA enrollees to 390,000; therefore, with maximum participation, registration with HCFA would take 32,500 hours. (i.e., 390,000 registration forms at 5 minutes each.)

Items 2 and 3, above, are IRS requirements and entail no reporting requirements for HCFA. Under item 4, above, we anticipate no further M+C MSA reporting requirements at this time.

Special Rules for Hospice Care (§ 422.266)

An M+C organization that has a contract under Subpart K of part 422 must inform each Medicare enrollee eligible to elect hospice care under section 1812(d)(1) of the Act about the availability of hospice care (in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the M+C organization or a related entity) if: (1) A Medicare hospice program is located within the organization's service area, or (2) It is common practice to refer patients to hospice programs outside that area.

At present, one-twentieth of one percent (three thousand) of Medicare managed care enrollees have elected the hospice option. We estimate that informing beneficiaries about their hospice choices would take about ten minutes. For three thousand beneficiaries, this represents a total burden of 500 hours. On a organizational level the annual burden would be 500 hours / 450 M+C organizations (100 new/350 current) = 1.2 annual burden hours per entity.

Submission of Proposed Premiums and Related Information (§ 422.306)

Not later than May 1 of each year, each M+C organization and any organization intending to contract as an M+C organization in the subsequent year must submit to HCFA, in the manner and form prescribed by HCFA, for each M+C plan it intends to offer in the following year: (1) The information specified in paragraph (b), (c), or paragraph (d) of this section for the type of M+C plan involved, and (2) The enrollment capacity (if any) in relation to the M+C plan and area.

This collection effort will require the submission of benefit and pricing forms that will be used to price the benefit package sold and describe the benefit package being priced to Medicare beneficiaries. Both collection efforts will be completed at the same time, in order to approve both the benefit and pricing structure of a particular benefit package.

Organizations submitting benefit and pricing forms would include all M+C organizations plus any organization intending to contract with HCFA as a M+C organization.

The estimate of the hour burden of this collection of information is as follows:

Pricing portion of the Adjusted Community Rate Proposal; 1 response per year per respondent × 450 (350 current/100 new) annual respondents × 100 hours of estimated burden per response = 45,000 total annual burden hours.

The Plan Benefit Package portion of the Adjusted Community Rate Proposal; 1 response per year per respondent × 450 (350 current/100 new) annual respondents × 20 hours of estimated burden per response = 9,000 total annual burden hours.

Requirement for Additional Benefits (§ 422.312)

An M+C organization's request to make a withdrawal from the stabilization fund established for an M+C plan to be used during a contract period must be made in writing when the M+C organization notifies HCFA under § 422.306 of its proposed premiums, other cost-sharing amounts, and related information in preparation for its next contract period.

The burden associated with this requirement is captured above in § 422.306.

State Licensure Requirement (§ 422.400)

Except in the case of a PSO granted a waiver under Subpart H of part 422, each M+C organization must: (1) Be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity (as defined in § 422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more M+C plans; (2) If not commercially licensed, obtain certification from the State that the organization meets a level of financial solvency and such other standards as the State may require for it to operate as an M+C organization; and (3) Demonstrate to HCFA that—(i) The scope of its license or authority allows the organization to offer the type of M+C plan or plans that it intends to offer in the State; and (ii) If applicable, it has obtained the State certification required under § 422.400(b).

The regulations at § 422.400 require health plans to demonstrate to HCFA that they meet the State licensure requirement of section 1855(a)(1) of the Social Security Act. As explained in the preamble, organizations must meet both the basic requirement of State licensure as a risk-bearing entity, as well as the requirement that the scope of licensure be consistent with the type (or types) of M+C plan(s) the organization will be offering. We are asking new organizations (i.e., other than current contractors) to submit, as part of the process of applying for an M+C contract, a written certification showing the organization's licensure status. As of the date of publication of this interim final regulation, we are working with the National Association of Insurance Commissioners to develop a form that may be used to satisfy this requirement. A written statement containing the same type of information that is requested in the form we are developing would also suffice to show compliance with the statutory requirement.

The written certification is a combination of information provided by the organization proposing to enter into an M+C contract, and information to be provided by the appropriate State regulatory body (e.g. the State department of insurance). This is necessary because the written certification serves two purposes. First, it provides us with written evidence of compliance with the State licensure requirement for all M+C plans an organization may wish to offer. Second, it serves to inform State regulators of the intention of organizations doing business within the State with regard to M+C offerings. The certification process enables the State to ensure that the organization is complying with the State's standards for licensure (for example, as noted in the preamble, an HMO that proposes to offer a Medicare point-of-service (POS) product may be informed by the State that HMO licensure does not allow an organization to offer POS products, and that licensure as an indemnity insurer is required in that State in order to offer a POS product).

The certification will have to be completed (or other written

documentation provided) only once by each M+C organization, unless the nature of the M+C plan(s) offered by the organization differ from the original certification (e.g., an HMO may decide at some later date, after its initial application to offer a POS product—though even in such a case, a new certification may not be necessary to the extent that we are aware that applicable State law does not require a different licensure status). We estimate that the time burden for the M+C organization is 10 minutes or less for completion of the certification form, or preparation of alternative written documentation. Similarly, we would estimate, that the time burden for the State regulatory body should be 15 minutes or less (including time necessary to verify information from electronic or paper files).

Because we are estimating that there will be an average of 100 new applicants per year for M+C contracts over the next 5 years, and because this requirement will be imposed for nearly all organizations on a one-time basis, we estimate the annual total burden to be 25 minutes per respondent × 100 annual responses for a total of 42 annual hours.

General Provisions (§ 422.501)/Contract Provisions (§ 422.502)

In order to qualify as an M+C organization, enroll beneficiaries in any M+C plans it offers, and be paid on behalf of Medicare beneficiaries enrolled in those plans, an M+C organization must enter into a contract with HCFA.

Since the contract requirements associated with these sections are reflective the requirements and associated burden set forth in other sections of Part 422, the remaining burden associated with the requirements of these sections is the time required for a M+C organizations to read and sign the contract. It is estimated that it will take 100 M+C organizations on an annual basis, 2 hours each for a total annual burden of 200 hours. However, we solicit comment on the burden associated with these sections as it relates to the burden of meeting the requirements of the contract as reflected elsewhere in this regulation.

Nonrenewal of Contract (§ 422.506)

An M+C organization that does not intend to renew its contract, must notify HCFA, each Medicare enrollee, and the general public, before the end of the contract. Based on current experience HCFA receives 10 notifications of non-renewal on an annual basis. We estimate that the burden of notifying HCFA is 2 hours per notification for an annual burden of 20 hours.

We estimate the burden associated with notifying enrollees would take 16 hours per plan to draft and disseminate through mass mailings information of changes to affected beneficiaries for an annual burden of 160 hours.

We anticipate notification to the general public would be through the same notice published in a general circulation newspaper and would be an additional burden of 4 hours per organization for an annual burden of 40 hours.

Modification or Termination of Contract by Mutual Consent (§ 422.508)

An M+C organization that modifies or terminates it contract by written mutual consent must notify HCFA, each Medicare enrollee, and the general public, within timeframes specified by HCFA. Based on current experience HCFA receives less then 10 notifications of Modification or termination on an annual basis that would require notification of Medicare enrollees or the general public. However, we estimate that the burden of notifying HCFA is 2 hours per notification for an annual burden of 20 hours.

Termination of Contract by HCFA (§ 411.510)

If HCFA decides to terminate a contract for reasons other than the grounds specified in § 422.510(a)(5), the M+C organization notifies its Medicare enrollees and the general public by publishing a notice in one or more newspapers of general circulation in each community or county located in the M+C organization's geographic area of the termination by mail and at least 30 days before the effective date of the termination. Based upon current experience this requirement is imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.4 and 5 CFR 1320.3(c).

Termination of Contract by the M+C Organization (§ 422.512)

The M+C organization may terminate the M+C contract if HCFA fails to substantially carry out the terms of the contract. The M+C organization must give advance notice as follows as required in paragraphs (a)(1) through (a)(3) of § 422.512. In summary, an M+C organization that does not intend to renew its contract, it must notify HCFA, each Medicare enrollee, and the general public, before the end of the contract.

Based upon current experience this requirement is imposed on fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c).

Reporting Requirements (§ 422.516)

Each M+C organization must report to HCFA annually, within 120 days of the end of its fiscal year (unless for good cause shown, HCFA authorizes an extension of time), the requirements in § 422.516 (b)(1) through (b)(3). The burden associate with these requirements is currently captured under form HCFA–906, OMB #0938–0469. Although the burden associated with the completion of the HCFA–906 differs by provider type, on average, the annual burden per provider is 17 annual hours, for a total burden of 3,130 hours. In the near future HCFA will resubmit this collection to OMB for approval for use by M+C organizations.

For any employees' health benefits plan that includes an M+C organization in its offerings, the M+C organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations under the Employee Retirement Income Security Act of 1974 (ERISA). The M+C organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term ''administrator'' is defined in ERISA.

These reporting requirements are currently imposed by the Department of Treasury and therefore impose no addition burden.

Each M+C organization must make the information reported to HCFA under § 422.502(f)(1) available to its enrollees upon reasonable request. This burden associated with this requirement is imposed pursuant to the dissemination of enrollment/disenrollment information referenced in Subpart B of this regulation.

Each organization must notify HCFA of any loans or other special financial arrangements it makes with contractors, subcontractors and related entities.

The burden associate with these requirements is currently captured under form HCFA–906, OMB #0938–0469. In the near future HCFA will resubmit this collection to OMB for approval for use by M+C organizations.

Change of Ownership (§ 422.550)

§ 422.550 is amended to require in paragraph (b) that an M+C organization must provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving

organization. The burden associated with these requirements, which is estimated to take 10 hours per respondent × 10 annual respondents, is currently captured under National Data Reporting Requirements, form HCFA–906, OMB #0938–0469. In the near future HCFA will resubmit this collection to OMB for approval for use by M+C organizations.

§ 422.562 General provisions.

An M+C organization, with respect to each M+C plan that it offers, must establish and maintain written procedures related to; (1) the grievance procedures as described in § 422.564, (2) making timely organization determinations, (3) an appeal process that meets the requirements of this Subpart for issues that involve organization determinations.

In addition, an M+C organization must ensure that all enrollees receive written information about the grievance and appeal procedures that are available to them through the M+C organization and complaint process available to the enrollee under the PRO process as set forth under section 1154(a)(14) of the Act.

While we believe the initial burden associated with meeting these requirements is captured elsewhere in this regulation, we solicit comment on the ongoing burden associated with maintaining and disseminating the information requirements set forth in this section.

Standard Timeframes and Notice Requirements for Organization Determinations (§ 422.568)

When a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date the organization receives the request for a standard organization determination.

If an M+C organization decides to deny service or payment in whole or in part, it must give the enrollee written notice of the determination.

The burden associated with this requirement is discussed below in § 422.572.

Expediting Certain Organization Determinations (§ 422.570)

To ask for an expedited determination, an enrollee or a health care professional must submit an oral or written request directly to the M+C organization or, if applicable, to the entity responsible for making the determination, as directed by the M+C organization. A physician may provide oral or written support for a request for an expedited determination.

If an M+C organization denies a request for expedited determination, it must give the enrollee prompt oral notice of the denial and follow up, within 2 working days, with a written letter that: (1) Explains that the M+C organization will process the request using the 30-calendar-day timeframe for standard determinations, (2) informs the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision not to expedite; and (3) provides instructions about the grievance process and its timeframes.

If an M+C organization grants a request for expedited determination, it must make the determination and give notice in accordance with § 422.572.

The burden associated with this requirement is discussed below in § 422.572.

Timeframes and Notice Requirements for Expedited Organization Determinations (§ 422.572)

Except as provided in paragraph (b) of § 422.572, an M+C organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician as warranted by the patient's medical condition or situation) of its decision, whether adverse or favorable, as expeditiously as the enrollee's health condition requires, but not later than 72 hours after receiving the request.

The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization finds that it needs additional information and the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination before or immediately upon expiration of the extension.

If the M+C organization first notifies an enrollee of its expedited determination orally, it must mail written confirmation to the enrollee within 2 working days of the oral notification.

Organizations that contract with HCFA under the M+C program are required to implement procedures for making timely organization determinations and for resolving reconsiderations and other levels of appeals with respect to these determinations. In general, organization determinations involve whether an enrollee is entitled to receive a health service or the amount the enrollee is expected to pay for that service. A reconsideration consists of a review of an adverse organization determination (a decision by an M+C organization that is unfavorable to the M+C enrollee, in whole or in part) by either the M+C organization itself or an independent review entity. We use the term ''appeal'' to denote any of the procedures that deal with the review of organization determinations, including reconsiderations, hearings before administrative law judges (ALJs), reviews by the Departmental Appeals Board (DAB) and judicial review. As discussed in detail in section II.M of this preamble, the organization determination and appeal requirements for M+C organizations that are set forth in this interim final rule are largely based on the existing rules for managed care organizations under Part 417, Subpart Q, Beneficiary Appeals.

Sections 422.568, 422.570, and 422.572 contain the applicable requirements for initial organization determinations, which include submission of an oral or written request from an enrollee, and notification procedures that the M+C organization must follow when it makes a determination. We estimate that approximately 20 percent of the approximately 1 million M+C enrollees may make a request for an organization determination in a year, with an estimated burden of 2 minutes per request. Estimated notification burden associated with these requests is 5 minutes per request. The total overall annual burden for enrollee requests and organizational notification burden is 33,333 hours and 83,333 hours respectively.

Request for a Standard Reconsideration (§ 422.582)

A party to an organization determination must ask for a reconsideration of the determination by filing a written request with: (1) The M+C organization that made the organization determination; (2) an SSA office; or (3) in the case of a qualified railroad retirement beneficiary, an RRB office.

If the 60-day period in which to file a request for a reconsideration has expired, a party to the organization determination may file a request for reconsideration with the M+C organization, SSA, or an RRB office. If SSA or RRB receives a request, it forwards the request to the M+C organization for its reconsideration. The request for reconsideration and to extend the timeframe must: (1) Be in writing; and(2) state why the request for reconsideration was not filed on time.

The party who files a request for reconsideration may withdraw it by filing a written request for withdrawal at one of the places listed in paragraph (a) of this section.

The burden associated with this requirement is discussed below in § 422.602.

Expediting Certain Reconsiderations (§ 422.584)

To ask for an expedited reconsideration, an enrollee or a health care professional (on behalf of an enrollee) must submit an oral or written request directly to the M+C organization or, if applicable, to the entity responsible for making the reconsideration, as directed by the M+C organization. A physician may provide oral or written support for a request for an expedited reconsideration.

If an M+C organization denies a request for expedited reconsideration, it must take the following actions: (1) Automatically transfer a request to the standard timeframe and make the determination within the 45-day timeframe established in § 422.590(a); (2) give the enrollee prompt oral notice, and follow up, within 2 working days, with a written letter that—(i) Explains that the M+C organization will process the enrollee's request using the 45-day timeframe for standard reconsiderations, (ii) informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite, and (iii) provides instructions about the grievance process and its timeframes.

If an M+C organization grants a request for expedited reconsideration, it must conduct the reconsideration and give notice in accordance with § 422.590(d).

The burden associated with this requirement is discussed below in § 422.602.

Timeframes and Responsibility for Reconsiderations (422.590)

If the M+C organization makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by HCFA as expeditiously as the enrollee's health condition requires, but no later than 45 calendar days from the date it receives the request for a standard reconsideration. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

If the M+C organization affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by HCFA no later than 60 calendar days from the date it receives the request for a standard reconsideration. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

If the M+C organization fails to provide the enrollee with a reconsidered determination within the timeframes specified in paragraph (a) or paragraph (b) of this section, or to obtain a good cause extension described in paragraph (e) of this section, this failure constitutes an affirmation of its adverse organization determination, and the M+C organization must submit the file to the independent entity in the same manner as described under paragraphs (a)(2) and (b)(2) of this section.

The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization finds that it needs additional information and the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination before or immediately upon expiration of the extension.

If the M+C organization first notifies an enrollee orally of a completely favorable expedited reconsideration, it must mail written confirmation to the enrollee within 2 working days.

If, as a result of its reconsideration, the M+C organization affirms, in whole or in part, its adverse expedited organization determination, the M+C organization must submit a written explanation and the case file to the independent entity contracted by HCFA within 24 hours. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

If the M+C organization refers the matter to the independent entity as described under this section, it must concurrently notify the enrollee of that action.

If the M+C organization fails to provide the enrollee with the results of its reconsideration within the timeframe described in paragraph (d) of this section, this failure constitutes an adverse reconsidered determination, and the M+C organization must submit the file to the independent entity within 24 hours of expiration of the timeframe set forth in paragraph (d) of this section.

The burden associated with this requirement is discussed below in § 422.602.

Notice of Reconsidered Determination by the Independent Entity (§ 422.594)

When the independent entity makes the reconsidered determination, it is responsible for mailing a notice of its reconsidered determination to the parties and for sending a copy to HCFA.

See discussion below.

Request for an ALJ Hearing (§ 422.602)

A party must file a written request for a hearing at one of the places listed in § 422.582(a) or with the independent, outside entity. The organizations listed in § 422.582(a) forward the request to the independent, outside entity, which is responsible for transferring the case to the appropriate ALJ hearing office.

Sections 422.582, 422.584, and 422.590 contain the applicable requirements for reconsiderations by an M+C organization of adverse organization determinations. The required procedures generally involve a written request from an enrollee, preparation of a brief written explanation and case file by the M+C organization, and notification of the decision by the M+C organization. Only about 0.5 percent of organization determinations, [that is, about 20,000 cases per year], ever reach the reconsideration stage. For these cases, we estimate a burden on the requesting enrollee of approximately 20 minutes per case and a burden on the M+C organization of approximately 4 hours, including both information collection and notification. Note that § 422.590 specifies that if an M+C organization affirms, in whole or in part, its adverse organization determination, it must forward the case to an independent entity contracted by HCFA for further review. We estimate that approximately 50 percent (10,000) of reconsidered cases result in a decision that is adverse to the enrollee, and thus review by the independent entity. For these cases, we estimate an additional burden on the M+C organization of approximately 2 hours per case. Thus, the estimated total annual burden on M+C organizations associated with reconsiderations is 100,000 hours (4 hours times 20,000 cases plus 2 hours times 10,000 cases).

About 30 percent of reconsideration requests that reach the independent entity level are resolved fully in favor of the enrollee. For the other 7,000 cases, an enrollee may pursue additional appeals, beginning with an appeal to an ALJ. Only about 10 percent of these cases are appealed to the ALJ, and for these 700 cases, we estimate an

incremental burden of 20 minutes on the enrollee to make the request for an appeal under § 422.602, and 2 hours on the M+C organization for additional information collection associated with the appeal. Finally, under §§ 422.608 and 422.612, enrollees or M+C organizations may appeal ALJ decisions to the Departmental Appeal Board, and subsequently request judicial review. We would estimate an incremental burden of an additional 2 to 4 hours per case, with only about 20 DAB cases and 10 judicial review cases per year.

How M+C Organizations Must Notify Enrollees of Noncoverage of Inpatient Hospital Care (§ 422.620)

The M+C organization must give the enrollee written notice that includes the following: (1) The reason why inpatient hospital care is no longer needed, (2) the effective date of the enrollee's liability for continued inpatient care, and (3) the enrollee's appeal rights. If the M+C organization allows the hospital to determine whether inpatient care is necessary, the hospital obtains the concurrence of the contracting physician responsible for the enrollee's hospital care or of another physician as authorized by the M+C organization, and notifies the enrollee, following the procedures set forth in § 412.42(c)(3) of this chapter.

The burden associated with this requirement is discussed below in § 422.622.

Requesting Immediate PRO Review of Noncoverage of Inpatient Hospital Care (§ 422.622)

For the immediate PRO review process, the enrollee must submit the request for immediate review in writing or by telephone to the PRO that has an agreement with the hospital under § 466.78 of this chapter by noon of the first working day after he or she receives written notice that the M+C organization or hospital has determined that the hospital stay is no longer necessary.

Under § 422.620, an M+C organization is required to provide an M+C enrollee, before a hospital discharge, with a written notice of noncoverage if it decides that inpatient care is no longer necessary. Section 422.622 provides the procedures that are to be followed if an enrollee by the enrollee and the M+C organization if the enrollee wishes to request PRO review of the M+C organization's decision. We estimate that there will be no more than 1,000 of these type of cases per year under the M+C program. We estimate that the reporting burden for an M+C organization to provide written notice of noncoverage to be approximately 10 minutes per notice; for an M+C enrollee to complete a request for immediate PRO review to be approximately 10 minutes per request; and for the M+C organization to submit requested medical information to the PRO, to be approximately 2 hours per response.

In response to a request from the M+C organization, the hospital must submit medical records and other pertinent information to the PRO by close of business of the first full working day immediately following the day the organization makes its request.

Given that this requirement is imposed pursuant to an administrative action against an organization, this requirement is not subject to the PRA as defined in 5 CFR 1320.4.

Request for Reconsideration (§ 422.650)

A request for reconsideration must be made in writing and filed with any HCFA office within 15 days from the date of the notice of the initial determination. Based upon current experience this requirement is imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

The M+C organization or M+C contract applicant who filed the request for a reconsideration may withdraw it at any time before the notice of the reconsidered determination is mailed. The request for withdrawal must be in writing and filed with HCFA. Based upon current experience this requirement is imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

Request for Hearing (§ 422.662)

A request for a hearing must be made in writing and filed by an authorized official of the applicant entity or M+C organization that was the party to the determination under appeal. The request for a hearing must be filed with any HCFA office within 15 days after the date of receipt of the notice of initial or reconsidered determination.

Based upon current experience this requirement is imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

Disqualification of Hearing Officer (§ 422.668)

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.

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 in writing to HCFA.

Based upon current experience these requirements are imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

Time and Place of Hearing (§ 422.670)

The hearing officer fixes a time and place for the hearing, which is not to exceed 30 days from the receipt of the request for the hearing, and sends written notice to the parties. The notice also informs the parties of the general and specific issues to be resolved and information about the hearing procedure.

Based upon current experience these requirements are imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

Record of Hearing (§ 422.686)

A complete record of the proceedings at the hearing is made and transcribed and made available to all parties upon request. Based upon current experience these requirements are imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

Notice and Effect of Hearing Decision (§ 422.690)

As soon as practical after the close of the hearing, the hearing officer issues a written decision that: (1) Is based upon the evidence of record, and (2) contains separately numbered findings of fact and conclusions of law. And, the hearing officer provides a copy of the hearing decision to each party. Based upon current experience these requirements are imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are

not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

Effect of Revised Determination (§ 422.698)

The revision of an initial or reconsidered determination is binding unless a party files a written request for hearing of the revised determination in accordance with § 422.662. Based upon current experience these requirements are imposed pursuant to an administrative action against fewer than 10 organizations on an annual basis. Therefore, these requirements are not subject to the PRA as defined in 5 CFR 1320.3(c) and 5 CFR 1320.4.

As a note, the public will be afforded several subsequent comment periods in future publications of **Federal Register** notices announcing our intention to seek OMB approval of standardized information collection requirements such as the ACR and contractor application forms that will be submitted to OMB in the near future.

We have submitted a copy of this rule to OMB for its review of the information collection requirements above. To obtain copies of the supporting statement for these collection requirements and any currently approved forms that are related to the proposed paperwork collections referenced above, E-mail your request, including your address, phone number and HCFA regulation identifier HCFA–1011, to Paperwork@hcfa.gov, or call the Reports Clearance Office on (410) 786–1326.

As noted above, comments on these information collection and record keeping requirements must be mailed and/or faxed to the designee referenced below, within ten working days of publication of this collection in the **Federal Register**:

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: John Burke HCFA–1030, Fax Number: (410) 786–1415

And

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Herron Eydt, HCFA Desk Officer, Fax Number: (202) 395–6974 or (202) 395–5167

VII. Responses to Comments

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

VIII. Waiver of Proposed Rulemaking and Waiver of Delayed Effective Date

Because the Secretary is exercising discretion in implementing sections 1851 through 1857 and section 1859 of the Act, ordinarily we would publish a notice of proposed rulemaking and afford a period for public comments. Further, we generally provide for final rules to be effective no sooner than 30 days after the date of publication unless we find good cause to waive the delay. However, section 1856(b)(1) of the Act requires that these regulations be published by June 1, 1998, and provides that in order to carry out this requirement we may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

On January 20, 1998, we published a notice in the **Federal Register** in which we requested public comments on the implementation of the M+C program. We received approximately 90 items of correspondence in response to that notice. Further, on February 4, 1998, we held a public meeting to discuss issues and concerns from plans, providers, beneficiaries, and other interested parties on the requirements and implementation of the Medicare+Choice program. Approximately 600 individuals representing managed care organizations, local governmental agencies, and advocacy groups attended that meeting.

Because of the need to publish regulations timely and in light of the fact that we previously provided opportunity for public comment, we find good cause to waive the notice of proposed rulemaking and to issue this final rule on an interim basis. We are providing a 90-day comment period for public comment. We also find good cause to waive the delay in the effective date of this rule.

IX. Effect of the Contract With America Advancement Act of 1996 (Public Law 104–121)

This rule has been determined to be a major rule as defined in Title 5, United States Code, section 804(2). Ordinarily under 5 U.S.C. 801, as added by section 251 of Public Law 104–121, a major rule shall take effect 60 days after the later of (1) the date a report on the rule is submitted to the Congress, or (2) the date the rule is published in the **Federal Register**. However, section 808(2) of Title 5, United States Code, provides that, notwithstanding 5 U.S.C. 801, a major rule shall take effect at such time as the Federal agency determines if for good cause the agency finds that notice and comment procedures are impracticable, unnecessary, or contrary to the public interest. As explained above, for good cause we find that it was impracticable, unnecessary, or contrary to the public interest to complete notice and comment procedures before publication of this rule. Accordingly, pursuant to 5 U.S.C. 808(2), these regulations are effective on July 27, 1998.

BILLING CODE 4120–01–P

42 CFR Chapter IV is amended as set forth below.

A. Part 400

PART 400—INTRODUCTION; DEFINITIONS

1. The authority citation for part 400 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh) and 44 U.S.C. chapter 35.

2. In § 400.200, the definition for ''PRO'' is revised and the following definitions are added in alphabetical order to read as follows.

§ 400.200 General definitions.

* * * * *

ALJ stands for administrative law judge.

* * * * *

NCD stands for national coverage determination.

* * * * *

Peer review organization means an organization that has a contract with HCFA, under part B of title XI of the Act, to perform utilization and quality control review of the health care furnished, or to be furnished, to Medicare beneficiaries.

PRO stands for peer review organization.

* * * * *

RRB stands for Railroad Retirement Board.

* * * * *

3. In § 400.202 a definition of ''national coverage determination'' is added in alphabetical order to read as follows.

§ 400.202 Definitions specific to Medicare.

* * * * *

National coverage determination (NCD) means a national policy determination regarding the coverage status of a particular service, that HCFA

makes under section 1862(a)(1) of the Act, and publishes as a **Federal Register** notice or HCFA Ruling. (The term does not include coverage changes mandated by statute.)

* * * * *

B. Part 403

PART 403—SPECIAL PROGRAMS AND PROJECTS

1. The authority citation for part 403 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 403.205, paragraph (d) introductory text is revised to read as follows:

§ 403.205 Medicare supplemental policy.

* * * * *

(d) Medicare supplemental policy does not include a Medicare+Choice plan or any of the following health insurance policies or health benefit plans:

* * * * *

C. Part 410

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Part 410 is amended as set forth below.

a. Section 410.57 is revised to read as follows:

§ 410.57 Pneumococcal vaccine and flu vaccine.

(a) Medicare Part B pays for pneumococcal vaccine and its administration when reasonable and necessary for the prevention of disease, if the vaccine is ordered by a doctor of medicine or osteopathy.

(b) Medicare Part B pays for the influenza virus vaccine and its administration.

b. Section 410.152 is amended to add a paragraph (1) to read as follows:

§ 410.152 Amounts of Payment.

* * * * *

(1) *Amount of payment: Flu vaccine.* Medicare Part B pays 100 percent of the Medicare allowed charge.

D. Part 411

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 411.15 [Amended]

2. In § 411.15, in paragraph (e), the following changes are made:

a. The ''and'' at the end of paragraph (e)(2) is removed.

b. A semicolon and the word ''and'' are added at the end of paragraph (e)(3).

c. A new paragraph (e)(4) is added, to read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(e) * * *

(4) Influenza vaccinations that are reasonable and necessary for the prevention of illness.

* * * * *

3. In § 411.355, a new paragraph (c)(5) is added, to read as follows:

§ 411.355 General exceptions to referral prohibitions related to both ownership/investment and compensation.

* * * * *

(c) * * *

(5) A coordinated care plan (within the meaning of section 1851(a)(2)(A) of the Act) offered by an organization in accordance with a contract with HCFA under section 1857 of the Act and part 422 of this chapter.

* * * * *

E. Part 417

PART 417—HEALTH MAINTENANCE ORGANIZATIONS, COMPETITIVE MEDICAL PLANS, AND HEALTH CARE PREPAYMENT PLANS

1. The authority citation for part 417 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh), secs. 1301, 1306, and 1310 of the Public Health Service Act (42 U.S.C. 300e, 300e–5, and 300e–9); and 31 U.S.C. 9701.

2. Section 417.402 is revised to read as follows:

§ 417.402 Effective date of initial regulations.

(a) The changes made to section 1876 of the Act by section 114 of the Tax Equity and Fiscal Responsibility Act of 1982 became effective on February 1, 1985, the effective date of the initial implementing regulations.

(b) The changes made to section 1876 of the Act by section 4002 of the Balanced Budget Act (BBA) of 1997 are incorporated in section 422 except for 1876 cost contracts. Upon enactment of the BBA (August 5, 1997) no new cost contracts or service area expansions are accepted by HCFA except for current Health Care Prepayment Plans that may convert to 1876 cost contracts. Also, 1876 cost contracts may not be extended or renewed beyond December 31, 2002.

3. In § 417.413, paragraphs (d)(1) and (d)(2) introductory text are revised and new paragraphs (d)(2) (iii) and (d)(8) are added to read as follows:

§ 417.413 Qualifying condition: Operating experience and enrollment.

* * * * *

(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 HMO's or CMP's enrollment may be Medicare beneficiaries.

(2) *Waiver of composition of enrollment standard.* HCFA may waive compliance with the requirements of paragraph (d)(1) of this section if the HMO or CMP has made and is making reasonable efforts to enroll individuals who are not Medicare beneficiaries and it meets one of the following requirements:

* * * * *

(iii) The HMO or CMP requests waiver of the composition rule because it is in the public interest. The organization provides documentation that supports one of the following:

(A) The organization serves a medically underserved rural or urban area.

(B) The organization demonstrates a long-term business and community service commitment to the area.

(C) The organization believes that a waiver is necessary to promote managed care choices in an area with limited or no managed care choices.

* * * * *

(8) *Termination of composition standard.* The 50 percent composition of Medicare beneficiaries terminates for all managed care plans on December 31, 1998.

* * * * *

4. In § 417.426, a new paragraph (a)(4) is added to read as follows:

§ 417.426 Open enrollment requirements.

(a) *Basic requirements.* * * *

(4) An HMO or CMP with a risk contract must accept applications from eligible Medicare beneficiaries during the month of November 1998.

* * * * *

5. Section 417.428 is revised to read as follows:

§ 417.428 Marketing activities.

The requirements and prohibitions set forth in § 422.80 of this chapter, for M+C organizations, apply also to HMOs and CMPs with contracts under section 1876 of the Act.

6. In § 417.472, paragraph (h) is revised to read as follows:

§ 417.472 Basic contract requirements.

* * * * *

(h) *Collection of fees from risk HMOs and CMPs.* (1) The rules set forth in § 422.10 of this chapter for M+C plans also apply to collection of fees from risk HMOs and CMPs.

(2) In applying the part 422 rules, references to ''M+C organizations'' or ''M+C plans'' must be read as references to ''risk HMOs and CMPs''.

Subpart M—[Amended]

7. Sections 417.520, 417.522 and 417.523 of subpart M are redesignated as §§ 422.550, 422.522 and 422.553 in a new subpart L in part 422, and the heading for the new subpart L to part 44 is added to read ''Change of Ownership and Leasing of Facilities: Effect on Medicare Contract, under part 422, Medicare+Choice Program''.

8. A new § 417.520 is added to subpart M to read as follows:

§ 417.520 Effect on HMO and CMP contracts.

(a) The provisions set forth in subpart L of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying these provisions, references to ''M+C organizations'' must be read as references to ''HMOs and CMPs''.

(c) In § 422.550, reference to ''subpart K of this part'' must be read as reference to ''subpart L of part 417 of this chapter''.

(d) In § 422.553, reference to ''subpart K of this part'' must be read as reference to ''subpart J of part 417 of this chapter''.

9. In § 417.584, a new paragraph (e) is added to read as follows:

§ 417.584 Payment to HMOs or CMPs with risk contracts.

* * * * *

(e) *Determination of rate for calendar year 1998.* For calendar year 1998, HMOs or CMPs with risk contracts will be paid in accordance with principles contained in subpart F of part 422 of this chapter.

Subpart Q—[Amended]

10. In subpart Q, §§ 417.600 through 417.638 are removed.

11. A new § 417.600 is added to subpart Q as follows:

§ 417.600 Beneficiary appeals and grievances.

(a) The rights, procedures, and requirements relating to beneficiary appeals and grievances set forth in subpart M of part 422 of this chapter also apply to Medicare contracts with HMOs and CMPs under section 1876 of the Act.

(b) In applying those provisions, references to section 1852 of the Act must be read as references to section 1876 of the Act; and references to M+C organizations as references to HMOs and CMPs.

12. In § 417.800 paragraph (a) introductory text is republished and the definition for ''Health care prepayment plan'' is revised to read as follows:

§ 417.800 Payment to HCPPs: Definitions and basic rules.

(a) *Definitions:* As used in this subpart, unless the context indicates otherwise—

* * * * *

Health care prepayment plan (HCPP) means an organization that—

(1) Is union or employer sponsored;

(2) Does not provide, or arrange for the provision of any in patient hospital services. Current HCPPs must meet this definition on January 1, 1999 and 1998 applicants must meet the definitions as of the effective date of the HCPP agreement. As of January 1, 1999, HCPPs are not required to meet Medigap requirements.

(3) Is responsible for the organization, financing and delivery of covered Part B services to a defined population on a prepayment basis;

(4) Meets the conditions specified in paragraph (b) of this section; and

(5) Elects to be reimbursed on a reasonable cost basis.

* * * * *

BILLING CODE 4120–01–M

F. Part 422

PART 422—MEDICARE+CHOICE PROGRAM

1. The authority citation continues to read as follows:

Authority: Secs. 1102, 1851 through 1857, 1859, and 1871 of the Social Security Act (42 U.S.C. 1302, 1395w–21 through 1395w–27, and 1395hh).

2. Subparts A through G are added as follows:

Subpart A—General Provisions

Sec.

Subpart B—Eligibility, Election, and Enrollment

Subpart C—Benefits and Beneficiary Protections

Subpart D—Quality Assurance

Subpart E—Relationships With Providers

Subpart A—General Provisions

§ 422.1 Basis and scope.

(a) *Basis.* This part is based on the indicated provisions of the following sections of the Act:

1851—Eligibility, election, and enrollment.
1852—Benefits and beneficiary protections.
1853—Payments to Medicare+Choice (M+C) organizations.
1854—Premiums.
1855—Organization, licensure, and solvency of M+C organizations.
1856—Standards.
1857—Contract requirements.
1859—Definitions; enrollment restriction for certain M+C plans.

(b) *Scope.* This part establishes standards and sets forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare+Choice organizations through Medicare+Choice plans.

§ 422.2 Definitions.

As used in this part—

ACR stands for adjusted community rate.

Additional benefits are health care services not covered by Medicare, and reductions in premiums or cost-sharing for Medicare covered services, funded from adjusted excess amounts as calculated in the ACR.

Adjusted community rate (ACR) is the equivalent of the maximum amount allowed under § 422.310.

Arrangement means a written agreement between an M+C organization and a provider or provider network, under which—

(1) The provider or provider network agrees to furnish for a specific M+C plan(s) specified services to the organization's M+C enrollees;

(2) The organization retains responsibilities for the services; and

(3) Medicare payment to the organization discharges the enrollee's obligation to pay for the services.

Balance billing generally refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer (for example, the original Medicare program) will pay for the service plus any cost-sharing by the individual.

Basic benefits means all Medicare-covered benefits, except hospice services, and additional benefits.

Benefits are health care services that are intended to maintain or improve the health status of enrollees, for which the M+C organization incurs a cost or liability under an M+C plan, and that are approved in the Benefit/ACR process.

Coinsurance is a fixed percentage of the total amount paid for a health care service that can be charged to an M+C enrollee on a per-service basis.

Copayment is a fixed amount that can be charged to an M+C plan enrollee on a per-service basis.

Cost-sharing includes deductibles, coinsurance, and copayments.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(1) Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency services means covered inpatient and outpatient services that are—

(1) Furnished by a provider qualified to furnish emergency services; and

(2) Needed to evaluate or stabilize an emergency medical condition.

Licensed by the State as a risk-bearing entity means the entity is licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage, such that the entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an M+C contract.

M+C stands for Medicare+Choice.

M+C eligible individual means an individual who meets the requirements of § 422.50.

M+C organization means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by HCFA as meeting the M+C contract requirements.

M+C plan means health benefits coverage offered under a policy or contract by an M+C organization that includes a specific set of health benefits offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the M+C plan.

M+C plan enrollee is an M+C eligible individual who has elected an M+C plan offered by an M+C organization.

Mandatory supplemental benefits are services not covered by Medicare that an M+C enrollee must purchase as part of an M+C plan that are paid for directly by (or on behalf of) Medicare enrollees, in the form of premiums or cost-sharing.

MSA stands for medical savings account.

MSA trustee means a person or business with which an enrollee establishes an M+C MSA. A trustee may be a bank, an insurance company, or any other entity that—

(1) Is approved by the Internal Revenue Service to be a trustee or custodian of an individual retirement account (IRA); and

(2) Meets the requirements of § 422.262(b).

Original Medicare means health insurance available under Medicare Part A and Part B through the traditional fee-for service payment system.

Optional supplemental benefits means health benefits normally not covered by Medicare purchased at the option of the M+C enrollee and that are

paid for directly by (or on behalf of) the Medicare enrollee, in the form of premiums or cost-sharing. These services may be grouped or offered individually.

Point of service (POS) is a benefit option that an M+C coordinated care plan can offer to its Medicare enrollees as an additional, mandatory supplemental, or optional supplemental benefit. Under the POS benefit option, the M+C plan allows members the option of receiving specified services outside of the M+C plan's provider network. In return for this flexibility, members typically have higher cost-sharing requirements for services received and, where offered as a mandatory or optional supplemental benefit, may also be charged a premium for the POS benefit option.

Provider means—

(1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and

(2) Any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

Provider network means the providers with which an M+C organization contracts or makes arrangements to furnish covered health care services to Medicare enrollees under an M+C coordinated care or network MSA plan.

Religious and Fraternal (RFB) Society means an organization that—

(1) Is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of that Act; and

(2) Is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches.

RFB plan means a coordinated care plan that is offered by an RFB society.

Service area means a geographic area approved by HCFA within which an M+C eligible individual may enroll in a particular M+C plan offered by the organization. For coordinated care plans and network medical savings account (MSA) plans only, the service area also is the area within which a network of providers exists that meets the access standards in § 422.112. The service area also defines the area where a uniform benefit package is offered. In deciding whether to approve a service area proposed by an M+C organization for an M+C plan, HCFA considers the M+C organization's commercial service area for the type of plan in question (if applicable), community practices generally, whether the boundaries of the service area are discriminatory in effect, and, in the case of coordinated care and network MSA plans, the adequacy of the provider network in the proposed service area. HCFA may approve single county M+C non-network MSA plans even if the M+C organization has a different commercial service area.

Urgently needed services means covered services provided when an enrollee is temporarily absent from the M+C plan's service (or, if applicable, continuation) area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area but the organization's provider network is temporarily unavailable or inaccessible) when such services are medically necessary and immediately required—

(1) As a result of an unforeseen illness, injury, or condition; and

(2) It was not reasonable given the circumstances to obtain the services through the organization offering the M+C plan.

§ 422.4 Types of M+C plans.

(a) *General rule.* An M+C plan may be a coordinated care plan, a combination of an M+C MSA plan and a contribution into an M+C MSA established in accordance with § 422.262, or an M+C private fee-for-service plan.

(1) *A coordinated care plan.* A coordinated care plan is a plan that includes a network of providers that are under contract or arrangement with the organization to deliver the benefit package approved by HCFA.

(i) The network is approved by HCFA to ensure that all applicable requirements are met, including access and availability, service area, and quality.

(ii) Coordinated care plans may include mechanisms to control utilization, such as referrals from a gatekeeper for an enrollee to receive services within the plan, and financial arrangements that offer incentives to providers to furnish high quality and cost-effective care.

(iii) Coordinated care plans include health maintenance organizations (HMOs), provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs), RFBs, and other network plans (except network MSA plans).

(2) *A combination of an M+C MSA plan and a contribution into the M+C MSA established in accordance with § 422.262.* (i) *M+C MSA plan* means a plan that—

(A) Pays at least for the services described in § 422.101, after the enrollee has incurred countable expenses (as specified in the plan) equal in amount to the annual deductible specified in § 422.103(d); and

(B) Meets all other applicable requirements of this part.

(ii) An M+C MSA plan may be either a network plan or a non-network plan.

(A) *M+C network MSA plan* means an MSA plan under which enrollees must receive services through a defined provider network that is approved by HCFA to ensure that all applicable requirements are met, including access and availability, service area, and quality.

(B) *M+C non-network MSA plan* means an MSA plan under which enrollees are not required to receive services through a provider network.

(iii) *M+C MSA* means a trust or custodial account—

(A) That is established in conjunction with an MSA plan for the purpose of paying the qualified expenses of the account holder; and

(B) Into which no deposits are made other than contributions by HCFA under the M+C program, or a trustee-to-trustee transfer or rollover from another M+C MSA of the same account holder, in accordance with the requirements of sections 138 and 220 of the Internal Revenue Code.

(3) *M+C private fee-for-service plan.* An M+C private fee-for-service plan is an M+C plan that—

(i) Pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(ii) Does not vary the rates for a provider based on the utilization of that provider's services; and

(iii) Does not restrict enrollees' choices among providers that are lawfully authorized to provide services and agree to accept the plan's terms and conditions of payment.

(b) *Multiple plans.* Under its contract, an M+C organization may offer multiple plans, regardless of type, provided that the M+C organization is licensed or approved under State law to provide those types of plans (or, in the case of a PSO plan, has received from HCFA a waiver of the State licensing requirement). If an M+C organization has received a waiver for the licensing requirement to offer a PSO plan, that waiver does not apply to the licensing requirement for any other type of M+C plan.

§ 422.6 Application requirements.

(a) *Scope.* This section sets forth application requirements for entities that seek a contract as an M+C organization offering an M+C plan.

(b) *Completion of an application.* (1) In order to obtain a determination on whether it meets the requirements to become an M+C organization and is qualified to provide a particular type of M+C plan, an entity, or an individual authorized to act for the entity (the applicant) must complete a certified application, in the form and manner required by HCFA, including the following:

(i) Documentation of appropriate State licensure or State certification that the entity is able to offer health insurance or health benefits coverage that meets State-specified standards applicable to M+C plans, and is authorized by the State to accept prepaid capitation for providing, arranging, or paying for the comprehensive health care services to be offered under the M+C contract; or

(ii) Federal waiver as described in subpart H of this part.

(2) The authorized individual must describe thoroughly how the entity and M+C plan meet, or will meet, the requirements described in this part.

(c) *Responsibility for making determinations.* HCFA is responsible for determining whether an entity qualifies as an M+C organization and whether proposed M+C plans meet the requirements of this part.

(d) *Resubmittal of application.* An application that has been denied by HCFA may not be resubmitted for 4 months after the date of the notice from HCFA denying the application.

(e) *Disclosure of application information under the Freedom of Information Act.* An applicant submitting material that he or she believes is protected from disclosure under 5 U.S.C. 552, the Freedom of Information Act, or because of exceptions provided in 45 CFR part 5 (the Department's regulations providing exceptions to disclosure), should label the material ''privileged'' and include an explanation of the applicability of an exception described in 45 CFR part 5.

§ 422.8 Evaluation and determination procedures.

(a) *Basis for evaluation and determination.* (1) HCFA evaluates an application for an M+C contract on the basis of information contained in the application itself and any additional information that HCFA obtains through on-site visits, public hearings, and any other appropriate procedures.

(2) If the application is incomplete, HCFA notifies the entity and allows 60 days from the date of the notice for the entity to furnish the missing information.

(3) After evaluating all relevant information, HCFA determines whether the entity's application meets the applicable requirements of § 422.6.

(b) *Use of information from a prior contracting period.* If an entity has failed to comply with the terms of a previous year's contract with HCFA under title XVIII of the Act as an HMO, competitive medical plan, health care prepayment plan, or M+C organization or an entity has failed to complete a corrective action plan during the term of the contract, HCFA may deny an application based on the entity's failure to comply with that prior contract with HCFA even if the entity meets all of the current requirements.

(c) *Notice of determination.* HCFA notifies each entity that applies for an M+C contract under this part of its determination and the basis for the determination. The determination may be approval, intent to deny, or denial.

(d) *Approval of application.* If HCFA approves the application, it gives written notice to the M+C organization, indicating that it meets the requirements for an M+C contract.

(e) *Intent to deny.* (1) If HCFA finds that the entity does not appear to meet the requirements of an M+C organization and appears to be able to meet those requirements within 60 days, HCFA gives the entity notice of intent to deny qualification and a summary of the basis for this preliminary finding.

(2) Within 60 days from the date of the notice, the entity may respond in writing to the issues or other matters that were the basis for HCFA's preliminary finding and may revise its application to remedy any defects HCFA identified.

(f) *Denial of application.* If HCFA denies the application, it gives written notice to the M+C organization indicating—

(1) That the M+C organization does not meet the contract requirements under part C of title XVIII of the Act;

(2) The reasons why the M+C organization does not meet the contract requirements; and

(3) The M+C organization's right to request reconsideration in accordance with the procedures specified in subpart N of this part.

(g) *Oversight of continuing compliance.* (1) HCFA oversees an entity's continued compliance with the requirements for an M+C organization.

(2) If an entity no longer meets those requirements, HCFA terminates the contract in accordance with § 422.510.

§ 422.10 Cost-sharing in enrollment-related costs.

(a) *Basis and scope.* This section implements that portion of section 1857 of the Act that pertains to cost-sharing in enrollment-related costs. It sets forth the procedures that HCFA follows to assess the required fees on M+C plans offered by M+C organizations.

(b) *Purpose of assessment.* Section 1857(e)(2) of the Act authorizes HCFA to charge and collect from each M+C plan offered by an M+C organization its pro rata share of fees for administering section 1851 of the Act, relating to dissemination of enrollment information; and section 4360 of the Omnibus Budget Reconciliation Act of 1990, relating to the health insurance counseling and assistance program.

(c) *Applicability.* The fee assessment also applies to those demonstrations for which enrollment is effected or coordinated under section 1851 of the Act.

(d) *Collection of fees*—(1) *Timing of collection.* HCFA collects the fees over nine consecutive months beginning with January of each fiscal year.

(2) *Amount to be collected.* The aggregate amount of fees for a fiscal year is the lesser of the following:

(i) The estimated costs to be incurred by HCFA in that fiscal year to carry out the activities described in paragraph (b) of this section.

(ii) The amount authorized in the DHHS appropriation for the fiscal year.

(e) *Assessment methodology.* (1) The amount assessed is a percentage of the total Medicare payments to each organization. HCFA determines the percentage rate using the following formula:

A times B divided by C where—

A is the total of the estimated January payments to all organizations subject to assessment;

B is the nine-month (January through September) assessment period; and

C is the total assessment amount authorized for the particular fiscal year in accordance with paragraph (d)(2) of this section.

(2) HCFA determines each organization's pro rata share of the annual fee on the basis of that organization's calculated monthly payment amount during the nine consecutive months beginning with January. HCFA calculates each organization's monthly pro rata share by multiplying the established percentage rate by the total monthly calculated Medicare payment amount to the organization as recorded in HCFA's payment system on the first day of the month.

(3) HCFA deducts the organization's fee from the amount of Federal funds otherwise payable to the organization for that month under the M+C program.

(4) If assessments reach the amount authorized for the year before the end of

September, HCFA discontinues assessment.

(5) If there are delays in determining the amount of the annual aggregate fees specified in paragraph (d)(2) of this section or the fee percentage rate specified in paragraph (e), HCFA may adjust the assessment time period and the fee percentage amount.

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Supbart B—Eligibility, Election, and Enrollment

§ 422.50 Eligibility to elect an M+C plan.

(a) an individual is eligible to elect an M+C plan if he or she—

(1) Is entitled to Medicare under Part A and enrolled in Part B (except that an individual entitled only to Part B and who is (or was) enrolled in an HMO or CMP with a risk contract under part 417 of this chapter on December 31, 1998 may continue to be enrolled in the M+C organization may continue to be enrolled in the M+C organization as an M+C plan enrollee);

(2) Has not been medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in an M+C plan or in a health plan offered by the M+C organization offering an M+C plan in the service area or continuation area in which the individual resides may continue to be enrolled in the M+C organization as an M+C plan enrollee;

(3) Resides in the service area of the plan, except that an individual who resides in a continuation area of an M+C plan while enrolled in a health plan offered by the M+C organization may continue to be enrolled in the M+C organization as an M+C plan enrollee;

(4) Completes and signs an election form and gives information required for enrollment; and

(5) Agrees to abide by the rules of the M+C organization after they are disclosed to him or her in connection with the election process.

(b) An M+C eligible individual may not be enrolled in more than one M+C plan at any given time.

§ 422.54 Continuation of enrollment.

(a) *Definition. Continuation area* means an additional area (outside the service area) within which the M+C organization furnishes or arranges for furnishing services to its continuation-of-enrollment enrollees. Enrollees must reside in a continuation area on a permanent basis. A continuation area does not expand the service area of any plan.

(b) *Basis rule.* An M+C organization may offer a continuation of enrollment option to enrollees when they no longer reside in the service area of a plan and permanently move into the geographic area designated by the M+C organization as a continuation of enrollment area. The intent to no longer reside in an area and permanently live in another area is verified through documentation that establishes residency, such as, driver's license, voter registration.

(c) *General requirements.* (1) An M+C organization that wishes to offer a continuation of enrollment option must meet the following requirements:

(i) Obtain HCFA's approval of the continuation area, the marketing materials that describe the option, and the M+C organization's assurances of access to services.

(ii) Describe the option(s) in the member materials it offers and make the option available to all enrollees residing in the continuation area.

(2) An enrollee who moves out of the service area and into the geographic area designated as the continuation area has the choice of continuing enrollment or disenrolling from the plan.

(d) *Specific requirements*—(1) *Basic benefits.* The M+C organization must, at a minimum, provide or arrange for the Medicare-covered benefits described in § 422.101(a).

(2) *Reasonable access.* The M+C organization must ensure reasonable access in the continuation area—

(i) Through contracts with providers, or through direct payment of claims that satisfy the requirements in § 422.100(b)(2), to other providers who meet requirements in subpart E of this part; and

(ii) By ensuring that the access requirements of § 422.112 are met.

(3) *Reasonable cost-sharing.* For services furnished in the continuation area, an enrollee's cost-sharing liability is limited to—

(i) The cost-sharing amounts required in the M+C plan's service area (in which the enrollee no longer resides) if provided by contract providers;

(ii) The cost-sharing amounts required by the continuation area plan if provided through agreements with another M+C plan; or

(iii) The amount for which a beneficiary would be liable under original Medicare if noncontracting providers furnish the services.

(4) *Protection of enrollee rights.* An M+C organization that offers a continuation of enrollment option must convey all enrollee rights conferred under this rule, with the understanding that—

(i) The ultimate responsibility for all appeals and grievance requirements remain with the organization that is receiving payment from HCFA; and

(ii) Organizations that require enrollees to give advance notice of intent to use the continuation of enrollment option, must stipulate the notification process in the marketing materials.

(e) *Capitation payments.* HCFA's capitation payments to all M+C organizations, for all Medicare enrollees, are based on rates established on the basis of the enrollee's permanent residence, regardless of where he or she receives services.

§ 422.56 Limitations on enrollment in an M+C MSA plan.

(a) *General.* An individual is not eligible to elect an M+C MSA plan—

(1) If the number of individuals enrolled in M+C MSA plans has reached 390,000;

(2) Unless the individual provides assurances that are satisfactory to HCFA that he or she will reside in the United States for at least 183 days during the year for which the election is effective; or

(3) On or after January 1, 2003, unless the enrollment is the continuation of an enrollment in effect as of that date.

(b) *Individuals eligible for or covered under other health benefits program.* An individual who is enrolled in a Federal Employee Health Benefit plan under 5 U.S.C. chapter 89, or is eligible for health care benefits through the Veteran's Administration under 10 U.S.C. chapter 55 or the Department of Defense under 38 U.S.C. chapter 17, may not enroll in an M+C MSA plan.

(c) *Individuals eligible for Medicare cost-sharing under Medicaid State plans.* An individual who is entitled to coverage of Medicare cost-sharing under a State plan under title XIX of the Act is not eligible to enroll in an M+C MSA plan.

(d) *Other limitations.* An individual who receives health benefits that cover all or part of the annual deductible under the M+C MSA plan may not enroll in an M+C MSA plan. Examples of this type of coverage include, but are not limited to, primary health care coverage other than Medicare, current coverage under the Medicare hospice benefit, supplemental insurance policies not specifically permitted under § 422.103, and retirement health benefits.

§ 422.57 Limited enrollment under M+C RFB plans.

An RFB society that offers an M+C RFB plan may offer that plan only to members of the church, or convention or group of churches with which the society is affiliated.

§ 422.60 Election process.

(a) *Acceptance of enrollees: General rule.* (1) Except for the limitations on enrollment in an M+C MSA plan provided by § 422.62(d)(1) and except as specified in paragraph (a)(2) of this section, each M+C organization must accept without restriction (except for an M+C RFB plan as provided by § 422.57) individuals who are eligible to elect an M+C plan that M+C organization offers and who elect an M+C plan during initial coverage election periods, annual election periods, and special election periods specified in § 422.62 (a)(1), (a)(2), and (b).

(2) M+C organizations must accept elections during the open enrollment periods specified in § 422.62(a)(3), (a)(4), and (a)(5) if their M+C plans are open to new enrollees.

(b) *Capacity to accept new enrollees.* (1) M+C organizations must submit information on enrollment capacity of plans they offer by May 1 of each year as provided by § 422.306(a)(2).

(2) If HCFA determines that an M+C plan offered by an M+C organization has a capacity limit, and the number of M+C eligible individuals who elect to enroll in that plan exceeds the limit, the M+C organization offering the plan may limit enrollment in the plan under this part, but only if it provides priority in acceptance as follows:

(i) First, for individuals who elected the plan prior to the HCFA determination that capacity has been exceeded, elections will be processed in chronological order by date of receipt of their election forms.

(ii) Then for other individuals in a manner that does not discriminate on the basis of any factor related to health as described in § 422.110.

(c) *Election forms.* (1) The election form must comply with HCFA instructions regarding content and format and have been approved by HCFA as described in § 422.80. The form must be completed and signed by the M+C eligible individual beneficiary (or the individual who will soon become entitled to Medicare benefits) and include authorization for disclosure and exchange of necessary information between the U.S. Department of Health and Human Services and its designees and the M+C organization. Persons who assist beneficiaries in completing forms must sign the form and indicate their relationship to the beneficiary.

(2) The M+C organization must file and retain election forms for the period specified in HCFA instructions.

(d) *When an election is considered to have been made.* An election in an M+C plan is considered to have been made on the date the election form is received by the M+C organization.

(e) *Handling of election forms.* The M+C organization must have an effective system for receiving, controlling, and processing election forms. The system must meet the following conditions and requirements:

(1) Each election form is dated as of the day it is received.

(2) Election forms are processed in chronological order, by date of receipt.

(3) The M+C organization gives the beneficiary prompt written notice of acceptance or denial in a format specified by HCFA.

(4) In a format specified by HCFA, a notice of acceptance—

(i) Promptly informs the beneficiary of the date on which enrollment will be effective under § 422.68; and

(ii) If the M+C plan is enrolled to capacity, explains the procedures that will be followed when vacancies occur.

(5) A notice of denial explains the reasons for denial in a format specified by HCFA.

(6) Within 30 days from receipt of the election form (or from the date a vacancy occurs for an individual who was accepted for future enrollment), the M+C organization transmits the information necessary for HCFA to add the beneficiary to its records as an enrollee of the M+C organization.

§ 422.62 Election of coverage under an M+C plan.

(a) *General: Coverage election periods*—(1) *Initial coverage election period.* The initial coverage election period is the period during which a new M+C eligible individual may make an initial election. This period begins 3 months prior to the month the individual is first entitled to both Part A and Part B and ends the last day of the month preceding the month of entitlement.

(2) *Annual election period.* (i) Beginning in 1999, the month of November is the annual election period for the following calendar year. Organizations offering M+C plans in January 1999 must open enrollment to Medicare beneficiaries in November 1998.

(ii) During the annual election period, an individual eligible to enroll in an M+C plan may change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan.

(3) *Open enrollment and disenrollment opportunities through 2001.* From 1998 through 2001, the number of elections or changes that an M+C eligible individual may make is not limited (except as provided for in paragraph (d) of this section for M+C MSA plans). Subject to the M+C plan being open to enrollees as provide under § 422.60(a)(2), an individual eligible to elect an M+C plan may change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan.

(4) *Open enrollment and disenrollment during 2002.* (i) Except as provided in paragraphs (a)(4)(ii) and (a)(4)(iii) of this section, an individual who is eligible to elect an M+C plan in 2002 may elect an M+C plan or change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan, but only once during the first 6 months of the year.

(ii) *Newly eligible M+C individual.* An individual who becomes an M+C eligible individual during 2002 may elect an M+C plan or original Medicare and then change his or her election once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 6th month of such entitlement, or on December 31, whichever is earlier. The individual can change the election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan during this period.

(iii) The limitation to one election or change in paragraphs (a)(4)(i) and (a)(4)(ii) of this section does not apply to elections or changes made during the annual election period specified in (a)(2) of this section or during a special enrollment period specified in paragraph (b) of this section.

(5) *Open enrollment and disenrollment beginning in 2003.* (i) For 2003 and subsequent years, except as provided in paragraphs (a)(5)(ii) and (a)(5)(iii) of this section, an individual who is eligible to elect an M+C plan may elect an M+C plan or change his or her election from an M+C plan to original Medicare or to a different M+C plan, or from original Medicare to an M+C plan, but only once during the first 3 months of the year.

(ii) *Newly eligible M+C individual.* An individual who becomes an M+C eligible individual during 2003 or later may elect an M+C plan or original Medicare and then change his or her election once during the period that begins the month the individual is entitled to both Part A and Part B and ends on the last day of the 3rd month of such entitlement, or on December 31, whichever is earlier. The individual can change the election from an M+C plan to original Medicare or to a different

M+C plan, or from original Medicare to an M+C plan during this period.

(iii) The limitation to one election or change in paragraphs (a)(5)(i) and (a)(5)(ii) of this section does not apply to elections or changes made during the annual election period specified in paragraph (a)(2) of this section or during a special election period specified in paragraph (b) of this section.

(b) *Special election periods.* Effective as of January 1, 1999 for M+C plans, and as of January 1, 2002, for all MSA other types of M+C MSA plans, an individual may at any time (that is, not limited to the annual election period) discontinue the election of an M+C plan offered by an M+C organization and change his or her election, in the form and manner specified by HCFA, from an M+C plan to original Medicare or to a different M+C plan under any of the following circumstances:

(1) HCFA has terminated the organization's contract for that plan or the organization has terminated or discontinued offering the plan in the service area or continuation area in which the individual resides.

(2) The individual is not eligible to remain enrolled in the plan because of a change in his or her place of residence to a location out of the service area or continuation area or other change in circumstances as determined by HCFA but not including terminations resulting from a failure to make timely payment of an M+C monthly or supplemental beneficiary premium, or from disruptive behavior.

(3) The individual demonstrates to HCFA, in accordance with guidelines issued by HCFA, that—

(i) The organization offering the plan substantially violated a material provision of its contract under this part in relation to the individual, including, but not limited to the following:

(A) Failure to provide the beneficiary on a timely basis medically necessary services for which benefits are available under the plan.

(B) Failure to provide medical services in accordance with applicable quality standards; or

(ii) The organization (or its agent, representative, or plan provider) materially misrepresented the plan's provisions in marketing the plan to the individual.

(4) The individual meets such other exceptional conditions as HCFA may provide.

(c) *Special election period for individual age 65.* Effective January 1, 2002, an M+C eligible individual who elects an M+C plan during the initial coverage election period, as defined under section 1837(d) of the Act, that surrounds his or her 65th birthday (this period begins 3 months before and ends 3 months after the month of the individual's 65th birthday) may discontinue the election of that plan and elect coverage under original Medicare at any time during the 12-month period that begins on the effective date of enrollment in the M+C plan.

(d) *Special rules for M+C plans*—(1) *Enrollment.* An individual may enroll in an M+C plan only during an initial or annual election period described in paragraphs (a)(1) and (a)(2) of this section or during November 1998.

(2) *Disenrollment.* (i) Except as provided in paragraph (d)(2)(ii) of this section, an individual may disenroll from an M+C plan only during—

(A) November 1998;

(B) An annual election period; or

(C) The special election period described in paragraph (b) of this section.

(ii) *Exception.* An individual who elects an M+C MSA plan during an annual election period and has never before elected an M+C MSA plan may revoke that election, no later than December 15 of that same year, by submitting to the organization that offers the M+C MSA plan a signed and dated request in the form and manner prescribed by HCFA or by filing the appropriate disenrollment form through other mechanisms as determined by HCFA.

§ 422.64 Information about the M+C program.

(a) *Source of information.* Each M+C organization must provide, on an annual basis and in a format and using standard terminology that may be specified by HCFA, the information necessary to enable HCFA to provide to current and potential beneficiaries the information they need to make informed decisions with respect to the available choices for Medicare coverage.

(b) *Timing and recipients of the information.* HCFA mails a notice containing the information described in paragraph (c) of this section—

(1) At least 15 days before each annual election period, to each individual eligible to elect an M+C plan; and

(2) To the extent practicable, not later than 30 days before his or her initial coverage election period to each individual who will become eligible to elect an M+C plan.

(c) *Content of notice*—(1) *Benefits under original Medicare.* (i) Covered services.

(ii) Beneficiary cost sharing, such as deductibles, coinsurance, and copayment amounts.

(iii) Any beneficiary liability for balance billing.

(2) *Enrollment procedures.* Information and instructions on how to exercise election options under this subpart.

(3) *Rights.* A general description of procedural rights (including grievance and appeals procedures) under original Medicare and the M+C program and the right to be protected against discrimination based on factors related to health status in accordance with § 422.110.

(4) *Medigap and Medicare Select.* A general description of the benefits, enrollment rights, and requirements applicable to Medicare supplemental policies under section 1882 of the Act, and provisions relating to Medicare Select policies under section 1882(t) of the Act.

(5) *Potential for contract termination.* The fact that an M+C organization may terminate or refuse to renew its contract, or reduce the service area included in its contract, and the effect that any of those actions may have on individuals enrolled in that organization's M+C plan.

(6) *Comparative information.* A list of M+C plans that are or will be available to residents of the service area in the following calendar year, and, for each available plan, information on the aspects described in paragraphs (c)(7) through (c)(11) of this section, presented in a manner that facilitates comparison among the plans.

(7) *Benefits.* (i) Covered services beyond those provided under original Medicare.

(ii) Any beneficiary cost sharing.

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an M+C MSA plan, the amount of the annual MSA deposit and the differences in cost-sharing, enrollee premiums, and balance billing, as compared to M+C plans.

(v) In the case of a M+C private fee-for-service plan, differences in cost-sharing, enrollee premiums, and balance billing, as compared to M+C plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The types of providers that participate in the plan's network and the extent to which an enrollee may select among those providers.

(viii) The coverage of emergency and urgently needed services.

(8) *Premiums.* (i) The M+C monthly basic beneficiary premiums.

(ii) The M+C monthly supplemental beneficiary premium.

(9) *The plan's service area.*

(10) *Quality and performance indicators* for benefits under a plan to

the extent they are available as follows (and how they compare with indicators under original Medicare):

(i) Disenrollment rates for Medicare enrollees for the 2 previous years, excluding disenrollment due to death or moving outside the plan's service area, calculated according to HCFA guidelines.

(ii) Medicare enrollee satisfaction.

(iii) Health outcomes.

(iv) Plan-level appeal data.

(v) The recent record of plan compliance with the requirements of this part, as determined by the Secretary.

(vi) Other performance indicators.

(11) *Supplemental benefits.* Whether the plan offers mandatory supplemental benefits or offers optional supplemental benefits and the premiums and other terms and conditions for those benefits.

(d) *Format and updating.* The information is written and formatted using language that is easily understandable, and is updated at least annually.

(e) *Mailing.* The mailing is coordinated, to the extent practicable, with the mailing of the annual notice of Medicare benefits under section 1804 of the Act.

§ 422.66 Coordination of enrollment and disenrollment through M+C organizations.

(a) *Enrollment.* An individual who wishes to elect an M+C plan offered by an M+C organization may make or change his or her election during the election periods specified in § 422.62 by filing the appropriate election form with the organization or through other mechanisms as determined by HCFA.

(b) *Disenrollment*—(1) *Basic rule.* An individual who wishes to disenroll from an M+C plan may change his or her election during the election periods specified in § 422.62 in either of the following manners:

(i) Elect a different M+C plan by filing the appropriate election form with the M+C organization or through other mechanisms as determined by HCFA.

(ii) Submit a signed and dated request for disenrollment to the M+C organization in the form and manner prescribed by HCFA or file the appropriate disenrollment form through other mechanisms as determined by HCFA.

(2) *When a disenrollment request is considered to have been made.* A disenrollment request is considered to have been made on the date the disenrollment request is received by the M+C organization.

(3) *Responsibilities of the M+C organization.* The M+C organization must—

(i) Submit a disenrollment notice to HCFA within 15 days of receipt;

(ii) Provide the enrollee with a copy of the request for disenrollment; and

(iii) In the case of a plan where lock-in applies, also provide the enrollee with a statement explaining that he or she—

(A) Remains enrolled until the effective date of disenrollment; and

(B) Until that date, neither the M+C organization nor HCFA pays for services not provided or arranged for by the M+C plan in which the enrollee is enrolled; and

(iv) File and retain disenrollment requests for the period specified in HCFA instructions.

(4) *Effect of failure to submit disenrollment notice to HCFA promptly.* If the M+C organization fails to submit the correct and complete notice required in paragraph (b)(3)(i) of this section, the M+C organization must reimburse HCFA for any capitation payments received after the month in which payment would have ceased if the requirement had been met timely.

(5) *Retroactive disenrollment.* HCFA may grant retroactive disenrollment in the following cases:

(i) There never was a legally valid enrollment.

(ii) A valid request for disenrollment was properly made but not processed or acted upon.

(c) *Election by default: Initial coverage election period.* An individual who fails to make an election during the initial coverage election period is deemed to have elected original Medicare.

(d) *Conversion of enrollment (seamless continuation of coverage*)—(1) *Basic rule.* An M+C plan offered by an M+C organization must accept any individual (residing in the service area or continuation area of the M+C plan) who is enrolled in a health plan offered by an M+C organization (regardless of whether the individual has end-stage renal disease) during the month immediately preceding the month in which he or she is entitled to both Part A and Part B as provided by § 422.50(a)(2) and (a)(3).

(2) *Reserved vacancies.* Subject to HCFA's approval, an M+C organization may set aside a reasonable number of vacancies in order to accommodate enrollment of conversions. Any set aside vacancies that are not filled within a reasonable time must be made available to other M+C eligible individuals.

(3) *Effective date of conversion.* Unless the individual chooses to disenroll from the health plan offered by the M+C organization, the individual's conversion to an M+C enrollee is effective the month in which he or she is entitled to both Part A and Part B.

(4) *Prohibition against disenrollment.* The M+C organization may disenroll an individual who is converting under the provisions of paragraph (a) of this section only under the conditions specified in § 422.74.

(5) *Election form.* The individual who is converting must complete and sign an election form as described in § 422.60(c)(1).

(6) *Submittal of information to HCFA.* The M+C organization must transmit the information necessary for HCFA to add the individual to its records as specified in § 422.60(e)(6).

(e) *Maintenance of enrollment.* An individual who has made or is deemed to have made an election under this section is considered to have continued to have made that election until either of the following, whichever occurs first:

(1) The individual changes the election under this section.

(2) The elected M+C plan is discontinued or no longer serves the service area in which the individual resides, and the organization does not offer or the individual does not elect the option of continuing enrollment, as provided in § 422.54.

422.68 Effective dates of coverage and change of coverage.

(a) *Initial coverage election period.* An election made during an initial coverage election period as described in § 422.62(a)(1) is effective as of the first day of the month of entitlement to both Part A and Part B.

(b) *Annual election periods.* For an election or change of election made during an annual election period as described in § 422.62(a)(2), coverage is effective as of the first day of the following calendar year.

(c) *Open enrollment periods.* For an election or change of election made during an open enrollment period as described in § 422.62(a)(3) through (a)(5), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

(d) *Special election periods.* For an election or change of election made during a special election period as described in § 422.62(b), the effective date of coverage shall be determined by HCFA, to the extent practicable, in a manner consistent with protecting the continuity of health benefits coverage.

(e) *Special election period for individual age 65.* For an election of coverage under original Medicare made during a special election period for an individual age 65 as described in

§ 422.62(c), coverage is effective as of the first day of the first calendar month following the month in which the election is made.

§ 422.74 Disenrollment by the M+C organization.

(a) *General rule.* Except as provided in paragraphs (b) through (d) of this section, an M+C organization may not—

(1) Disenroll an individual from any M+C plan it offers; or

(2) Orally or in writing, or by any action or inaction, request or encourage an individual to disenroll.

(b) *Basis for disenrollment*—(1) *Optional disenrollment.* An M+C organization may disenroll an individual from an M+C plan it offers in any of the following circumstances:

(i) Any monthly basic and supplementary beneficiary premiums are not paid on a timely basis, subject to the grace period for late payment established under paragraph (d)(1) of this section.

(ii) The individual has engaged in disruptive behaviors specified at paragraph (d)(2) of this section.

(iii) The individual provides fraudulent information on his or her election form or permits abuse of his or her enrollment card as specified in paragraph (d)(3) of this section.

(2) *Required disenrollment.* An M+C organization must disenroll an individual from an M+C plan it offers in any of the following circumstances:

(i) The individual no longer resides in the M+C plan's service area as specified in paragraph (d)(4) of this section, and optional continued enrollment has not been offered or elected pursuant to § 422.54.

(ii) The individual loses entitlement to Part A or Part B benefits as described in paragraph (d)(5) of this section.

(iii) Death of the individual as described in paragraph (d)(6) of this section.

(3) *Plan termination or reduction of service area or continuation area.* An M+C plan offered by an M+C organization that terminates with respect to all M+C individuals in the area where the individual resides or is terminated or reduces service area or continuation area must comply with the process for disenrollment set forth at paragraph (d)(7) of this section.

(c) *Notice requirement.* If the disenrollment is for any of the reasons specified in paragraphs (b)(1) through (b)(2)(i) and (b)(3) of this section, that is, other than death or loss of entitlement to Part A or Part B, the M+C organization must give the individual a written notice of the disenrollment with an explanation of why the M+C organization is planning to disenroll the individual.

(1) The notice must be mailed to the individual before submission of the disenrollment notice to HCFA.

(2) The notice must include an explanation of the individual's right to a hearing under the M+C organization's grievance procedures.

(d) *Process for disenrollment*—(1) *Monthly basic and supplementary premiums are not paid timely.* An M+C organization may disenroll an individual from the M+C plan for failure to pay any basic or supplementary premiums if the M+C organization—

(i) Makes a reasonable effort to collect unpaid premium amounts by sending a written notice of nonpayment to the enrollee within 20 days after the date that the delinquent charges were due—

(A) Alerting the individual that the premiums are delinquent;

(B) Providing the individual with an explanation of the disenrollment procedures and any lock-in requirements of the M+C plan; and

(C) Advising that failure to pay the premiums within the 90-day grace period will result in termination of M+C coverage;

(ii) Only disenrolls a Medicare enrollee when the organization has not received payment within 90 days after the date it has sent the notice of nonpayment to the enrollee; and

(iii) Gives the individual a written notice of disenrollment that meets the requirements set forth in paragraph (c) of this section.

(2) *Disenrollment for disruptive behavior*—(i) *Basis for disenrollment.* An M+C organization may disenroll an individual from the M+C plan if the individual's behavior is disruptive, unruly, abusive, or uncooperative to the extent that his or her continued enrollment in the plan seriously impairs the M+C plan's ability to furnish services to either the particular individual or other individuals enrolled in the plan.

(ii) *Effort to resolve the problem.* The M+C organization must make a serious effort to resolve the problems presented by the individual, including the use (or attempted use) of the M+C organization's grievance procedures. The beneficiary has a right to submit any information or explanation that he or she may wish to submit to the M+C organization.

(iii) *Consideration of extenuating circumstances.* The M+C organization must establish that the individual's behavior is not related to the use of medical services or to diminished mental capacity.

(iv) *Documentation.* The M+C organization must document the enrollee's behavior, its own efforts to resolve any problems, and any extenuating circumstances, as described in paragraphs (d)(2)(i) through (d)(2)(iii) of this section.

(v) *HCFA review of the M+C organization's proposed disenrollment.* (A) HCFA decides after reviewing the documentation submitted by the M+C organization and any information submitted by the beneficiary (which the M+C organization must forward to HCFA) whether the M+C organization has met the disenrollment requirements.

(B) HCFA makes the decision within 20 working days after receipt of the documentation and notifies the M+C organization within 5 working days after making its decision.

(vi) *Effective date of disenrollment.* If HCFA permits an M+C organization to disenroll an individual for disruptive behavior, the termination is effective the first day of the calendar month after the month in which the M+C organization gives the individual written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(3) *Individual commits fraud or permits abuse of enrollment care.* (i) *Basis for disenrollment.* An M+C organization may disenroll the individual from an M+C plan if the individual—

(A) Knowingly provides, on the election form, fraudulent information that materially affects the individual's eligibility to enroll in the M+C plan; or

(B) Intentionally permits others to use his or her enrollment card to obtain services under the M+C plan.

(ii) *Notice of disenrollment.* The M+C organization must give the individual a written notice of the disenrollment that meets the requirements set forth in paragraph (c) of this section.

(iii) *Report to HCFA.* The M+C organization must report to HCFA any disenrollment based on fraud or abuse by the individual.

(4) *Individual no longer resides in the M+C plan's service area*—(i) *Basis for disenrollment.* Unless continuation of enrollment is elected under § 422.54, the M+C organization must disenroll an individual who moves out of a plan's service area if the M+C organization establishes, on the basis of a written statement from the individual, or other evidence acceptable to HCFA, that the individual has moved out of a plan's service area for over 12 months.

(ii) *Notice of disenrollment.* The M+C organization must give the individual a written notice of the disenrollment that

meets the requirements set forth in paragraph (c) of this section.

(5) *Loss of entitlement to Part A or Part B benefits.* If an individual is no longer entitled to Part A or Part B benefits, HCFA notifies the M+C organization that the disenrollment is effective the first day of the calendar month following the last month of entitlement to Part A or Part B benefits.

(6) *Death of the individual.* If the individual dies, disenrollment is effective the first day of the calendar month following the month of death.

(7) *Plan termination or area reduction.* (i) If the plan terminates or is terminated or the service area or continuation area are reduced with respect to all M+C enrollees in the area in which they reside, the M+C organization must give each Medicare enrollee a written notice of the effective date of the plan termination or area reduction and a description of alternatives for obtaining benefits under the M+C program.

(ii) The notice must be sent before the effective date of the plan termination or area reduction.

(e) *Consequences of disenrollment*—(1) *Disenrollment for non-payment of premiums, disruptive behavior, fraud or abuse, loss of Part A or Part B.* An individual who is disenrolled under paragraph (b)(1)(i), (b)(1)(ii), (b)(1)(iii), or paragraph (b)(2)(ii) of this section is deemed to have elected original Medicare.

(2) *Disenrollment based on plan termination, area reduction, or individual moves out of area.* (i) An individual who is disenrolled under paragraph (b)(2)(i) or (b)(3) of this section has a special election period in which to make a new election as provided in § 422.62(b)(1) and (b)(2).

(ii) An individual who fails to make an election during the special election period is deemed to have elected original Medicare.

§ 422.80 Approval of marketing materials and election forms.

(a) *HCFA review of marketing materials.* An M+C organization may not distribute any marketing materials (as defined in paragraph (b)), or election forms, or make such materials or forms available to individuals eligible to elect an M+C plan, unless—

(1) At least 45 days before the date of distribution the M+C organization has submitted the material or form to HCFA for review under the guidelines in paragraph (c); and

(2) HCFA has not disapproved the distribution of the material or form.

(b) *Definition of marketing materials.* Marketing materials include any informational materials targeted to Medicare beneficiaries which:

(1) Promote the M+C organization, or any M+C plan offered by the M+C organization;

(2) Inform Medicare beneficiaries that they may enroll, or remain enrolled in, an M+C plan offered by the M+C organization;

(3) Explain the benefits of enrollment in an M+C plan, or rules that apply to enrollees;

(4) Explain how Medicare services are covered under an M+C plan, including conditions that apply to such coverage;

(5) Examples of marketing materials include, but are not limited to:

(i) General audience materials such as general circulation brochures, newspapers, magazines, television, radio, billboards, yellow pages, or the internet.

(ii) Marketing representative materials such as scripts or outlines for telemarketing or other presentations.

(iii) Presentation materials such as slides and charts.

(iv) Promotional materials such as brochures or leaflets, including materials for circulation by third parties (*e.g.*, physicians or other providers).

(v) Membership communication materials such as membership rules, subscriber agreements (evidence of coverage), member handbooks, and newsletters.

(vi) Letters to members about contractual changes; changes in providers, premiums, benefits, plan procedures *etc.*

(vii) Membership or claims processing activities (*e.g.*, materials on rules involving non-payment of premiums, confirmation of enrollment or disenrollment, or annual notification information).

(c) *Guidelines for HCFA Review*. In reviewing marketing material or election forms under paragraph (a) of this section, HCFA determines that the marketing materials:

(1) Provide, in a format (and, where appropriate, print size), and using standard terminology that may be specified by HCFA, the following information to Medicare beneficiaries interested in enrolling:

(i) Adequate written description of rules (including any limitations on the providers from whom services can be obtained), procedures, basic benefits and services, and fees and other charges.

(ii) Adequate written description of any supplemental benefits and services.

(iii) Adequate written explanation of the grievance and appeals process, including differences between the two, and when it is appropriate to use each.

(iv) Any other information necessary to enable 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 service and continuation area.

(3) Include in the written materials notice that the organization is authorized by law to refuse to renew its contract with HCFA, that HCFA also may refuse to renew the contract, and that termination or non-renewal may result in termination of the beneficiary's enrollment in the plan.

(4) Contain no statements that are inaccurate or misleading or otherwise make misrepresentations.

(5) For markets with a significant non-English speaking population, provide materials in the language of these individuals.

(d) *Deemed approval (one-stop shopping).* If HCFA has not disapproved the distribution of marketing material or forms submitted by an M+C organization with respect to an M+C plan in an area, HCFA is deemed not to have disapproved the distribution in all other areas covered by the M+C plan and organization except with regard to any portion of the material or form that is specific to the particular area.

(e) *Standards for M+C organization marketing.*

(1) In conducting marketing activities, M+C organizations may not:

(i) Provide for cash or other monetary rebates as an inducement for enrollment or otherwise. This does not prohibit explanation of any legitimate benefits the beneficiary might obtain as an enrollee of the M+C plan, such as eligibility to enroll in a supplemental benefit plan that covers deductibles and coinsurance, or preventive services.

(ii) Engage in any discriminatory activity such as, for example, attempts to recruit Medicare beneficiaries from higher income areas without making comparable efforts to enroll Medicare beneficiaries from lower income areas.

(iii) Solicit door-to-door for Medicare beneficiaries.

(iv) Engage in activities that could mislead or confuse Medicare beneficiaries, or misrepresent the M+C organization, the M+C organization may not claim that it is recommended or endorsed by HCFA or Medicare or that HCFA or Medicare recommends that the beneficiary enroll in the M+C plan. It may, however, explain that the organization is approved for participation in Medicare.

(v) Distribute marketing materials for which, before expiration of the 45-day

period, the M+C organization receives from HCFA written notice of disapproval because it is inaccurate or misleading, or misrepresents the M+C organization, its marketing representatives, or HCFA.

(2) In its marketing, the M+C organization must:

(i) Demonstrate the HCFA's satisfaction that marketing resources are allocated to marketing to the disabled Medicare population as well as beneficiaries age 65 and over.

(ii) Establish and maintain a system for confirming that enrolled beneficiaries have in fact, enrolled in the M+C plan, and understand the rules applicable under the plan.

(f) *Employer group retiree Marketing.* HCFA may permit M+C organizations to develop marketing materials designed for members of an employer group who are eligible for employer-sponsored benefits through the M+C organization, and to furnish these materials only to such group members. While such materials must be submitted for approval under paragraph (a) of this section, HCFA will only review potions of these materials that related to M+C plan benefits.

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Subpart C—Benefits and Beneficiary Protections

§ 422.100 General requirements.

(a) *Basic rule.* Subject to the conditions and limitations set forth in this subpart, an M+C organization offering an M+C plan must provide enrollees in that plan with coverage of the basic benefits described in § 422.101 (and, to the extent applicable, the benefits described in § 422.102) by furnishing the benefits directly or through arrangements, or by paying for the benefits. HCFA reviews these benefits subject to the requirements of § 422.100(g) and the requirements in subpart G of this part.

(b) *Services of noncontracting providers and suppliers.* (1) An M+C organization must make timely and reasonable payment to or on behalf of the plan enrollee for the following services obtained from a provider or supplier that does not contract with the M+C organization to provide services covered by the M+C plan:

(i) Emergency services as defined in § 422.2.

(ii) Urgently needed services as defined § 422.2.

(iii) Renal dialysis services provided while the enrollee was temporarily outside the plan's service area.

(iv) Post-stabilization care services that were—

(A) Pre-approved by the organization; or

(B) Were not pre-approved by the organization because the organization did not respond to the provider of post-stabilization care services' request for pre-approval within 1 hour after being requested to approve such care, or could not be contacted for pre-approval.

(v) Services for which coverage has been denied by the M+C organization and found (upon appeal under subpart M of this part) to be services the enrollee was entitled to have furnished, or paid for, by the M+C organization.

(2) An M+C plan (other than an M+C MSA plan) offered by an M+C organization satisfies paragraph (a) of this section with respect to benefits for services furnished by a noncontracting provider if that M+C plan provides payment in an amount the provider would have received under original Medicare (including balance billing permitted under Medicare Part A and Part B).

(c) *Types of benefits.* An M+C plan may include two types of benefits:

(1) Basic benefits as defined in § 422.2.

(2) Supplemental benefits, which consist of—

(i) Mandatory supplemental benefits as defined in § 422.2; and

(ii) Optional supplemental benefits as defined in § 422.2.

(d) *Availability and structure of plans.* An M+C organization offering an M+C plan must offer it—

(1) To all Medicare beneficiaries residing in the service area of the M+C plan;

(2) At a uniform premium; and

(3) With a uniform level of cost-sharing, as defined in § 422.2.

(e) *Terms of M+C plans.* Terms of M+C plans described in instructions to beneficiaries, as required by § 422.111, will include basic and supplemental benefits and terms of coverage for those benefits.

(f) *Multiple plans in one service area.* An M+C organization may offer more than one M+C plan in the same service area subject to the conditions and limitations set forth in this subpart for each M+C plan.

(g) *HCFA review and approval of M+C plans.* HCFA reviews and approves each M+C plan to ensure that the plan does not—

(1) Promote discrimination;

(2) Discourage enrollment;

(3) Steer specific subsets of Medicare beneficiaries to particular M+C plans; or

(4) Inhibit access to services.

(h) *Benefits affecting screening mammography, influenza vaccine, and pneumococcal vaccine.* (1) Enrollees of M+C organizations may directly access (through self-referral) screening mammography and influenza vaccine.

(2) M+C organizations may not impose cost-sharing for influenza vaccine and pneumococcal vaccine.

(i) *Requirements relating to Medicare conditions of participation.* Basic benefits must be provided through providers meeting the requirements in § 422.204(a)(3).

(j) *Choice of practitioners.* Consistent with the requirements of § 422.204 relating to the prohibition of discrimination against providers, if more than one type of practitioner is qualified to furnish a particular service, the M+C organization may select the type of practitioner to be used.

§ 422.101 Requirements relating to basic benefits.

Except as specified in § 422.264 (for entitlement that begins or ends during a hospital stay) and § 422.266 (with respect to hospice care), each M+C organization must—

(a) Provide coverage of, through the provision of or payment for, all services that are covered by Part A and Part B of Medicare (if the enrollee is entitled to benefits under both parts) or by Medicare Part B (if entitled only under Part B) and that are available to beneficiaries residing in the geographic area in which services are covered under the M+C plan (or to Part A and Part B services obtained outside the geographic area if it is common practice to refer patients to sources outside that geographic area); and

(b) Comply with—

(1) HCFA's national coverage decisions; and

(2) Written coverage decisions of local carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered under the M+C plan.

§ 422.102 Supplemental benefits.

(a) *Mandatory supplemental benefits.* (1) Subject to HCFA's approval, an M+C organization may require Medicare enrollees of an M+C plan other than an MSA plan to accept and pay for services in addition to those included in the basic benefits described in § 422.101.

(2) If the M+C organization imposes mandatory supplemental benefits, it must impose them on all Medicare beneficiaries enrolled in the M+C plan.

(3) HCFA approves mandatory supplemental benefits if it determines that imposition of the mandatory benefits will not substantially discourage Medicare beneficiaries from enrolling in the M+C plan.

(b) *Optional supplemental benefits.* Except as provided in § 422.104 in the

case of MSA plans, each M+C organization may offer (for election by the enrollee and without regard to health status) services that are in addition to those included in the basic benefits described in § 422.101 and any mandatory supplemental benefits described in paragraph (a) of this section. Optional supplemental benefits must be offered to all Medicare beneficiaries enrolled in the M+C plan.

(c) *Payment for supplemental services.* All supplemental benefits are paid for directly by (or on behalf of) the enrollee of the M+C plan.

§ 422.103 Benefits under an M+C MSA plan.

(a) *General rule.* An M+C organization offering an M+C MSA plan must make available to an enrollee, or provide reimbursement for, at least the services described under in § 422.101 after the enrollee incurs countable expenses equal to the amount of the plan's annual deductible.

(b) *Countable expenses.* An M+C organization offering an M+C MSA plan must count toward the annual deductible at least all amounts that would be paid for the particular service under original Medicare, including amounts that would be paid by the enrollee as deductibles or coinsurance.

(c) *Services after the deductible.* For services received by the enrollee after the annual deductible is satisfied, an M+C organization offering an M+C MSA plan must pay, at a minimum, the lesser of the following amounts:

(1) 100 percent of the expense of the services.

(2) 100 percent of the amounts that would have been paid for the services under original Medicare, including amounts that would be paid by the enrollee as deductibles and coinsurance.

(d) *Annual deductible.* The annual deductible for an M+C MSA plan—

(1) For contract year 1999, may not exceed $6,000; and

(2) For subsequent contract years may not exceed the deductible for the preceding contract year, increased by the national per capita growth percentage determined under § 422.252(b).

§ 422.104 Special rules on supplemental benefits for M+C MSA plans.

(a) An M+C organization offering an M+C MSA plan may not provide supplemental benefits that cover expenses that count towards the deductible specified in § 422.103(d).

(b) In applying the limitation of paragraph (a) of this section, the following kinds of policies are not considered as covering the deductible:

(1) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(2) A policy of insurance in which substantially all of the coverage relates to liabilities incurred under workers' compensation laws, tort liabilities, liabilities relating to use or ownership of property, and any other similar liabilities that HCFA may specify by regulation.

(3) A policy of insurance that provides coverage for a specified disease or illness or pays a fixed amount per day (or other period) of hospitalization.

§ 422.105 Special rules for point of service option.

(a) A POS benefit is an option that an M+C organization may offer in an M+C coordinated care plan or network M+C MSA plan to provide enrollees with additional choice in obtaining specified health care services from individuals or entities that do not have a contract with the M+C organization to provide service through the M+C coordinated care plan or network M+C MSA plan offering the POS option. The plan may offer a POS option—

(1) Under a coordinated care plan only as an additional benefit as described in § 422.312;

(2) Under a coordinated care plan only as a mandatory supplemental benefit as described in § 422.102(a); or

(3) Under a coordinated care plan or network MSA plan as an optional supplemental benefit as described in § 422.102(b).

(b) *Approval required.* An M+C organization may not implement a POS benefit until it has been approved by HCFA.

(c) *Ensuring availability and continuity of care.* An M+C network plan that includes a POS benefit must continue to provide all benefits and ensure access as required under this subpart.

(d) *Enrollee information and disclosure.* The disclosure requirements specified in § 422.111 apply in addition to the following requirements:

(1) *Written rules.* M+C organizations must maintain written rules on how to obtain health benefits through the POS benefit.

(2) *Evidence of coverage document.* The M+C organization must provide to beneficiaries enrolling in a plan with a POS benefit an ''evidence of coverage'' document, or otherwise provide written documentation, that specifies all costs and possible financial risks to the enrollee, including—

(i) Any premiums and cost-sharing for which the enrollee is responsible;

(ii) Annual limits on benefits and on out-of-pocket expenditures;

(iii) Potential financial responsibility for services for which the plan denies payment because they were not covered under the POS benefit, or exceeded the dollar limit for the benefit; and

(iv) The annual maximum out-of-pocket expense an enrollee could incur.

(e) *Prompt payment.* Health benefits payable under the POS benefit are subject to the prompt payment requirements in § 422.520.

(f) *POS Related Data.* An M+C organization that offers a POS benefit must report data on the POS benefit in the form and manner prescribed by HCFA.

§ 422.106 Special arrangements with employer groups.

An M+C organization may negotiate with an employer group to provide benefits to members of the employer group who are enrolled in an M+C plan offered by the organization. While these negotiated employer group benefits may be designed to complement the benefits available to Medicare beneficiaries enrolled in the M+C plan, they are offered by the employer group independently as the product of private negotiation. Examples of such employer-benefits include the following:

(a) Reductions in the portion of the premium that the M+C organization charges to the beneficiary.

(b) Reductions in portion of other cost sharing amounts the M+C organization charges to the beneficiary.

(c) The addition of benefits that may require additional premium and cost sharing. The addition of benefits and the charges for those benefits are not subject to HCFA review or approval.

§ 422.108 Medicare secondary payer (MSP) procedures.

(a) *Basic rule.* HCFA does not pay for services to the extent that Medicare is not the primary payer under section 1862(b) of the Act and part 411 of this chapter.

(b) *Responsibilities of the M+C organization.* The M+C organization must, for each M+C plan—

(1) Identify payers that are primary to Medicare under section 1862(b) of the Act and part 411 of this chapter;

(2) Determine the amounts payable by those payers; and

(3) Coordinate its benefits to Medicare enrollees with the benefits of the primary payers.

(c) *Charges to other entities.* The M+C organization may charge, or authorize a provider to charge, other individuals or entities for covered Medicare services

for which Medicare is not the primary payer, as specified in paragraphs (d) and (e) of this section.

(d) *Charge to other insurers or the enrollee.* If a Medicare enrollee receives from an M+C organization covered services that are also covered under State or Federal workers' compensation, any no-fault insurance, or any liability insurance policy or plan, including a self-insured plan, the M+C organization may charge, or authorize a provider to charge any of the following—

(1) The insurance carrier, the employer, or any other entity that is liable for payment for the services under section 1862(b) of the Act and part 411 of this chapter.

(2) The Medicare enrollee, to the extent that he or she has been paid by the carrier, employer, or entity for covered medical expenses.

(e) *Charge to group health plans (GHPs) and large group health plans (LGHPs).* An M+C organization may charge a GHP or LGHP for services it furnishes to a Medicare enrollee who is also covered under the GHP or LGHP and may charge the Medicare enrollee to the extent that he or she has been paid by the GHP or LGHP.

§ 422.109 Effect of national coverage determinations (NCDs).

(a) If HCFA determines and announces that an NCD meets the criteria for ''significant cost'' described in paragraph (c) of this section, an M+C organization is not required to assume risk for the costs of that service until the contract year for which the annual M+C capitation rate is determined on a basis that includes the cost of the NCD service.

(b) The M+C organization must furnish, arrange or pay for an NCD ''significant cost'' service prior to the adjustment of the annual M+C capitation rate. The following rules apply to such services:

(1) Medicare payment for the service is:

(i) In addition to the capitation payment to the M+C organization; and

(ii) Made directly by the fiscal intermediary and carrier to the M+C organization in accordance with original Medicare payment rules, methods, and requirements.

(2) NCD costs for which HCFA intermediaries and carriers will not make payment and are the responsibility of the M+C organization are—

(i) Services necessary to diagnose a condition covered by the NCD;

(ii) Most services furnished as follow-up care to the NCD service;

(iii) Any service that is already a Medicare-covered service and included in the annual M+C capitation rate; and

(iv) Any service, including the costs of the NCD service itself, to the extent the M+C organization is already obligated to cover it as an additional benefit under § 422.312 or supplemental benefit under § 422.102.

(3) NCD costs for which HCFA intermediaries and carriers make payment are—

(i) Costs relating directly to the provision of services related to the NCD that were noncovered services prior to the issuance of the NCD; and

(ii) A service that is not included in the M+C per capita payment rate.

(4) If the M+C organization does not provide or arrange for the service consistent with HCFA's NCD, enrollees may obtain the services through qualified providers not under contract to the M+C organization, and the organization will pay for the services consistent with § 422.109(c).

(5) Beneficiaries are liable for Part A deductible and any applicable coinsurance amounts.

(c) The term ''significant cost'' as it relates to a particular NCD means either of the following:

(1) The average cost of furnishing a single service exceeds a cost threshold that—

(i) For calendar years 1998 and 1999, is $100,000;

(ii) For calendar year 2000 and subsequent calendar years, is the preceding year's dollar threshold adjusted to reflect the national per capita growth percentage described in § 422.254(b).

(2) The estimated cost of all of Medicare services furnished nationwide as a result of a particular NCD represents at least 0.1 percent of the national standardized annual capitation rate (see § 422.254(f)), multiplied by the total number of Medicare beneficiaries nationwide for the applicable calendar year.

§ 422.110 Discrimination against beneficiaries prohibited.

(a) *General prohibition.* Except as provided in paragraph (b) of this section, an M+C organization may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an M+C plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following:

(1) Medical condition, including mental as well as physical illness.

(2) Claims experience.

(3) Receipt of health care.

(4) Medical history.

(5) Genetic information.

(6) Evidence of insurability, including conditions arising out of acts of domestic violence.

(7) Disability.

(b) *Exception.* An M+C organization may not enroll an individual who has been medically determined to have end-stage renal disease. However, an enrollee who develops end-stage renal disease while enrolled in a particular M+C organization may not be disenrolled for that reason. An individual who is an enrollee of a particular M+C organization, and resides in the M+C plan service area at the time he or she first becomes M+C eligible, is considered to be ''enrolled'' in the M+C organization for purposes of the preceding sentence.

(c) Plans are required to observe the provisions of the Civil Rights Act, Age Discrimination Act, and Americans with Disabilities Act (see § 422.501(h)).

§ 422.111 Disclosure requirements.

(a) *Detailed description of plan provisions.* An M+C organization must disclose the information specified in § 422.64 and in paragraph (b) of this section—

(1) To each enrollee electing an M+C plan it offers;

(2) In clear, accurate, and standardized form; and

(3) At the time of enrollment and at least annually thereafter.

(b) *Content of plan description.* The description must include the following information:

(1) *Service area.* The M+C plan's service area and any enrollment continuation area.

(2) *Benefits.* The benefits offered under the plan, including applicable conditions and limitations, premiums and cost-sharing (such as copayments, deductibles, and coinsurance) and any other conditions associated with receipt or use of benefits; and for purposes of comparison—

(i) The benefits offered under original Medicare, including the content specified in § 422.64(c);

(ii) For an M+C MSA plan, the benefits under other types of M+C plans; and

(iii) The availability of the Medicare hospice option and any approved hospices in the service area, including those the M+C organization owns, controls, or has a financial interest in.

(3) *Access.* The number, mix, and distribution (addresses) of providers from whom enrollees may obtain services; any out-of network coverage; any point-of-service option, including the supplemental premium for that

option; and how the M+C organization meets the requirements of §§ 422.112 and 422.114 for access to services offered under the plan.

(4) *Out-of-area coverage.* Out-of-area coverage provided by the plan.

(5) *Emergency coverage.* Coverage of emergency services, including—

(i) Explanation of what constitutes an emergency, referencing the definitions of emergency services and emergency medical condition at § 422.2;

(ii) The appropriate use of emergency services, stating that prior authorization cannot be required;

(iii) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; and

(iv) The locations where emergency care can be obtained and other locations at which contracting physicians and hospitals provide emergency services and post-stabilization care included in the M+C plan.

(6) *Supplemental benefits.* Any mandatory or optional supplemental benefits and the premium for those benefits.

(7) *Prior authorization and review rules.* Prior authorization rules and other review requirements that must be met in order to ensure payment for the services. The M+C organization must instruct enrollees that, in cases where noncontracting providers submit a bill directly to the enrollee, the enrollee should not pay the bill, but submit it to the M+C organization for processing and determination of enrollee liability, if any.

(8) *Grievance and appeals procedures.* All grievance and appeals rights and procedures.

(9) *Quality assurance program.* A description of the quality assurance program required under § 422.152.

(10) *Disenrollment rights and responsibilities.*

(c) *Disclosure upon request.* Upon request of an individual eligible to elect an M+C plan, an M+C organization must provide to the individual the following information:

(1) The information required under § 422.64(c).

(2) The procedures the organization uses to control utilization of services and expenditures.

(3) The number of disputes, and the disposition in the aggregate, in a manner and form described by the Secretary. Such disputes shall be categorized as

(i) Grievances according to § 422.564; and

(ii) Appeals according to § 422.578 et. seq.

(4) A summary description of the method of compensation for physicians.

(5) Financial condition of the M+C organization, including the most recently audited information regarding, at least, a description of the financial condition of the M+C organization offering the plan.

(d) *Changes in rules.* If an M+C organization intends to change its rules for an M+C plan, it must—

(1) Submit the changes for HCFA review under the procedures of § 422.80; and

(2) Give notice to all enrollees 30 days before the intended effective date of the changes.

(e) *Changes to provider network.* The M+C organization must make a good faith effort to provide written notice of a termination of a contracted provider within 15 working days of receipt or issuance of a notice of termination, as described in § 422.204(c)(4), to all enrollees who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. When a contract termination involves a primary care professional, all enrollees who are patients of that primary care professional must also be notified.

§ 422.112 Access to services.

(a) *Rules for coordinated care plans and network M+C MSA plans.* An M+C organization that offers an M+C coordinated care plan or network M+C MSA plan may specify the networks of providers from whom enrollees may obtain services if the following conditions are met:

(1) The M+C organization ensures that all covered services, including additional or supplemental services contracted for by (or on behalf of) the Medicare enrollee, are available and accessible under the plan. To do this, the M+C organization must do the following:

(i) Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically utilized in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.

(ii) Select the panel of PCPs from which the enrollee selects a PCP.

(iii) Provide or arrange for necessary specialty care, and in particular—

(A) Women enrollees may choose direct access to a women's health specialist within the network for women's routine and preventive health care services provided as basic benefits (as defined in § 422.2) while the plan maintains a PCP or some other means for continuity of care; and

(B) Plans must have procedures approved by HCFA for—

(*1*) Identification of individuals with complex or serious medical conditions;

(*2*) Assessment of those conditions, including medical procedures to diagnose and monitor them on an ongoing basis; and

(*3*) Establishment and implementation of a treatment plan appropriate to those conditions, with an adequate number of direct access visits to specialists to accommodate the treatment plan. Treatment plans must be time-specific and updated periodically by the PCP.

(2) In the case of involuntary termination of an M+C plan or specialist(s) for a reason other than for cause, the M+C organization must do the following:

(i) Inform beneficiaries, at the time of termination, of their right to maintain access to specialists.

(ii) Provide the names of other M+C plans in the area that contract with specialists of the beneficiary's choice, as well as an explanation of the process the beneficiary would need to follow should he or she decide to return to original Medicare.

(iii) If seeking a service area expansion for an M+C plan, demonstrate that the number and type of providers available to plan enrollees are sufficient to meet projected needs of the population to be served.

(iv) Demonstrate to HCFA that its providers in an M+C plan are credentialed through the process set forth at § 422.204(a).

(v) Establish written standards for—

(A) Timeliness of access to care and member services that meet or exceed standards established by HCFA. Timely access to care and member services within a plan's provider network must be continuously monitored to ensure compliance with these standards, and the M+C organization must take corrective action as necessary;

(B) Policies and procedures (coverage rules, practice guidelines, payment policies, and utilization management) that allow for individual medical necessity determinations; and

(C) Provider consideration of beneficiary input into the provider's proposed treatment plan.

(vi) Ensure that the hours of operation of its M+C plan providers are convenient to the population served by the plan and do not discriminate against Medicare enrollees.

(vii) Ensure services are provided in a culturally competent manner to all enrollees, including those with limited

English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

(viii) Make plan services available 24 hours a day, 7 days a week, when medically necessary.

(ix) Provide coverage for emergency and urgent care services in accordance with paragraph (b) of this section.

(3) The M+C organization must ensure continuity of care and integration of services through arrangements that include, but are not limited to—

(i) Use of a practitioner who is specifically designated as having primary responsibility for coordinating the enrollee's overall health care;

(ii) Policies that specify whether services are coordinated by the enrollee's primary care practitioner or through some other means;

(iii) An ongoing source of primary care, regardless of the mechanism adopted for coordination of services;

(iv) Programs for coordination of care that coordinate services with community and social services generally available through contracting or noncontracting providers in the area served by the M+C plan, including nursing home and community-based services;

(v) Procedures to ensure that the M+C organization and its provider network have the information required for effective and continuous patient care and quality review, including procedures to ensure that—

(A) An initial assessment of each enrollee's health care needs is completed within 90 days of the effective date of enrollment.

(B) Each provider, supplier, and practitioner furnishing services to enrollees maintains an enrollee health record in accordance with standards established by the M+C organization, taking into account professional standards; and

(C) Appropriate and confidential exchange of information among provider network components;

(vi) Procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health; and

(vii) Systems to address barriers to enrollee compliance with prescribed treatments or regimens.

(b) *Special rules for all M+C organizations for emergency and urgently needed services.* (1) The M+C organization covers emergency and urgently needed services—

(i) Regardless of whether the services are obtained within or outside the organization; and

(ii) Without required prior authorization.

(2) The M+C organization may not deny payment for a condition that—

(i) Is an emergency medical condition as defined in § 422.2; or

(ii) A plan provider or other M+C organization representative instructs an enrollee to seek emergency services within or outside the plan.

(3) The physician treating the enrollee must decide when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the M+C organization.

(4) For emergency services obtained outside the M+C plan's provider network, the organization may not charge the enrollee more than $50 or what it would charge the enrollee if he or she obtained the services through the organization, whichever is less.

§ 422.114 Access to services under an M+C private fee-for-service plan.

(a) *Sufficient access.* (1) An M+C organization that offers an M+C private fee-for-service plan must demonstrate to HCFA that it has sufficient number and range of providers willing to furnish services under the plan.

(2) HCFA finds that an M+C organization meets the requirement in paragraph (a)(1) of this section if, with respect to a particular category of health care providers, the M+C organization has—

(i) Payment rates that are not less than the rates that apply under original Medicare for the provider in question;

(ii) Contracts or agreements with a sufficient number and range of providers to furnish the services covered under the M+C private fee-for-service plan; or

(iii) A combination of paragraphs (a)(2)(i) and (a)(2)(ii) of this section.

(b) *Freedom of choice.* M+C fee-for-service plans must permit enrollees to obtain services from any entity that is authorized to provide services under Medicare Part A and Part B and agrees to provide services under the terms of the plan.

§ 422.118 Confidentiality and accuracy of enrollee records.

For any medical records or other health and enrollment information it maintains with respect to enrollees, an M+C organization must establish procedures to do the following:

(a) Safeguard the privacy of any information that identifies a particular enrollee. Information from, or copies of, records may be released only to authorized individuals, and the M+C organization must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with Federal or State laws, court orders, or subpoenas.

(b) Maintain the records and information in an accurate and timely manner.

(c) Ensure timely access by enrollees to the records and information that pertain to them.

(d) Abide by all Federal and State laws regarding confidentiality and disclosure for mental health records, medical records, other health information, and enrollee information.

§ 422.128 Information on advance directives.

(a) Each M+C organization must maintain written policies and procedures that meet the requirements for advance directives, as set forth in subpart I of part 489 of this chapter. For purposes of this part, *advance directive* has the meaning given the term in § 489.100 of this chapter.

(b) An M+C organization must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the M+C organization.

(1) An M+C organization must provide written information to those individuals with respect to the following:

(i) Their rights under the law of the State in which the organization furnishes services (whether statutory or recognized by the courts of the State) to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Providers may contract with other entities to furnish this information but remain legally responsible for ensuring that the requirements of this section are met. The information must reflect changes in State law as soon as possible, but no later than 90 days after the effective date of the State law.

(ii) The M+C organization's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the M+C organization cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following:

(A) Clarify any differences between institution-wide conscientious objections and those that may be raised by individual physicians.

(B) Identify the state legal authority permitting such objection.

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(D) Provide the information specified in paragraph (a)(1) of this section to each enrollee at the time of initial enrollment. If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive, the M+C organization may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accordance with State law. The M+C organization is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

(E) Document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive.

(F) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive.

(G) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives.

(H) Provide for education of staff concerning its policies and procedures on advance directives.

(I) Provide for community education regarding advance directives that may include material required in paragraph (a)(1)(i) of this section, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the M+C organization. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State law concerning advance directives. An M+C organization must be able to document its community education efforts.

(2) The M+C organization—

(i) Is not required to provide care that conflicts with an advance directive; and

(ii) Is not required to implement an advance directive if, as a matter of conscience, the M+C organization cannot implement an advance directive and State law allows any health care provider or any agent of the provider to conscientiously object.

(3) The M+C organization must inform individuals that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.

§ 422.132 Protection against liability and loss of benefits.

Enrollees of M+C organizations are entitled to the protections specified in § 422.502(g).

Subpart D—Quality Assurance

§ 422.152 Quality assessment and performance improvement program.

(a) *General rule.* Each M+C organization that offers one or more M+C plans must have, for each of those plans, an ongoing quality assessment and performance improvement program that meets the applicable requirements of this section for the services it furnishes to its M+C enrollees.

(b) *Requirements for M+C coordinated care plans and network M+C MSA plans.* An organization offering an M+C coordinated care plan or M+C network MSA plan must do the following:

(1) Meet the requirements in paragraph (c)(1) of this section concerning performance measurement and reporting. With respect to an M+C coordinated care plan, an organization must also meet the requirements of paragraph (c)(2) of this section concerning the achievement of minimum performance levels. The requirements of paragraph (c)(2) of this section do not apply with respect to an M+C MSA plan.

(2) Conduct performance improvement projects as described in paragraph (d) of this section. These projects must achieve, through ongoing measurement and intervention, demonstrable and sustained improvement in significant aspects of clinical care and nonclinical care areas that can be expected to have a favorable effect on health outcomes and enrollee satisfaction.

(3) In processing requests for initial or continued authorization of services, follow written policies and procedures that reflect current standards of medical practice.

(4) Have in effect mechanisms to detect both underutilization and overutilization of services.

(5) Make available to HCFA information on quality and outcomes measures that will enable beneficiaries to compare health coverage options and select among them, as provided in § 422.64(c)(10).

(c) *Performance measurement and reporting.* The organization offering the plan must do the following:

(1) Measure performance under the plan, using standard measures required by HCFA, and report its performance to HCFA. The standard measures may be specified in uniform data collection and reporting instruments required by HCFA, and will relate to—

(i) Clinical areas including effectiveness of care, enrollee perception of care, and use of services; and

(ii) Nonclinical areas including access to and availability of services, appeals and grievances, and organizational characteristics.

(2) Achieve any minimum performance levels that HCFA establishes locally, regionally, or nationally with respect to the standard measures.

(i) In establishing minimum performance levels, HCFA considers historical plan and original Medicare performance data and trends.

(ii) HCFA establishes the minimum performance levels prospectively upon contract initiation and renewal.

(iii) The organization must meet the minimum performance levels by the end of the contract year.

(iv) In accordance with § 422.506, HCFA may decline to renew the organization's contract in the year that HCFA determines that it did not meet the minimum performance levels.

(d) *Performance improvement projects.* (1) Performance improvement projects are organization initiatives that focus on specified clinical and nonclinical areas and that involve the following:

(i) Measurement of performance.

(ii) System interventions, including the establishment or alteration of practice guidelines.

(iii) Improving performance.

(iv) Systematic follow-up on the effect of the interventions.

(2) Each project must address the entire population to which the measurement specified in paragraph (d)(1)(i) of this section is relevant.

(3) HCFA establishes M+C organization and M+C plan-specific obligations for the number and distribution of projects among the required clinical and nonclinical areas, in accordance with paragraphs (d)(4) and (d)(5) of this section, to ensure that the projects are representative of the entire spectrum of clinical and nonclinical care areas associated with a plan.

(4) The required clinical areas include:

(i) Prevention and care of acute and chronic conditions.

(ii) High-volume services.

(iii) High-risk services.

(iv) Continuity and coordination of care.

(5) The required nonclinical areas include:

(i) Appeals, grievances, and other complaints.

(ii) Access to, and availability of, services.

(6) In addition to requiring that the organization initiate its own performance improvement projects, HCFA may require that the organization—

(i) Conduct particular performance improvement projects that are specific to the organization; and

(ii) Participate in national or statewide performance improvement projects.

(7) For each project, the organization must assess performance under the plan using quality indicators that are—

(i) Objective, clearly and unambiguously defined, and based on current clinical knowledge or health services research; and

(ii) Capable of measuring outcomes such as changes in health status, functional status and enrollee satisfaction, or valid proxies of those outcomes.

(8) Performance assessment on the selected indicators must be based on systematic ongoing collection and analysis of valid and reliable data.

(9) Interventions must achieve improvement that is significant and sustained over time.

(10) The organization must report the status and results of each project to HCFA as requested.

(e) *Requirements for non-network M+C MSA plans and M+C private fee-for-service plans.* An organization offering an M+C non-network MSA plan or an M+C private fee-for-service plan must do the following:

(1) Measure performance under the plan using standard measures required by HCFA and report its performance to HCFA. The standard measures may be specified in uniform data collection and reporting instruments required by HCFA and will relate to—

(i) Prevention and care of acute and chronic conditions;

(ii) High-volume services;

(iii) High-risk services; and

(iv) Enrollee satisfaction.

(2) Evaluate the continuity and coordination of care furnished to enrollees.

(3) If the organization uses written protocols for utilization review, the organization must—

(i) Base those protocols on current standards of medical practice; and

(ii) Have mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation.

(f) *Requirements for all types of plans*—(1) *Health information.* For all types of plans that it offers, an organization must—

(i) Maintain a health information system that collects, analyzes, and integrates the data necessary to implement its quality assessment and performance improvement program;

(ii) Ensure that the information it receives from providers of services is reliable and complete; and

(iii) Make all collected information available to HCFA.

(2) *Program review.* For each plan, there must be in effect a process for formal evaluation, at least annually, of the impact and effectiveness of its quality assessment and performance improvement program.

§ 422.154 External review.

(a) *Basic rule.* Except as provided in paragraph (c) of this section, each M+C organization must, for each M+C plan it operates, have an agreement with an independent quality review and improvement organization (review organization) approved by HCFA to perform functions of the type described in part 466 of this chapter.

(b) *Terms of the agreement.* The agreement must be consistent with HCFA guidelines and include the following provisions:

(1) Require that the organization—

(i) Allocate adequate space for use of the review organization whenever it is conducting review activities; and

(ii) Provide all pertinent data, including patient care data, at the time the review organization needs the data to carry out the reviews and make its determinations.

(2) Except in the case of complaints about quality, exclude review activities that HCFA determines would duplicate review activities conducted as part of an accreditation process or as part of HCFA monitoring.

(c) *Exceptions.* The requirement of paragraph (a) of this section does not apply for an M+C private fee-for-service plan or a non-network M+C MSA plan if the organization does not carry out utilization review with respect to the plan.

§ 422.156 Compliance deemed on the basis of accreditation.

(a) *General rule.* An M+C organization may be deemed to meet any of the requirements of paragraph (b) of this section if—

(1) The M+C organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by HCFA; and

(2) The accreditation organization used the standards approved by HCFA for the purposes of assessing the M+C organization's compliance with Medicare requirements.

(b) *Deeming requirements.* The following requirements are deemable:

(1) The quality assessment and performance improvement requirements of § 422.152.

(2) The confidentiality and accuracy of enrollee records requirements of § 422.118.

(c) *Effective date of deemed status.* The date on which the organization is deemed to meet the applicable requirements is the later of the following:

(1) The date on which the accreditation organization is approved by HCFA.

(2) The date the M+C organization is accredited by the accreditation organization.

(d) *Obligations of deemed M+C organizations.* An M+C organization deemed to meet Medicare requirements must—

(1) Submit to surveys by HCFA to validate its accreditation organization's accreditation process; and

(2) Authorize its accreditation organization to release to HCFA a copy of its most recent accreditation survey, together with any survey-related information that HCFA may require (including corrective action plans and summaries of unmet HCFA requirements).

(e) *Removal of deemed status.* HCFA removes part or all of an M+C organization's deemed status for any of the following reasons:

(1) HCFA determines, on the basis of its own survey or the results of the accreditation survey, that the M+C organization does not meet the Medicare requirements for which deemed status was granted.

(2) HCFA withdraws its approval of the accreditation organization that accredited the M+C organization.

(3) The M+C organization fails to meet the requirements of paragraph (d) of this section.

(f) *Enforcement authority.* HCFA retains the authority to initiate enforcement action against any M+C

organization that it determines, on the basis of its own survey or the results of an accreditation survey, no longer meets the Medicare requirements for which deemed status was granted.

§ 422.157 Accreditation organizations.

(a) *Conditions for approval.* HCFA may approve an accreditation organization with respect to a given standard under this part if it meets the following conditions:

(1) In accrediting M+C organizations, it applies and enforces standards that are at least as stringent as Medicare requirements with respect to the standard or standards in question.

(2) It complies with the application and reapplication procedures set forth in § 422.158.

(3) It is not controlled, as defined in § 413.17 of this chapter, by the entities it accredits.

(b) *Notice and comment*—(1) *Proposed notice.* HCFA publishes a proposed notice in the **Federal Register** whenever it is considering granting an accreditation organization's application for approval. The notice—

(i) Specifies the basis for granting approval;

(ii) Describes how the accreditation organization's accreditation program meets or exceeds all of the Medicare requirements for which HCFA would deem compliance on the basis of the organization's accreditation; and

(iii) Provides opportunity for public comment.

(2) *Final notice.* (i) After reviewing public comments, HCFA publishes a final **Federal Register** notice indicating whether it has granted the accreditation organization's request for approval.

(ii) If HCFA grants the request, the final notice specifies the effective date and the term of the approval, which may not exceed 6 years.

(c) *Ongoing responsibilities of an approved accreditation organization.* An accreditation organization approved by HCFA must undertake the following activities on an ongoing basis:

(1) Provide to HCFA in written form and on a monthly basis all of the following:

(i) Copies of all accreditation surveys, together with any survey-related information that HCFA may require (including corrective action plans and summaries of unmet HCFA requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to deemed M+C organizations.

(iv) Information about any M+C organization against which the accrediting organization has taken remedial or adverse action, including revocation, withdrawal or revision of the M+C organization's accreditation. (The accreditation organization must provide this information within 30 days of taking the remedial or adverse action.)

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without HCFA approval, HCFA may withdraw its approval of the accreditation organization.

(2) Within 30 days of a change in HCFA requirements, submit to HCFA—

(i) An acknowledgment of HCFA's notification of the change;

(ii) A revised cross-walk reflecting the new requirements; and

(iii) An explanation of how the accreditation organization plans to alter its standards to conform to HCFA's new requirements, within the time-frames specified in the notification of change it receives from HCFA.

(3) Permit its surveyors to serve as witnesses if HCFA takes an adverse action based on accreditation findings.

(4) Within 3 days of identifying, in an accredited M+C organization, a deficiency that poses immediate jeopardy to the organization's enrollees or to the general public, give HCFA written notice of the deficiency.

(5) Within 10 days of HCFA's notice of withdrawal of approval, give written notice of the withdrawal to all accredited M+C organizations.

(d) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of an accreditation organization.

(1) *Equivalency review.* HCFA compares the accreditation organization's standards and its application and enforcement of those standards to the comparable HCFA requirements and processes when—

(i) HCFA imposes new requirements or changes its survey process;

(ii) An accreditation organization proposes to adopt new standards or changes in its survey process; or

(iii) The term of an accreditation organization's approval expires.

(2) *Validation review.* HCFA or its agent may conduct a survey of an accredited organization, examine the results of the accreditation organization's own survey, or attend the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, HCFA identifies any accreditation programs for which validation survey results—

(i) Indicate a 20 percent rate of disparity between certification by the accreditation organization and certification by HCFA or its agent on standards that do not constitute immediate jeopardy to patient health and safety if unmet;

(ii) Indicate any disparity between certification by the accreditation organization and certification by HCFA or its agent on standards that constitute immediate jeopardy to patient health and safety if unmet; or

(iii) Indicate that, irrespective of the rate of disparity, there are widespread or systematic problems in an organization's accreditation process such that accreditation no longer provides assurance that the Medicare requirements are met or exceeded.

(3) *Onsite observation.* HCFA may conduct an onsite inspection of the accreditation organization's operations and offices to verify the organization's representations and assess the organization's compliance with its own policies and procedures. The onsite inspection may include, but is not limited to, reviewing documents, auditing meetings concerning the accreditation process, evaluating survey results or the accreditation status decision making process, and interviewing the organization's staff.

(4) *Notice of intent to withdraw approval.* If an equivalency review, validation review, onsite observation, or HCFA's daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this subpart, HCFA gives the organization written notice of its intent to withdraw approval.

(5) *Withdrawal of approval.* HCFA may withdraw its approval of an accreditation organization at any time if HCFA determines that—

(i) Deeming based on accreditation no longer guarantees that the M+C organization meets the M+C requirements, and failure to meet those requirements could jeopardize the health or safety of Medicare enrollees and constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations under this section or under § 422.156 or § 422.158.

(6) *Reconsideration of withdrawal of approval.* An accreditation organization dissatisfied with a determination to withdraw HCFA approval may request a reconsideration of that determination in accordance with subpart D of part 488 of this chapter.

§ 422.158 Procedures for approval of accreditation as a basis for deeming compliance.

(a) *Required information and materials.* A private, national accreditation organization applying for approval must furnish to HCFA all of the following information and materials. (When reapplying for approval, the organization need furnish only the particular information and materials requested by HCFA.)

(1) The types of M+C plans that it would review as part of its accreditation process.

(2) A detailed comparison of the organization's accreditation requirements and standards with the Medicare requirements (for example, a crosswalk).

(3) Detailed information about the organization's survey process, including—

(i) Frequency of surveys and whether surveys are announced or unannounced.

(ii) Copies of survey forms, and guidelines and instructions to surveyors.

(iii) Descriptions of—

(A) The survey review process and the accreditation status decision making process;

(B) The procedures used to notify accredited M+C organizations of deficiencies and to monitor the correction of those deficiencies; and

(C) The procedures used to enforce compliance with accreditation requirements.

(4) Detailed information about the individuals who perform surveys for the accreditation organization, including—

(i) The size and composition of accreditation survey teams for each type of plan reviewed as part of the accreditation process;

(ii) The education and experience requirements surveyors must meet;

(iii) The content and frequency of the in-service training provided to survey personnel;

(iv) The evaluation systems used to monitor the performance of individual surveyors and survey teams; and

(v) The organization's policies and practice with respect to the participation, in surveys or in the accreditation decision process by an individual who is professionally or financially affiliated with the entity being surveyed.

(5) A description of the organization's data management and analysis system with respect to its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(6) A description of the organization's procedures for responding to and investigating complaints against accredited organizations, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and ombudsmen programs.

(7) A description of the organization's policies and procedures with respect to the withholding or removal of accreditation for failure to meet the accreditation organization's standards or requirements, and other actions the organization takes in response to noncompliance with its standards and requirements.

(8) A description of all types (for example, full, partial) and categories (for example, provisional, conditional, temporary) of accreditation offered by the organization, the duration of each type and category of accreditation and a statement identifying the types and categories that would serve as a basis for accreditation if HCFA approves the accreditation organization.

(9) A list of all currently accredited M+C organizations and the type, category, and expiration date of the accreditation held by each of them.

(10) A list of all full and partial accreditation surveys scheduled to be performed by the accreditation organization as requested by HCFA.

(11) The name and address of each person with an ownership or control interest in the accreditation organization.

(b) *Required supporting documentation.* A private, national accreditation organization applying or reapplying for approval must also submit the following supporting documentation:

(1) A written presentation that demonstrates its ability to furnish HCFA with electronic data in HCFA compatible format.

(2) A resource analysis that demonstrates that its staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(3) A statement acknowledging that, as a condition for approval, it agrees to comply with the ongoing responsibility requirements of § 422.157(c).

(c) *Additional information.* If HCFA determines that it needs additional information for a determination to grant or deny the accreditation organization's request for approval, it notifies the organization and allows time for the organization to provide the additional information.

(d) *Onsite visit.* HCFA may visit the accreditation organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents, and interviews with the organization's staff.

(e) *Notice of determination.* HCFA gives the accreditation organization a formal notice that—

(1) States whether the request for approval has been granted or denied;

(2) Gives the rationale for any denial; and

(3) Describes the reconsideration and reapplication procedures.

(f) *Withdrawal.* An accreditation organization may withdraw its application for approval at any time before it receives the formal notice specified in paragraph (e) of this section.

(g) *Reconsideration of adverse determination.* An accreditation organization that has received notice of denial of its request for approval may request reconsideration in accordance with subpart D of part 488 of this chapter.

(h) *Request for approval following denial.* (1) Except as provided in paragraph (h)(2) of this section, an accreditation organization that has received notice of denial of its request for approval may submit a new request if it—

(i) Has revised its accreditation program to correct the deficiencies on which the denial was based;

(ii) Can demonstrate that the M+C organizations that it has accredited meet or exceed applicable Medicare requirements; and

(iii) Resubmits the application in its entirety.

(2) An accreditation organization that has requested reconsideration of HCFA's denial of its request for approval may not submit a new request until the reconsideration is administratively final.

Subpart E—Relationships with Providers.

422.200 Basis and scope.

This subpart is based on sections 1852(a)(1), (a)(2), (b)(2), (c)(2)(D), (j), and (k) of the Act; section 1859(b)(2)(A) of the Act; and the general authority under 1856(b) of the Act requiring the establishment of standards. It sets forth the requirements and standards for the M+C organization's relationships with providers including physicians, other health care professionals, institutional providers and suppliers, under contracts or arrangements or deemed contracts under M+C private fee-for-service plans. This subpart also contains some requirements that apply to noncontracting providers.

§ 422.202 Participation procedures.

(a) *Notice and appeal rights.* An M+C organization that operates a coordinated care plan or network MSA plan must provide for the participation of individual health care professionals, and the management and members of groups of health care professionals, through reasonable procedures that include the following:

(1) Written notice of rules of participation such as terms for payment, utilization review, quality improvement programs, credentialing, data reporting, confidentiality, guidelines or criteria for the furnishing of particular services, and other rules related to administrative policy.

(2) Written notice of material changes in participation rules before the changes are put into effect.

(3) Written notice of participation decisions that are adverse to health care professionals.

(4) A process for appealing adverse decisions, including the right of physicians and other health care professionals to present information and their views on the decision. In the case of a termination of a provider contract by the M+C organization, this process must conform to the rules in § 422.204(c).

(b) *Consultation.* The M+C organization must consult with the physicians, and other health care professionals who have agreed to provide services under an M+C plan offered by the organization, regarding the organization's medical policy, quality assurance program, and medical management procedures and ensure that the following standards are met:

(1) Practice guidelines and utilization management guidelines—

(i) Are based on reasonable medical evidence or a consensus of health care professionals in the particular field;

(ii) Consider the needs of the enrolled population;

(iii) Are developed in consultation with contracting health care professionals; and

(iv) Are reviewed and updated periodically.

(2) The guidelines are communicated to providers and, as appropriate, to enrollees.

(3) Decisions with respect to utilization management, enrollee education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines.

(c) An M+C organization that operates an M+C plan through subcontracted physician groups or other subcontracted networks of health care professionals must provide that the participation procedures in this section apply equally to physicians and other health care professionals within those subcontracted groups.

§ 422.204 Provider credentialing and provider rights.

(a) *Basic requirements.* An M+C organization must follow a documented process with respect to providers and suppliers who have signed contracts or participation agreements that—

(1) For providers (other than physicians and other health care professionals) requires determination, and redetermination at specified intervals, that each provider—

(i) Licensed to operate in the State, and in compliance with any other applicable State or Federal requirements; and

(ii) Reviewed and approved by an accrediting body, or meets the standards established by the organization itself;

(2) For physicians and other health care professionals, including members of physician groups, covers—

(i) Initial credentialing that includes written application, verification of licensure and other information from primary sources, disciplinary status, eligibility for payment under Medicare, and site visits as appropriate. The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application;

(ii) Recredentialing at least every 2 years that updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of grievances and appeals, enrollee satisfaction surveys, and other plan activities, and that includes an attestation of the correctness and completeness of the new information; and

(iii) A process for receiving advice from contracting health care professionals with respect to criteria for credentialing and recredentialing; and

(iv) Requiring that, to the extent applicable, the requirements in paragraphs (a)(2)(i) and (a)(2)(iii) of this section are satisfied; and

(3)(i) Specify that basic benefits must be provided through, or payments must be made to, providers that meet applicable requirements of title XVIII and part A of title XI of the Act. In the case of providers meeting the definition of ''provider of services'' in section 1861(u), basic benefits may only be provided through such providers if they have a provider agreement with HCFA permitting them to provide services under original Medicare.

(ii) Ensures compliance with the requirements at § 422.752(a)(8) that prohibit employment or contracts with individuals (or with an entity that employs or contracts with such an individual) excluded from participation under Medicare and with the requirements at § 422.220 regarding physicians and practitioners who opt out of Medicare.

(b) *Discrimination prohibited*—(1) *General rule.* An M+C organization may not discriminate, in terms of participation, reimbursement, or indemnification, against any health care professional who is acting within the scope of his or her license or certification under State law, solely on the basis of the license or certification.

(2) *Construction.* The prohibition in paragraph (b)(1) of this section does not preclude any of the following by the M+C organization:

(i) Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees (except for M+C private-fee-for-service plans, which may not refuse to contract on this basis).

(ii) Use of different reimbursement amounts for different specialties.

(iii) Implementation of measures designed to maintain quality and control costs consistent with its responsibilities.

(c) *Denial, suspension, or termination of contract.* The requirements in this paragraph (c) apply to an M+C organization that operates a coordinated care plan or network MSA plan providing benefits through contracting providers.

(1) *Notice to health care professional.* An M+C organization that denies, suspends, or terminates an agreement under which the health care professional provides services to M+C plan enrollees must give the affected individual written notice of the following:

(i) The reasons for the action.

(ii) The standards and the profiling data the organization used to evaluate the health care professional.

(iii) The numbers and mix of health care professionals the organization needs.

(iv) The affected health care professional's right to appeal the action and the process and timing for requesting a hearing.

(2) *Composition of hearing panel.* The M+C organization must ensure that the majority of the hearing panel members are peers of the affected health care professional.

(3) *Notice to licensing or disciplinary bodies.* An M+C organization that suspends or terminates a contract with a health care professional because of deficiencies in the quality of care must give written notice of that action to licensing or disciplinary bodies or to other appropriate authorities.

(4) *Timeframes.* An M+C organization and a contracting provider must provide at least 60 days written notice to each other before terminating the contract without cause.

§ 422.206 Interference with health care professionals' advice to enrollees prohibited.

(a) *General rule.* (1) An M+C organization may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising, or advocating on behalf of, an individual who is a patient and enrolled under an M+C plan about—

(i) The patient's health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options;

(ii) The risks, benefits, and consequences of treatment or non-treatment; or

(iii) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

(2) Health care professionals must provide information regarding treatment options in a culturally-competent manner, including the option of no treatment. Health care professionals must ensure that individuals with disabilities have effective communications with participants throughout the health system in making decisions regarding treatment options.

(b) *Conscience protection.* The general rule in paragraph (a) of this section does not require the M+C plan to cover, furnish, or pay for a particular counseling or referral service if the M+C organization that offers the plan—

(1) Objects to the provision of that service on moral or religious grounds; and

(2) Through appropriate written means, makes available information on these policies as follows:

(i) To HCFA, with its application for a Medicare contract, or within 10 days of submitting its ACR proposal, as appropriate.

(ii) To prospective enrollees, before or during enrollment.

(iii) With respect to current enrollees, the organization is eligible for the exception provided in paragraph (a)(1) of this section if it provides notice within 90 days after adopting the policy at issue; however, under § 422.111(d), notice of such a change must be given in advance.

(c) *Construction.* Nothing in paragraph (b) of this section may be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(d) *Sanctions.* An M+C organization that violates the prohibition of paragraph (a) of this section or the conditions in paragraph (b) of this section is subject to intermediate sanctions under subpart O of this part.

§ 422.208 Physician incentive plans: requirements and limitations.

(a) *Definitions.* In this subpart, the following definitions apply:

Bonus means a payment made to a physician or physician group beyond any salary, fee-for-service payments, capitation, or returned withhold.

Capitation means a set dollar payment per patient per unit of time (usually per month) paid to a physician or physician group to cover a specified set of services and administrative costs without regard to the actual number of services provided. The services covered may include the physician's own services, referral services, or all medical services.

Physician group means a partnership, association, corporation, individual practice association, or other group of physicians that distributes income from the practice among members. An individual practice association is defined as a physician group for this section only if it is composed of individual physicians and has no subcontracts with physician groups.

Physician incentive plan means any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

Potential payments means the maximum payments possible to physicians or physician groups including payments for services they furnish directly, and additional payments based on use and costs of referral services, such as withholds, bonuses, capitation, or any other compensation to the physician or physician group. Bonuses and other compensation that are not based on use of referrals, such as quality of care furnished, patient satisfaction or committee participation, are not considered payments in the determination of substantial financial risk.

Referral services means any specialty, inpatient, outpatient, or laboratory services that a physician or physician group orders or arranges, but does not furnish directly.

Risk threshold means the maximum risk, if the risk is based on referral services, to which a physician or physician group may be exposed under a physician incentive plan without being at substantial financial risk. This is set at 25 percent risk.

Substantial financial risk, for purposes of this section, means risk for referral services that exceeds the risk threshold.

Withhold means a percentage of payments or set dollar amounts deducted from a physician's service fee, capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

(b) *Applicability.* The requirements in this section apply to an M+C organization and any of its subcontracting arrangements that utilize a physician incentive plan in their payment arrangements with individual physicians or physician groups. Subcontracting arrangements may include an intermediate entity, which includes but is not limited to, an individual practice association that contracts with one or more physician groups or any other organized group such as those specified in § 422.4.

(c) *Basic requirements.* Any physician incentive plan operated by an M+C organization must meet the following requirements:

(1) The M+C organization makes no specific payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to any particular enrollee. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future.

(2) If the physician incentive plan places a physician or physician group at substantial financial risk (as determined under paragraph (d) of this section) for services that the physician or physician group does not furnish itself, the M+C organization provides aggregate or per-patient stop-loss protection in accordance with paragraph (f) of this section, and conducts periodic surveys in accordance with paragraph (g) of this section.

(3) For all physician incentive plans, the M+C organization provides to HCFA the information specified in § 422.210.

(d) *Determination of substantial financial risk*—(1) *Basis.* Substantial financial risk occurs when risk is based on the use or costs of referral services,

and that risk exceeds the risk threshold. Payments based on other factors, such as quality of care furnished, are not considered in this determination.

(2) *Risk threshold.* The risk threshold is 25 percent of potential payments.

(3) *Arrangements that cause substantial financial risk.* The following incentive arrangements cause substantial financial risk within the meaning of this section, if the physician's or physician group's patient panel size is not greater than 25,000 patients, as shown in the table at paragraph (f)(2)(iii) of this section:

(i) Withholds greater than 25 percent of potential payments.

(ii) Withholds less than 25 percent of potential payments if the physician or physician group is potentially liable for amounts exceeding 25 percent of potential payments.

(iii) Bonuses that are greater than 33 percent of potential payments minus the bonus.

(iv) Withholds plus bonuses if the withholds plus bonuses equal more than 25 percent of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula—Withhold % = −0.75 (Bonus %) +25%.

(v) Capitation arrangements, if—

(A) The difference between the maximum potential payments and the minimum potential payments is more than 25 percent of the maximum potential payments;

(B) The maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group.

(vi) Any other incentive arrangements that have the potential to hold a physician or physician group liable for more than 25 percent of potential payments.

(e) An M+C fee-for-service plan may not operate a physician incentive plan.

(f) Stop-loss protection requirements. (1) *Basic rule.* The M+C organization must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with the following requirements:

(2) *Specific requirements.* (i) Aggregate stop-loss protection must cover 90 percent of the costs of referral services that exceed 25 percent of potential payments.

(ii) For per-patient stop-loss protection if the stop-loss protection provided is on a per-patient basis, the stop-loss limit (deductible) per patient must be determined based on the size of the patient panel and may be a combined policy or consist of separate policies for professional services and institutional services. In determining patient panel size, the patients may be pooled in accordance with paragraph (g) of this section.

(iii) Stop-loss protection must cover 90 percent of the costs of referral services that exceed the per patient deductible limit. The per-patient stop-loss deductible limits are as follows:

Panel size	Single combined deductible	Separate institutional deductible	Separate professional deductible
1–1,000	$6,000	$10,000	$3,000
1,001–5,000	30,000	40,000	10,000
5,001–8,000	40,000	60,000	15,000
8,001–10,000	75,000	100,000	20,000
10,001–25,000	150,000	200,000	25,000
>25,000	(1)	(1)	(1)

1 None.

(g) *Pooling of patients.* Any entity that meets the pooling conditions of this section may pool commercial, Medicare, and Medicaid enrollees or the enrollees of several M+C organizations with which a physician or physician group has contracts. The conditions for pooling are as follows:

(1) It is otherwise consistent with the relevant contracts governing the compensation arrangements for the physician or physician group.

(2) The physician or physician group is at risk for referral services with respect to each of the categories of patients being pooled.

(3) The terms of the compensation arrangements permit the physician or physician group to spread the risk across the categories of patients being pooled.

(4) The distribution of payments to physicians from the risk pool is not calculated separately by patient category.

(5) The terms of the risk borne by the physician or physician group are comparable for all categories of patients being pooled.

(h) *Periodic surveys of current and former enrollees.* An M+C organization must conduct periodic surveys of current and former enrollees where substantial financial risk exists. These periodic surveys must—

(1) Include either a sample of, or all, current Medicare/Medicaid enrollees in the M+C organization and individuals disenrolled in the past 12 months for reasons other than—

(i) The loss of Medicare or Medicaid eligibility;

(ii) Relocation outside the M+C organization's service area;

(iii) For failure to pay premiums or other charges;

(iv) For abusive behavior; and

(v) Retroactive disenrollment.

(2) Be designed, implemented, and analyzed in accordance with commonly accepted principles of survey design and statistical analysis;

(3) Measure the degree of enrollees/disenrollees' satisfaction with the quality of the services provided and the degree to which the enrollees/disenrollees have or had access to the services provided under the M+C organization; and

(4) Be conducted no later than 1 year after the effective date of the M+C organization's contract and at least annually thereafter.

(i) *Sanctions.* An M+C organization that fails to comply with the requirements of this section is subject to intermediate sanctions under subpart O of this part.

§ 422.210 Disclosure of physician incentive plans

(a) *Disclosure to HCFA*—(1) *Basic requirement.* Each M+C organization must provide to HCFA descriptive information about its physician incentive plan in sufficient detail to enable HCFA to determine whether that plan complies with the requirements of § 422.208. Reporting should be on the HCFA PIP Disclosure Form (OMB No. 0938–0700).

(2) *Content.* The information must include at least the following:

(i) Whether services not furnished by the physician or physician group are covered by the incentive plan.

(ii) The type or types of incentive arrangements, such as, withholds, bonus, capitation.

(iii) The percent of any withhold or bonus the plan uses.

(iv) Assurance that the physicians or physician group has adequate stop-loss protection, and the amount and type of stop-loss protection.

(v) The patient panel size and, if the plan uses pooling, the pooling method.

(vi) If the M+C organization is required to conduct enrollee surveys, a summary of the survey results.

(3) *When disclosure must be made to HCFA.* An M+C organization must disclose annually to HCFA the physician incentive arrangements that are effective at the start of each year. In addition, HCFA does not approve an M+C organization's application for a contract unless the M+C organization discloses the physician incentive arrangements effective for that contract.

(b) *Disclosure to Medicare beneficiaries—Basic requirement.* An M+C organization must provide the following information to any Medicare beneficiary who requests it:

(1) Whether the M+C organization uses a physician incentive plan that affects the use of referral services.

(2) The type of incentive arrangement.

(3) Whether stop-loss protection is provided.

(4) If the M+C organization was required to conduct a survey, a summary of the survey results.

§ 422.212 Limitations on provider indemnification.

An M+C organization may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to an enrollee as a result of the M+C organization's denial of medically necessary care:

(a) A physician or health care professional.

(b) Provider of services.

(c) Other entity providing health care services.

(d) Group of such professionals, providers, or entities.

§ 422.214 Special rules for services furnished by noncontract providers.

(a) *Services furnished to enrollees of coordinated care plans by providers.* (1) Any provider (other than a provider of services as defined in section 1861(u) of the Act) that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

(2) Any statutory provisions (including penalty provisions) that apply to payment for services furnished to a beneficiary not enrolled in an M+C plan also apply to the payment described in paragraph (a)(1) of this section.

(b) *Services furnished by providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an M+C coordinated care plan must accept as payment in full the amounts (less any payments under §§ 412.105(g) and 413.86(d)) that it could collect if the beneficiary were enrolled in original Medicare.

§ 422.216 Special rules for M+C private fee-for-service plans.

(a) *Payment to providers*—(1) *Payment rate.* (i) The M+C organization must establish uniform payment rates for items and services that apply to all contracting providers, regardless of whether the contract is signed or deemed under paragraph (f) of this section.

(ii) Contracting providers must be reimbursed on a fee-for-service basis.

(iii) The M+C organization must make information on its payment rates available to providers that furnish services that may be covered under the M+C private fee-for-service plan.

(2) *Payment to contract providers.* For each service, the M+C organization pays a contract provider (including one deemed to have a contract) an amount that is equal to the payment rate under paragraph (a)(1) of this section minus any applicable cost-sharing.

(3) *Noncontract providers.* The organization pays for services of noncontract providers in accordance with § 422.100(b)(2).

(4) *Service furnished by providers of service.* Any provider of services as defined in section 1861(u) of the Act that does not have in effect a contract establishing payment mounts for services furnished to a beneficiary enrolled in an M+C private fee-for-service plan must accept as payment in full the amounts (less any payments under §§ 412.109(g) and 413.86(d) of this chapter) that it could collect if the beneficiary were enrolled in original Medicare.

(b) *Charges to enrollees*—(1) *Contract providers.* (i) Contract providers and ''deemed'' contract providers may charge enrollees no more than the cost-sharing and, subject to the limit in paragraph (b)(1)(ii) of this section, balance billing amounts that are permitted under the plan, and these amounts must be the same for ''deemed'' contract providers as for those that have signed contracts in effect.

(ii) The organization may permit balance billing no greater than 15 percent of the payment rate established under paragraph (a)(1) of this section.

(iii) The M+C organization must specify the amount of cost-sharing and balance billing in its contracts with providers and these amounts must be the same for ''deemed'' contract providers as for those that have signed contracts in effect.

(iv) The M+C organization is subject to intermediate sanctions under § 422.752(a)(7), under the rules in subpart O of this part, if it fails to enforce the limit specified in paragraph (b)(1)(i) of this section.

(2) *Noncontract providers.* A noncontract provider may not collect from an enrollee more than the cost-sharing established by the M+C private fee-for-service plan as specified in § 422.308(b).

(c) *Enforcement of limit*—(1) *Contract providers.* An M+C organization that offers an M+C fee-for-service plan must enforce the limit specified in paragraph (b)(1) of this section.

(2) *Noncontract providers.* An M+C organization that offers an M+C private fee-for-service plan must monitor the amount collected by noncontract providers to ensure that those amounts do not exceed the amounts permitted to be collected under paragraph (b)(2) of this section. The M+C organization must develop and document violations specified in instructions and must forward documented cases to HCFA.

(d) *Information on enrollee liability*—(1) *General information.* An M+C organization that offers an M+C fee-for-service plan must provide to plan enrollees, for each claim filed by the enrollee or the provider that furnished the service, an appropriate explanation of benefits. The explanation must include a clear statement of the enrollee's liability for deductibles, coinsurance, copayment, and balance billing.

(2) *Advance notice for hospital services.* In its terms and conditions of payment to hospitals, the M+C organization must require the hospital, if it imposes balance billing, to provide to the enrollee, before furnishing any services for which balance billing could amount to not less than $500—

(i) Notice that balance billing is permitted for those services;

(ii) A good faith estimate of the likely amount of balance billing, based on the enrollees presenting condition; and

(iii) The amount of any deductible, coinsurance, and copayment that may be due in addition to the balance billing amount.

(e) *Coverage determinations.* The M+C organization must make coverage determinations in accordance with subpart M of this part.

(f) *Rules describing deemed contract providers.* Any provider furnishing health services to an enrollee in an M+C private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, is treated as having a contract in effect and is subject to the limitations of this section that apply to contract providers if the following conditions are met:

(1) The services are covered under the plan and are furnished—

(i) To an enrollee of an M+C fee-for-service plan; and

(ii) Provided by a provider including a provider of services (as defined in section 1861(u) of the Act) that does not have in effect a signed contract with the M+C organization.

(2) Before furnishing the services, the provider—

(i) Was informed of the individual's enrollment in the plan; and

(ii) Was informed (or given a reasonable opportunity to obtain information) about the terms and conditions of payment under the plan, including the information described in § 422.202(a)(1).

(3) The information was provided in a manner that was reasonably designed to effect informed agreement and met the requirements of paragraphs (g) and (h) of this section.

(g) *Enrollment information.* Enrollment information was provided by one of the following methods or a similar method:

(1) Presentation of an enrollment card or other document attesting to enrollment.

(2) Notice of enrollment from HCFA, a Medicare intermediary or carrier, or the M+C organization itself.

(h) *Information on payment terms and conditions.* Information on payment terms and conditions was made available through either of the following methods:

(1) The M+C organization used postal service, electronic mail, FAX, or telephone to communicate the information to one of the following:

(i) The provider.

(ii) The employer or billing agent of the provider.

(iii) A partnership of which the provider is a member.

(iv) Any party to which the provider makes assignment or reassigns benefits.

(2) The M+C organization has in effect a procedure under which—

(i) Any provider furnishing services to an enrollee in an M+C private fee-for-service plan, and who has not previously entered into a contract or agreement to furnish services under the plan, can receive instructions on how to request the payment information;

(ii) The organization responds to the request before the entity furnishes the service; and

(iii) The information the organization provides includes the following:

(A) Billing procedures.

(B) The amount the organization will pay towards the service.

(C) The amount the provider is permitted to collect from the enrollee.

(D) The information described in § 422.202(a)(1).

(3) Announcements in newspapers, journals, or magazines or on radio or television are not considered communication of the terms and conditions of payment.

(i) *Provider credentialing requirements.* Contracts with providers must provide that, in order to be paid to provide services to plan enrollees, providers must meet the requirements specified in § 422.204(a)(1) and (a)(1)(iii).

§ 422.220 Exclusion of services furnished under a private contract.

An M+C organization may not pay, directly or indirectly, on any basis, for services (other than emergency or urgently needed services as defined in § 422.2) furnished to a Medicare enrollee by a physician (as defined in section 1861(r)(1) of the Act) or other practitioner (as defined in section 1842(b)(18)(C) of the Act) who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts under section 1802(b) of the Act with the beneficiaries. An M+C organization must pay for emergency or urgently needed services furnished by a physician or practitioner who has not signed a private contract with the beneficiary.

Subpart F—Payments to Medicare+Choice Organizations

§ 422.249 Terminology.

In this subpart—

(a) The terms ''per capita rate'' and ''capitation rate'' (see § 422.252) are used interchangeably; and

(b) In the term ''area-specific,'' ''area'' refers to any of the payment areas described in § 422.250(c).

§ 422.250 General provisions.

(a) *Monthly payments*—(1) *General rule.* Except as provided in paragraph (a)(2) of this section, HCFA makes advance monthly payments equal to 1/12th of the annual M+C capitation rate for the payment area described in paragraph (c) of this section adjusted for such demographic risk factors as an individual's age, disability status, sex, institutional status, and other such factors as it determines to be appropriate to ensure actuarial equivalence. Effective January 1, 2000, HCFA adjusts for health status as provided in § 422.256(c). When the new risk adjustment is implemented, 1/12th of the annual capitation rate for the payment area described in paragraph (c) of this section will be adjusted by the risk adjustment methodology under § 422.256(d).

(2) *Special rules.* (i) *Enrollees with end-stage renal disease.* (A) For enrollees determined to have end-stage renal disease (ESRD), HCFA establishes special rates that are determined under an actuarially equivalent approach to that used in establishing the rates under original Medicare.

(B) HCFA reduces the payment rate by the equivalent of 50 cents per renal dialysis treatment. These funds will be used to help pay for the ESRD network program in the same manner as similar reductions are used in original Medicare.

(ii) *MSA enrollees.* For MSA enrollees, HCFA makes advanced monthly payments as described in paragraph (a)(1) less the amount (if any) identified in § 422.262(c)(1)(ii) to be deposited in the M+C MSA. In addition, HCFA deposits in the M+C MSA the lump sum amounts (if any) determined in accordance with § 422.262(c).

(iii) *RFB plan enrollees.* For RFB plan enrollees, HCFA adjusts the capitation payments otherwise determined under this subpart to ensure that the payment level is appropriate for the actuarial characteristics and experience of these enrollees. Such adjustment can be made on an individual or organization basis.

(b) *Adjustment of payments to reflect number of Medicare enrollees—General rule.* HCFA adjusts payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which HCFA based an advance monthly payment.

(c) *Payment areas*—(1) *General rule.* Except as provided in paragraph (e) of this section, the M+C payment area is a county or an equivalent geographic area specified by HCFA.

(2) *Special rule for ESRD enrollees.* For ESRD enrollees, the M+C payment

area is a State or other geographic area specified by HCFA.

(d) *Terminology.* As used in paragraph (e) of this section, ''metropolitan statistical area,'' ''consolidated metropolitan statistical area,'' and ''primary metropolitan statistical area'' mean any areas so designated by the Secretary of Commerce.

(e) *Geographic adjustment of payment areas.* For contract years beginning after 1999—

(1) *State request.* A State's chief executive may request, no later than February 1 of any year, a geographic adjustment of the State's payment areas for the following calendar year. The chief executive may request any of the following adjustments to the payment area specified in paragraph (c)(1) of this section:

(i) A single Statewide M+C payment area.

(ii) A metropolitan-based system in which all nonmetropolitan areas within the State constitute a single payment area and any of the following constitutes a separate M+C payment area:

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(A) All portions of each single metropolitan statistical area within the State.

(B) All portions of each primary metropolitan statistical area within each consolidated metropolitan statistical area within the State.

(iii) A consolidation of noncontiguous counties.

(2) *HCFA response.* In response to the request, HCFA makes the payment adjustment requested by the chief executive.

(3) *Budget neutrality adjustment for geographically adjusted payment areas.* If HCFA adjusts a State's payment areas in accordance with paragraph (e)(2) of this section, HCFA at that time, and each year thereafter, adjusts the capitation rates so that the aggregate Medicare payments do not exceed the aggregate Medicare payments that would have been made to all the State's payments areas, absent the geographic adjustment.

(f) *Determination and applicability of payment rates.* (1) All payment rates are annual rates, determined and promulgated no later than March 1st, for the following calendar year.

(2) For purposes of paragraphs (b) and (c) of § 422.252, except as provided in § 422.254(e)(4), the ''capitation payment rate for 1997'' is the rate determined under section 1876(a)(1)(c) of the Act.

§ 422.252 Annual capitation rates.

Subject to the adjustments specified in this subpart, the annual capitation rate for a particular payment area is equal to the largest of the following:

(a) *Blended capitation rate.* The blended capitation rate is the sum of—

(1) The area-specific percentage (specified in § 422.254(a)) for the year multiplied by the annual area-specific capitation rate for the payment area as determined under § 422.254(e) for the year, and

(2) The national percentage (specified in § 422.254(a)) for the year multiplied by the national input-price-adjusted capitation rate for the payment area as determined under § 422.254(g) for the year.

(3) Multiplied by the budget neutrality adjustment factor determined under § 422.254(d).

(b) *Minimum amount rate.* (1) For 1998—

(i) For the 50 States and the District of Columbia, the minimum amount rate is 12 times $367.

(ii) For all other jurisdictions the minimum amount rate is the lesser of the rate described in (b)(1)(i) or 150 percent of the capitation payment rate for 1997.

(2) For each succeeding year, the minimum amount rate is the minimum amount rate for the preceding year, increased by the national per capita growth percentage (specified in § 422.254(b)) for the year.

(c) *Minimum percentage increase rate.* (1) For 1998, the minimum percentage increase rate is 102 percent of the annual capitation rate for 1997.

(2) For each succeeding year, the minimum percentage increase rate is 102 percent of the annual capitation rate for the preceding year.

§ 422.254 Calculation and adjustment factors.

The following are the factors used in calculating the per capita payment rates:

(a) *Area-specific and national percentages.* For purposes of § 422.252(a)(1), the area-specific percentage and the national percentage, for each year, are as follows:

	Area-specific	National
For 1998	90	10
For 1999	82	18
For 2000	74	26
For 2001	66	34
For 2002	58	42
For years after 2002	50	50

(b) *National per capita growth percentage.* For purposes of § 422.252(a)(2),

(1) The national per capita growth percentage for a year is HCFA's estimate of the rate of growth in per capita expenditures, reduced by the percentage points specified in paragraph (b)(2) of this section for the year. HCFA may make separate estimates for aged enrollees, disabled enrollees, and enrollees who have ESRD.

(2) The percentage points that HCFA uses to reduce its estimates are as follows:

(i) For 1998, 0.8 percentage points.

(ii) For years 1999–2002, 0.5 percentage points.

(iii) For years after 2002, 0 percentage points.

(c) *Medical education payment adjustments.* For purposes of paragraph (e)(2) the medical education payment adjustments are amounts that HCFA estimates were payable to teaching hospitals during 1997 for—

(1) the indirect costs of medical education under section 1886(d)(5)(B) of the Act; and

(2) The direct costs of graduate medical education under section 1886(h) of the Act.

(d) *General budget neutrality factor.* For each year, HCFA applies a budget neutrality factor to the blended capitation rates under § 422.252(a) so that the estimated aggregate payments made under this part equal the estimated aggregate payments that would have been made if based entirely on area-specific capitation rates.

(e) *Annual Area-specific capitation rate* (1) *Basic rule.* Subject to the provisions of paragraphs (e)(2) and (e)(3) of this section, the annual area-specific capitation rate for a particular payment area is—

(i) For 1998, subject to paragraph (e)(4) of this section, the per capita rate determined for that area for 1997 under section 1876(a)(1)(c) of the Act, increased by the national per capita growth percentage for 1998; and

(ii) For a subsequent year, the area-specific capitation rate determined for the previous year, increased by the national per capita growth percentage for the year.

(2) *Exclusion of medical education costs.* In calculating the area-specific capitation rates, the following percentages of the amounts estimated by HCFA under § 422.254(c) as medical education payment adjustments to hospitals, are excluded:

For 1998	20 percent.
For 1999	40 percent.
For 2000	60 percent.
For 2001	80 percent.
For years after 2001	100 percent.

(3) *Payments under the State hospital reimbursement system.* To the extent that HCFA estimates that a 1997 per

capita rate reflects payments to hospitals under section 1814(b)(3) of the Act, HCFA makes a payment adjustment that is comparable to the adjustment that would have been made under paragraph (e)(2) of this section if the hospitals had not been reimbursed under section 1814(b)(3) of the Act.

(4) *Areas with highly variable per capita rates.* With respect to a payment area for which the per capita rate for 1997 varies by more than 20 percent from the per capita rate for 1996, HCFA may substitute for the 1997 rate a rate that is more representative of the costs of the enrollees in the area.

(f) *National standardized annual capitation rate.* The national standardized annual capitation rate is equal to—

(1) The sum, for all payment areas, of the products of—

(i) The annual area-specific capitation rate and

(ii) The average number of Medicare beneficiaries residing in the area multiplied by the average of the risk-factor weights used to adjust payments under § 422.256(c);

(2) Divided by the sum, for all payment areas, of the products specified in paragraph (f)(1)(ii) of this section for all payment areas.

(g) *The input-price-adjusted annual national capitation rate*—(1) *General rule.* The input-price-adjusted annual national capitation rate for a M+C payment area for a year is equal to the sum, for all the types of Medicare services (as classified by HCFA), of the product (for each service) of—

(i) The national standardized annual M+C capitation rate (determined under paragraph (f) of this section) for the year;

(ii) The proportion of such rates for the year which is attributable to such type of services; and

(iii) An index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price for such services.

(2) HCFA may, subject to the special rules for 1988, use indices that are used in applying or updating national payment rates for particular areas and localities.

(3) *Special rules for 1988.* In applying this paragraph for 1998—

(i) Medicare services are classified as Part A and Part B services;

(ii) The proportion attributable to Part A services is the ratio (expressed as a percentage) of the national average per capita rate of payment for Part A services for 1997 to the national average per capita rate of payment for Part A and Part B services for that year;

(iii) The proportion attributed to part B services is 100 percent minus the ratio described in paragraph (g)(3)(ii) of this section;

(iv) For Part A services, 70 percent of the payments attributable to those services are adjusted by the index used under section 1886(d)(3)(E) of the Act to adjust payment rates for relative hospital wage levels for hospitals located in the particular payment area; and

(v) For part B services—

(A) 66 percent of payments attributable to those services are adjusted by the index of the geographic area factors under section 1848(e) of the Act used to adjust payment rates for physician services in the particular payment area; and

(B) Of the remaining 34 percent, 40 percent is adjusted by the index specified in paragraph (g)(3)(iv) of this section.

§ 422.256 Adjustments to capitation rates and aggregate payments.

(a) *Adjustment for over or under projection of national per capita growth percentages.* (1) Beginning with rates for 1999, HCFA adjusts all area-specific and national capitation rates for the previous year to reflect any differences between the projected national per capita growth percentages for that year and previous years, and the current estimates of those percentages for such years.

(2) Beginning with rates for 2000, HCFA also adjusts the minimum amount rate (calculated under § 422.252(b)) in the same manner.

(b) *Adjustment for national coverage determination (NCD) services.* If HCFA determines that the cost of furnishing an NCD service is ''significant,'' HCFA adjusts capitation rates for the next calendar year to take account of the cost of that service. Until the new capitation rates are in effect, the M+C organization is paid for the ''significant cost'' service on a fee-for-service basis as provided under section 422.105(b).

(c) *Risk adjustment: General rule.* Capitation payments are adjusted for age, gender, institutional status, and other appropriate factors, including health status.

(d) *Risk adjustment: Health status*—(1) *Data collection.* To adjust for health status, HCFA applies a risk factor based on data obtained in accordance with § 422.257.

(2) *Initial implementation.* HCFA applies this adjustment factor to payments beginning January 1, 2000.

(3) *Uniform application.* Except as provided for M+C RFB plans under § 422.250(a)(2)(iii), HCFA applies this adjustment factor to all types of plans.

§ 422.257 Encounter data.

(a) *Data collection: Basic rule.* Each M+C organization must submit to HCFA (in accordance with HCFA instructions) all data necessary to characterize the context and purposes of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

(b) *Types of service and timing of submittal.* M+C organizations must submit data as follows:

(1) Beginning on a date determined by HCFA, inpatient hospital care data for all discharges that occur on or after July 1, 1997.

(2) HCFA will provide advance notice to M+C organizations to collect and submit data for services that occur on or after July 1, 1998, as follow:

(i) Physician, outpatient hospital, SNF, and HHA data beginning no earlier than October 1, 1999; and

(ii) All other data HCFA deems necessary beginning no earlier than October 1, 2000.

(c) *Sources and extent of data.* (1) To the extent required by HCFA, the data must account for services covered under the original Medicare program, for Medicare covered services for which Medicare is not the primary payor, or for other additional or supplemental benefits that the M+C organization may provide.

(2) The data must account separately for each provider, supplier, physician, or other practitioner that would be permitted to bill separately under the Medicare fee-for-service program, even if they participate jointly in the same encounter.

(d) *Other data requirements.* The data must—

(1) Conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards; and

(2) Be submitted electronically to the appropriate HCFA contractor.

(e) *Validation of data.* M+C organizations and their providers and practitioners will be required to submit medical records for the validation of encounter data, as prescribed by HCFA.

(f) *Use of data.* HCFA uses the data obtained under this section to determine the risk adjustment factor that it applies to annual capitation rates under § 422.256(c). HCFA may also use the data for other purposes.

§ 422.258 Announcement of annual capitation rates and methodology changes.

(a) *Capitation rates.* (1) No later than March 1 of each year, HCFA announces to M+C organizations and other interested parties the capitation rates for the following calendar year.

(2) HCFA includes in the announcement a description of the risk and other factors and explains the methodology in sufficient detail to enable M+C organizations to compute monthly adjusted capitation rates for individuals in each of its payment areas.

(b) *Advance notice of changes in methodology.* (1) No later than January 15 of each year, HCFA notifies M+C organizations of changes it proposes to make in the factors and the methodology it used in the previous determination of capitation rates.

(2) The M+C organizations have 15 days to comment on the proposed changes.

§ 422.262 Special rules for beneficiaries enrolled in M+C MSA plans.

(a) *Establishment and designation of medical savings account (MSA).* A beneficiary who elects coverage under an M+C MSA plan—

(1) Must establish an M+C MSA with a trustee that meets the requirements of paragraph (b) of this section; and

(2) If he or she has more than one M+C MSA, designate the particular account to which payments under the M+C MSA plan are to be made.

(b) *Requirements for MSA trustees.* An entity that acts as a trustee for an M+C MSA must—

(1) Register with HCFA;

(2) Certify that it is a licensed bank, insurance company, or other entity qualified, under sections 408(a)(2) or 408(h) of the IRS Code, to act as a trustee of individual retirement accounts;

(3) Agree to comply with the M+C MSA provisions of section 138 of the IRS Code of 1986; and

(4) Provide any other information that HCFA may require.

(c) *Deposit in the M+C MSA.* (1) The payment is calculated as follows:

(i) The monthly M+C MSA premium is compared with 1/12 of the annual capitation rate for the area determined under § 422.252.

(ii) If the monthly M+C MSA premium is less than 1/12 of the annual capitation rate, the difference is the amount to be deposited in the M+C MSA for each month for which the beneficiary is enrolled in the MSA plan.

(2) HCFA deposits the full amount to which a beneficiary is entitled under paragraph (c)(1)(ii) of this section for the calendar year, beginning with the month in which M+C MSA coverage begins.

(3) If the beneficiary's coverage under the M+C MSA plan ends before the end of the calendar year, HCFA recovers the amount that corresponds to the remaining months of that year.

§ 422.264 Special rules for coverage that begins or ends during an inpatient hospital stay.

(a) *Applicability.* This section applies to inpatient services in a ''subsection (d) hospital'' as defined in section 1886(d)(1)(B) of the Act.

(b) *Coverage that begins during an inpatient hospital stay.* If coverage under an M+C plan offered by an M+C organization begins while the beneficiary is an inpatient in a subsection (d) hospital—

(1) Payment for inpatient services until the date of the beneficiary's discharge is made by the previous M+C organization or original Medicare, as appropriate.

(2) The M+C organization offering the newly-elected M+C plan is not responsible for the inpatient services until the date after the beneficiary's discharge; and

(3) The M+C organization offering the newly-elected M+C plan is paid the full amount otherwise payable under this subpart.

(c) *Coverage that ends during an inpatient hospital stay.* If coverage under an M+C plan offered by an M+C organization ends while the beneficiary is an inpatient in a subsection (d) hospital—

(1) The M+C organization is responsible for the inpatient services until the date of the beneficiary's discharge;

(2) Payment for those services during the remainder of the stay is not made by original Medicare or by any succeeding M+C organization offering a newly-elected M+C plan; and

(3) The M+C organization that no longer provides coverage receives no payment for the beneficiary for the period after coverage ends.

§ 422.266 Special rules for hospice care.

(a) *Information.* An M+C organization that has a contract under subpart K of this part must inform each Medicare enrollee eligible to elect hospice care under section 1812(d)(1) of the Act about the availability of hospice care (in a manner that objectively presents all available hospice providers, including a statement of any ownership interest in a hospice held by the M+C organization or a related entity) if—

(1) A Medicare hospice program is located within the plan's service area; or

(2) It is common practice to refer patients to hospice programs outside that area.

(b) *Enrollment Status.* Unless the enrollee disenrolls from the M+C plan, a beneficiary electing hospice continues his or her enrollment in the M+C plan and is entitled to receive, through the M+C plan, any benefits other than those that are the responsibility of the Medicare hospice.

(c) *Payment.* During the time the hospice election is in effect, HCFA's monthly capitation payment to the M+C organization is reduced to an amount equal to the adjusted excess amount determined under § 422.312. In addition, HCFA pays through the original Medicare program (subject to the usual rules of payment)—

(1) The hospice program for hospice care furnished to the Medicare enrollee; and

(2) The M+C organization, provider or supplier for other Medicare-covered services furnished to the enrollee.

§ 422.268 Source of payment and effect of election of the M+C plan election on payment.

(a) *Source of payments.* Payments under this subpart, to M+C organizations or M+C MSAs, are made from the Federal Hospital Insurance Trust Fund or the Supplementary Medical Insurance Trust Fund. HCFA determines the proportions to reflect the relative weight that benefits under Part A, and benefits under Part B represents of the actuarial value of the total benefits under title XVIII of the Act.

(b) *Payments to the M+C organization.* Subject to §§ 412.105(g) and 413.86(d) of this chapter and §§ 422.105, 422.264, and 422.266, HCFA's payments under a contract with an M+C organization (described in § 422.250) with respect to an individual electing an M+C plan offered by the organization are instead of the amounts which (in the absence of the contract) would otherwise be payable under original Medicare for items and services furnished to the individual.

(c) *Only the M+C organization entitled to payment.* Subject to § 422.262, 422.264, 422.266, and 422.520 of this part and sections 1886(d)(11) and 1886(h)(3)(D) of the Act, only the M+C organization is entitled to receive payment from HCFA under title XVIII of the Act for items and services furnished to the individual.

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Subpart G—Premiums and Cost-Sharing

§ 422.300 Basis and scope.

(a) *General.* This subpart is based on section 1854 of the Act. It sets forth the requirements and limitations for payments by and on behalf of Medicare beneficiaries who elect an M+C plan.

(b) *Transition period.* For contract periods beginning before January 1,

2002, HCFA applies the following special rules.

(1) M+C organizations may, with HCFA's agreement, modify an M+C plan offered prior to January 1, 2002 by—

(i) Adding benefits at no additional cost to the M+C plan enrollee; and

(ii) Lowering the premiums approved through the ACR process;

(iii) Lowering other cost-sharing amounts approved through the ACR process.

(2) For contracts beginning on a date other than January 1 (according to § 422.504(d)), M+C organizations may submit ACRs on a date other than May 1 approved by HCFA.

§ 422.302 Terminology.

As used in this subpart, unless specified otherwise—

Additional revenues are revenues collected or expected to be collected from charges for M+C plans offered by an M+C organization in excess of costs actually incurred or expected to be incurred. Additional revenues would include such things as revenues in excess of expenses of an M+C plan, profits, contribution to surplus, risk margins, contributions to risk reserves, assessments by a related entity that do not represent a direct medical or related administrative cost, and any other premium component not reflected in direct medical care costs and administrative costs.

APR stands for the M+C plan's average per capita rates of payment. The APR is the average amount the M+C organization estimates HCFA will pay (without any needed offsets or reductions, such as, those required by § 422.250(a)(2)(ii) for M+C MSA plan enrollees) for the period covered by the ACR for all of the Medicare beneficiaries electing the M+C plan.

M+C monthly basic beneficiary premium means, with respect to an M+C coordinated care plan, the amount authorized to be charged under § 422.308(a)(1) for the plan, or, with respect to a M+C private fee-for-service plan, the amount filed under § 422.306(d)(1).

M+C monthly supplemental beneficiary premium means, with respect to an M+C coordinated care plan, the amount authorized to be charged under § 422.308(a)(2) for the M+C plan, or, with respect to an MSA or an M+C private fee-for-service plan, the amount filed under § 422.306(c)(2) or § 422.306(d)(2).

M+C monthly MSA premium means, with respect to an M+C plan, the amount of such premium filed under § 422.306(c)(1).

§ 422.304 Rules governing premiums and cost-sharing.

(a) *Monthly premiums.* The monthly premium charged to the beneficiary is—

(1) For an individual enrolled in an M+C plan (other than an M+C MSA plan) offered by an M+C organization, the sum of the M+C monthly basic beneficiary premium plus the M+C monthly supplemental beneficiary premium (if any); or

(2) For an individual enrolled in an M+C MSA plan offered by an M+C organization, the M+C monthly supplemental beneficiary premium (if any).

(b) *Uniformity.* The M+C monthly basic beneficiary premium, the M+C monthly supplemental beneficiary premiums, and the M+C monthly MSA premium of an M+C organization may not vary among individuals enrolled in the M+C plan. In addition, the M+C organization may not vary the level of copayments, coinsurance, or deductibles charged for basic benefits or supplemental benefits (if any), among individuals enrolled in the M+C plan.

(c) *Timing of payments.* The M+C organization must permit payments of M+C monthly basic and supplemental beneficiary premium on a monthly basis and may not terminate coverage for failure to make timely payments except as provided in § 422.74(b)(1).

(d) *Monetary inducements prohibited.* An M+C organization may not provide for cash or other monetary rebates as an inducement for enrollment or for any other reason or purpose.

§ 422.306 Submission of proposed premiums and related information.

(a) *General rule.* (1) Not later than May 1 of each year, each M+C organization and any organization intending to contract as an M+C organization in the subsequent year must submit to HCFA, in the manner and form prescribed by HCFA, for each M+C plan it intends to offer in the following year—

(i) The information specified in paragraph (b), (c), or paragraph (d) of this section for the type of M+C plan involved; and

(ii) The service area and enrollment capacity (if any).

(2) If the submission is not complete, timely, or accurate, HCFA has the authority to impose sanctions under Subpart O of this part or may choose not to renew the contract.

(b) *Information required for coordinated care plans*—(1) *Basic benefits.* For basic benefits, the following information is required:

(i) The ACR as specified in § 422.310.

(ii) The M+C monthly basic beneficiary premium.

(iii) A description of cost-sharing to be imposed under the plan, and its actuarial value.

(iv) A description of any additional benefits to be provided pursuant to § 422.312 and the actuarial value determined for those benefits.

(v) Amounts collected in the previous contract period for basic benefits.

(2) *Supplemental benefits.* For supplemental benefits, the following information is required:

(i) The ACR.

(ii) The M+C monthly supplemental beneficiary premium.

(iii) A description of supplemental benefits being offered, the cost sharing to be imposed, and their actuarial value.

(iv) Amounts collected in the previous contract period for supplemental benefits.

(c) *Information required for MSA plans.* (1) The monthly MSA premium for basic benefits.

(2) The M+C monthly supplementary beneficiary premium for supplemental benefits.

(3) A description of all benefits offered under the M+C MSA plan.

(4) The amount of the deductible imposed under the plan.

(5) Amounts collected in the previous contract period for supplemental benefits.

(d) *Information required for M+C private fee-for-service plans.* (1) The information specified under paragraph (b)(1) of this section.

(2) The amount of the M+C monthly supplemental beneficiary premium.

(3) A description of all benefits offered under the plan.

(4) Amounts collected in the previous contract period for basic and supplemental benefits.

(e) *HCFA review*—(1) *Basic rule.* Except as specified in paragraph (e)(2) of this section, HCFA reviews and approves or disapproves the information submitted under this section.

(2) *Exception.* HCFA does not review or approve or disapprove the following information:

(i) Any amounts submitted with respect to M+C MSA plans.

(ii) The M+C monthly basic and supplementary beneficiary premiums for M+C private fee-for-service plans.

§ 422.308 Limits on premiums and cost sharing amounts.

(a) *Rules for coordinated care plans*—(1) For basic benefits, the M+C monthly basic beneficiary premium (multiplied by 12) charged, plus the actuarial value of the cost-sharing applicable, on average, to beneficiaries enrolled under this part may not exceed the annual actuarial value of the deductibles and

coinsurance that would be applicable, on average, to beneficiaries entitled to Medicare Part A and enrolled in Medicare Part B if they were not enrollees of an M+C organization as determined in the ACR under § 422.310. For those M+C plan enrollees that are enrolled in Medicare Part B only, the M+C monthly basic beneficiary premium (multiplied by 12) charged, plus the actuarial value of the deductibles, coinsurance and copayments applicable, on average, to those beneficiaries enrolled under this part may not exceed the annual actuarial value of the deductibles and coinsurance that would be applicable, on average, to beneficiaries enrolled in Medicare Part B if they were not enrollees of an M+C organization as determined in the ACR under § 422.310.

(2) *For supplemental benefits*, the M+C monthly supplemental beneficiary premium (multiplied by 12) charged, plus the actuarial value of its cost-sharing, may not exceed the amounts approved in the ACR for those benefits, as determined under § 422.310 on an annual basis.

(3) *Coverage of Part A services for Part B-only Medicare enrollees.* If an M+C organization furnishes coverage of Medicare Part A-type services to a Medicare enrollee entitled to Part B only, the M+C plan's premium plus the actuarial value of its cost-sharing for these services may not exceed the lesser of—

(i) The APR that is payable for these services for those beneficiaries entitled to Part A plus the actuarial value of Medicare deductibles and Coinsurance for the services;

(ii) or the ACR for such services.

(b) *Rule for M+C private fee-for-service plans.* The average actuarial value of the cost-sharing for basic benefits may not exceed the actuarial value of the cost-sharing that would apply, on average, to beneficiaries entitled to Medicare Part A and enrolled in Medicare Part B if they were not enrolled in an M+C plan as determined in the ACR under § 422.310.

(c) *Special rules for determination of actuarial value.* If HCFA determines that adequate data are not available to determine actuarial value under paragraph (a) or (b) of this section, HCFA may make the determination with respect to all M+C eligible individuals in the same geographic area or State or in the United States, or on the basis of other appropriate data.

§ 422.309 Incorrect collections of premiums and cost-sharing.

(a) *Definitions.* As used in this section—

(1) *Amounts incorrectly collected*

(i) Means amounts that:

(A) Exceed the limits imposed by § 422.308;

(B) In the case of a M+C private fee-for-service plan, exceed the M+C monthly basic beneficiary premium or the M+C monthly supplemental premium submitted under § 422.306; and

(C) In the case of a M+C MSA plan, exceed the M+C monthly supplemental premium submitted under § 422.306 and the deductible for basic benefits; and

(ii) Includes amounts collected from an enrollee who was believed not entitled to Medicare benefits but was later found to be entitled.

(2) *Other amounts due* are amounts due for services that were—

(i) Emergency, urgently needed services, or other services obtained outside the M+C plan; or

(ii) Initially denied but, upon appeal, found to be services the enrollee was entitled to have furnished by the M+C organization.

(b) *Basic commitments.* An M+C organization must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf.

(c) *Refund methods*—(1) *Lump-sum payment.* The M+C organization must use lump-sum payments for the following:

(i) Amounts incorrectly collected that were not collected as premiums.

(ii) Other amounts due.

(iii) All amounts due if the M+C organization is going out of business or terminating its M+C contract for an M+C plan(s).

(2) *Premium adjustment or lump-sum payment, or both.* If the amounts incorrectly collected were in the form of premiums, or included premiums as well as other charges, the M+C organization may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payments.

(3) *Refund when enrollee has died or cannot be located.* If an enrollee has died or cannot be located after reasonable effort, the M+C organization must make the refund in accordance with State law.

(d) *Reduction by HCFA.* If the M+C organization does not make the refund required under 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 reduces the premium the M+C organization is allowed to charge an M+C plan enrollee by the amounts incorrectly collected or otherwise due. In addition, the M+C organization would be subject to sanction under Subpart O for failure to refund amounts incorrectly collected from M+C plan enrollees.

§ 422.310 Adjusted community rate (ACR) approval process.

(a) *General rule.* (1) Except with respect to M+C MSA plans, each M+C organization must compute a separate ACR for each M+C coordinated care or private fee-for-service plan offered to Medicare beneficiaries. In computing the ACR, the M+C organization calculates an initial rate (for years after 1999, using the methods described in paragraph (b), for 1999, under § 417.594(b)) that represents the ''commercial premium'' the M+C organization would charge its general non-Medicare eligible enrollment population for the basic benefits, and any mandatory supplemental benefits covered under the M+C plan. The M+C organization should also calculate a separate initial rate (using the same approach) for each optional supplemental benefit package it offers under an M+C plan. For years after 1999 the M+C 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 (c)(6) of this section. For 1999, adjustments are made under section 417.594(c). All data submitted as part of the ACR process is subject to audit by HCFA or any person or organization designated by HCFA.

(2) To calculate the adjusted excess described in section 422.312, the M+C organization or HCFA further reduces the rate for Medicare-covered services 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 for each M+C plan offered, and for each optional supplemental benefit option.

(4) In calculating its initial rate, the M+C organization must identify and take into account anticipated revenue collectible from other payers for those services for which Medicare is not the primary payer as described in § 422.108.

(5) Except as provided in paragraph (a)(6) of this section, the M+C organization must have an adequate accounting system that is accrual based and uses generally-accepted accounting principles to develop its ACR.

(6) For M+C organizations that are part of a government entity that uses a cash basis of accounting, ACR cost data

developed on this basis is acceptable. However, only depreciation on capital assets, rather than the expenditure for the asset, is acceptable.

(b) *Initial rate calculation for years after 1999.* (1) The M+C organization's initial rate for each M+C plan is calculated on a 12-month basis for non-Medicare enrollees, using either, at the M+C organization's election—

(i) A community rating system (as defined in section 1308(8) of the PHS Act, other than subparagraph (C)); or

(ii) A system, approved by HCFA, under which the M+C organization develops an aggregate premium for each M+C plan for all enrollees of that M+C plan that is weighted by the size of the various enrolled groups and individuals that compose the M+C organization's enrollment in that M+C plan. For purposes of this section, enrolled groups are defined as employee groups or other bodies of subscribers (including individual subscribers) that enroll in the M+C plan on a premium basis.

(2) Regardless of which method the M+C organization uses to calculate its initial rate, the initial rate must be equal to the premium the M+C organization would charge its non-Medicare enrollees on a yearly basis for services included in the M+C plan.

(3) Except as provided in paragraph (b)(4) of this section, the M+C organization must identify in its initial rate calculation for an M+C plan, the following components whose rates must be consistent with rates used by the M+C organization in calculating premiums for non-Medicare enrollees:

(i) Direct medical care.

(ii) Administration.

(iii) Additional Revenues.

(iv) Enrollee cost sharing (for example, deductibles, coinsurance, or copayments) for Medicare-covered services and for additional and supplemental benefits.

(4) An M+C 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 M+C organization provides HCFA with the documentation necessary to support any adjustments the M+C organization makes to the initial rate in accordance with paragraph (c)(5) of this section.

(5) The initial rate calculation must not carry forward any losses experienced by the M+C organization during prior contract periods. The M+C organization must submit supporting documentation to assure HCFA that ACR values do not include past losses but only premiums for covered services, additional services, and supplemental benefits for the upcoming 12-month period.

(c) *Adjustment factors for years after 1999.* Adjustment factors are designed to adjust on a component basis the initial rate calculated under paragraph (b) of this section to reflect differences in utilization characteristics of the M+C organization's Medicare enrollees electing an M+C plan using a relative cost ratio. Adjustment factors are as follows:

(1) *Direct medical care.* The relative cost ratio for direct medical care for an M+C plan is determined by comparing the direct medical care costs actually incurred on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees that elected the M+C plan to the direct medical care costs of non-Medicare enrollees incurred over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation.

(2) *Administration.* The relative cost ratio for Administration for an M+C plan is determined by comparing the administrative costs actually incurred on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees that elected the M+C plan to the administrative costs of non-Medicare enrollees incurred over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation.

(3) *Additional revenues.* The relative cost ratio for additional revenues for an M+C plan is determined by comparing the additional revenues collected on an accrual basis during the most recently ended calendar year prior to submission of the ACR for Medicare enrollees that elected the M+C plan to the additional revenues of non-Medicare enrollees collected over the same period. The non-Medicare enrollees included in this computation must be consistent with the non-Medicare enrollees included in the initial rate computation.

(4) *Additional adjustments.* Additional adjustments may be necessary if the M+C organization, with agreement of HCFA, determines that the adjustment of the initial rate by the relative cost ratios does not represent an accurate ACR value of the initial rate component. Adjustments will be allowed that are designed to reduce ACR values to equal the actuarial value of the M+C plan charge structure.

(5) *Supporting documentation.* All adjustments made by the M+C organization must be accompanied by adequate supporting data. If an M+C organization does not have sufficient enrollment experience to develop this data, it may, during its initial contract period use reasonable estimates acceptable to HCFA to establish its ACR values.

(6) *Adjustment by HCFA.* If it is determined that the M+C organization does not have adequate data to adjust the initial rate calculated under paragraph (b) of this section to reflect the utilization characteristics of Medicare enrollees, HCFA adjusts the initial rate. HCFA adjusts the rate on the basis of differences in the utilization characteristics of—

(i) Medicare and non-Medicare enrollees in other M+C plans; or

(ii) Medicare beneficiaries in the M+C organization's area, State, or the United States who are eligible to elect an M+C plan and other individuals in that same area, State, or the United States.

(d) *Special rules for certain organizations.* An M+C organization that does not have non-Medicare enrollees or sufficient Medicare enrollment experience to adequately calculate ACR values may calculate its ACR using estimates described in paragraphs (a)(1) and (a)(2) of this section as an additional adjustment described in paragraph (c)(4) of this section.

(1) The M+C organization may use an estimate of the ACR value for the direct medical and administrative components of a service or services offered using generally-accepted accounting principles.

(2) The M+C organization may use an estimate of the ACR value for the additional revenue component of a service or services offered based on the lesser of (if the information is available)—

(i) The average of additional revenues received through risk payments for health services contracted to be furnished to an enrolled population of other organizations;

(ii) The average of additional revenues received for health services furnished; or

(iii) A reasonable estimate of additional revenues of other M+C organizations in the general marketplace.

(e) *Adjustment by HCFA.* If HCFA finds that there is insufficient enrollment experience to determine the APR or ACR for a M+C plan at the beginning of a contract period, HCFA may—

(1) Determine the APR based on the enrollment experience of other M+C organizations;

(2) Determine ACR using data in the general commercial marketplace; or

(3) Determine either or both rates using the best available information, which may include enrollment experience of other M+C organizations and section 1876 risk contractors.

(f) *HCFA review.* (1) The M+C organization's methodology and computation of its ACR are subject to review and approval by HCFA. When the M+C organization submits the ACR computation, it must include adequate supporting data. Except as provided in § 422.306(e)(2), HCFA authorizes the M+C organization to collect premiums and other cost sharing amounts described in § 422.306 that are equal to the amounts calculated in the ACR.

(2) If the M+C organization is dissatisfied with an HCFA determination that the M+C organization's computation is not acceptable, the M+C organization may within 2 weeks after the date of receipt of notification of this determination, file a request for a hearing with HCFA. The request must state why the M+C organization believes the determination is incorrect and must be accompanied by any supporting evidence the M+C organization wishes to submit. The hearing is conducted by a hearing officer designated by HCFA under the hearing procedures described in subpart N.

§ 422.312 Requirement for additional benefits.

(a) *Definitions.* As used in this section—

(1) *Excess amount* is the amount by which the APR exceeds the actuarial value of the Medicare covered services required under § 422.101(a), as determined on the basis of the ACR determined under § 422.310, as reduced for the actuarial value of the cost-sharing under Medicare Parts A and B. A separate excess amount must be determined for Part B-only enrollees.

(2) *Adjusted excess amount* is the excess amount minus any amount withheld and reserved for the organization in a stabilization fund, as provided in paragraph (c) of this section.

(b) *Requirement for additional benefits.* If there is an adjusted excess amount for the plan it offers, the M+C organization must—

(1) Provide additional benefits with an actuarial value (less the actuarial value of any copayment or coinsurance associated with the benefit) which HCFA determines is at least equal to the adjusted excess amount; and

(2) Provide those benefits uniformly for all Medicare enrollees electing the plan.

(c) *Stabilization fund.* (1) An M+C organization may request for part of an excess amount to be withheld and reserved, for a specified number of contract periods, in the Federal Hospital Insurance Trust Fund, or the Federal Supplementary Insurance Trust Fund in the proportions that HCFA determines to be appropriate.

(2) The reserved funds are to be used to stabilize and prevent undue fluctuations in the additional benefits that are required under this section and are provided during subsequent contract periods.

(3) Any amounts not provided as additional benefits during the period specified by the M+C organization for which the stabilization fund is established, reverts for the use of the trust funds.

(4) *Establishment of a stabilization fund.* An M+C organization's request to have monies withheld in a stabilization fund for a specific M+C plan must be made when the M+C organization notifies HCFA under § 422.306 of its proposed premiums, other cost-sharing amounts, and related information in preparation for its next contract period.

(i) *Limit per contract period.* Except as provided in paragraph (c)(4)(iii) of this section, HCFA does not withhold in a stabilization fund more than 15 percent of the excess amount for a given contract period.

(ii) *Cumulative limit.* If HCFA has established a stabilization fund for an M+C plan, it does not approve a request for withholding made by that M+C organization for a subsequent contract period that would cause the total value of the stabilization fund to exceed 25 percent of the excess amount applicable to the M+C plan for that subsequent contract period.

(iii) *Exception.* HCFA may grant an exception to the limit described in paragraph (c)(3)(i) of this section if the M+C organization can demonstrate to HCFA's satisfaction that the value of the additional benefits it provides to its Medicare enrollees electing this M+C plan fluctuates substantially in excess of 15 percent from one contract period to another.

(iv) *Interest.* The amounts withheld in a stabilization fund are accounted for by HCFA in accounts for which interest does not accrue to the M+C organization.

(5) *Withdrawal from a stabilization fund.* An M+C organization's request to make a withdrawal from the stabilization fund established for an M+C plan to be used during a contract period must be made when the M+C organization notifies HCFA under § 422.306 of its proposed premiums, cost-sharing amounts, and related information in preparation for its next contract period.

(i) *Notification requirements.* An M+C organization must—

(A) Indicate how it intends to use the withdrawn amounts;

(B) Justify the need for the withdrawal in terms of stabilizing the additional benefits it provides to Medicare enrollees;

(C) Document the M+C plan's experience with fluctuations of revenue requirements relative to the additional benefits it provides to Medicare enrollees; and

(D) Document its experience during the contract period previous to the one for which it requests withdrawal to ensure that the M+C organization will not be using the withdrawn amounts to refinance losses suffered during that previous contract period.

(ii) *Criteria for HCFA approval.* HCFA approves a request for a withdrawal from a benefit stabilization fund for use during the next contract period only if—

(A) The average of the APR for the M+C plan's next contract period of the M+C plan is less than that of the previous contract period;

(B) The M+C plan's ACR for the next contract period is significantly higher than that of the previous contract period;

(C) The M+C plan'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; or

(D) The ACR for the next contract period results in additional benefits that are significantly less in total value than that of the previous contract period.

(iii) *Basis for denial.* HCFA does not approve a request for a withdrawal from a stabilization fund if the withdrawal would allow the M+C organization to refinance prior contract period losses or to avoid losses in the upcoming contract period.

(iv) *Form of payment.* Payment of monies withdrawn from a stabilization fund is made, in equal parts, as an additional amount to the monthly advance payment made to the M+C organization for Medicare beneficiaries electing the M+C plan during the period of the contract.

(d) Construction. Nothing in this section may be construed as preventing an M+C organization from providing supplemental benefits in addition to those required under this section and

from imposing a premium for those supplemental benefits.

Subpart H—Provider-Sponsored Organizations

3. *Nomenclature change.* Throughout subpart H, ''Medicare+Choice'', wherever it appears, is revised to read ''M+C''.

4. *Nomenclature change.* Throughout subpart H, ''items and services'', wherever it appears, is revised to read ''services''.

§ 422.350 [Amended]

5. In § 422.350, the following changes are made:

a. In paragraph (a)(1), ''hereinafter referred to as PSOs'' is revised to read ''(PSOs)''.

b. The definition of ''capitated basis'' is removed and a definition of ''capitation payment'' is added in its place, to read as set forth below.

c. In the definition of ''cash equivalent'', ''accounts receivables, which'' is revised to read ''accounts receivable that''.

d. The definition of ''health care provider'' and the statement for ''M+C'' are removed.

e. In the definition of ''insolvency'', ''where'' is revised to read ''in which''.

f. The definition of ''provider-sponsored organization is revised to read as set forth below.

§ 422.350 Basis, scope, and definitions.

* * * * *

Capitation payment means a fixed per enrollee per month amount paid for contracted services without regard to the type, cost, or frequency of services furnished.

* * * * *

Provider-sponsored organization (PSO) means a public or private entity that—

(1) Is established or organized, and operated, by a health care provider or group of affiliated health care providers;

(2) Provides a substantial proportion (as defined in § 422.352) of the health care services under the M+C contract directly through the provider or affiliated group of providers; and

(3) When it is a group, is composed of affiliated providers who—

(i) Share, directly or indirectly, substantial financial risk, as determined under § 422.356, for the provision of services that are the obligation of the PSO under the M+C contract; and

(ii) Have at least a majority financial interest in the PSO.

§ 422.352 [Amended]

6. In § 422.352, the following changes are made:

a. In paragraph (a)(1) ''such licensure'' is revised to read ''State licensure'', and ''section 1855(a)(2) of the Act'' is revised to read ''§ 422.370''.

b. In paragraph (b)(2), ''as defined in § 422.354'' is removed.

c. Paragraph (c) is revised to read as follows:

§ 422.352 Basic requirements.

* * * * *

(c) *Rural PSO.* To qualify as a rural PSO, a PSO must—

(1) Demonstrate to HCFA that—

(i) It has available in the rural area, as defined in § 412.62(f) of this chapter, routine services including but not limited to primary care, routine specialty care, and emergency services; and

(ii) The level of use of providers outside the rural area is consistent with general referral patterns for the area; and

(2) Enroll Medicare beneficiaries, the majority of which reside in the rural area the PSO serves.

§ 422.354 [Amended]

7. In § 422.354, the following changes are made:

a. In the introductory text, ''of by two or more'' is revised to read ''of two or more''.

b. In paragraphs (a)(1), (a)(2), and (c), the parenthetical phrases are removed.

c. Paragraph (b) is revised to read as follows:

§ 422.354 Requirements for affiliated providers.

* * * * *

(b) Each affiliated provider of the PSO shares, directly or indirectly, substantial financial risk for the furnishing of services the PSO is obligated to provide under the contract.

* * * * *

§ 422.356 [Amended]

8. In § 422.356, in paragraph (a)(3)(ii), ''Agreement by the affiliated provider'' is revised to read ''Affiliated providers agree''.

§ 422.370 [Amended]

9. In § 422.370 the following changes are made:

a. In the introductory text, the word ''as'' is revised to read ''to offer''.

b. Paragraphs (1) and (2) are redesignated as paragraphs (a) and (b).

10. § 422.372 is revised to read as follows:

§ 422.372 Basis for waiver of State licensure.

(a) *General rule.* Subject to this section and to paragraphs (a) and (e) of § 422.374, HCFA may waive the State licensure requirement if the organization has applied (except as provided in paragraph (b)(4) of this section) for the most closely appropriate State license or authority to conduct business as an M+C plan.

(b) *Basis for waiver of State licensure.* Any of the following may constitute a basis for HCFA's waiver of State licensure.

(1) *Failure to act timely on application.* The State failed to complete action on the licensing application within 90 days of the date the State received a substantially complete application.

(2) *Denial of application based on discriminatory treatment.* The State has—

(i) Denied the license application on the basis of material requirements, procedures, or standards (other than solvency requirements) not generally applied by the State to other entities engaged in a substantially similar business; or

(ii) Required, as a condition of licensure that the organization offer any product or plan other than an M+C plan.

(3) *Denial of application based on different solvency requirements.* (i) The State has denied the application, in whole or in part, on the basis of the organization's failure to meet solvency requirements that are different from those set forth in §§ 422.380 through 422.390; or

(ii) HCFA determines that the State has imposed, as a condition of licensure, any documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, or standards set forth by HCFA to implement, monitor, and enforce §§ 422.380 through 422.390.

(4) *State declines to accept licensure application.* The appropriate State licensing authority has given the organization written notice that it will not accept its licensure application.

11. In § 422.374, paragraph (b) is revised to read as follows:

§ 422.374 Waiver request and approval process.

* * * * *

(b) HCFA gives the organization written notice of granting or denial of waiver within 60 days of receipt of a substantially complete waiver request.

* * * * *

12. In § 422.384, paragraph (b)(3) is revised to read as follows:

§ 422.384 Financial plan requirement.

* * * * *

(b) * * *

(3) Cash-flow statements;

* * * * *

13. *Nomenclature change:* Throughout subpart H, the phrase ''health care provider'', wherever it appears, is revised to read ''provider''.

14. Subpart I is added as follows:

Subpart I—Organization Compliance with State Law and Preemption by Federal Law

Sec.
422.400 State licensure requirement.
422.402 Federal preemption of State law.
422.404 State premium taxes prohibited.

Subpart I—Organization Compliance with State Law and Preemption by Federal Law

§ 422.400 State licensure requirement.

Except in the case of a PSO granted a waiver under subpart H of this part, each M+C organization must—

(a) Be licensed under State law, or otherwise authorized to operate under State law, as a risk-bearing entity (as defined in § 422.2) eligible to offer health insurance or health benefits coverage in each State in which it offers one or more M+C plans;

(b) If not commercially licensed, obtain certification from the State that the organization meets a level of financial solvency and such other standards as the State may require for it to operate as an M+C organization; and

(c) Demonstrate to HCFA that—

(1) The scope of its license or authority allows the organization to offer the type of M+C plan or plans that it intends to offer in the State; and

(2) If applicable, it has obtained the State certification required under paragraph (b) of this section.

§ 422.402 Federal preemption of State law.

(a) *General preemption.* Except as provided in paragraph (b) of this section, the rules, contract requirements, and standards established under this part supersede any State laws, regulations, contract requirements, or other standards that would otherwise apply to M+C organizations and their M+C plans only to the extent that such State laws are inconsistent with the standards established under this part. This preemption of State laws and other standards applies only to coverage pursuant to an M+C contract, and does not extend to benefits outside of such contract or to individuals who are not M+C enrollees of an organization with an M+C contract.

(b) *Specific preemption.* As they might otherwise apply to the M+C plans of an M+C organization in a State, State laws and regulations pertaining to the following areas are specifically preempted by this part:

(1) Benefit requirements, such as mandating the inclusion in an M+C plan of a particular service, or specifying the scope or duration of a service (for example, length of hospital stay, number of home health visits). State cost-sharing standards with respect to any benefits are preempted only if they are inconsistent with this part, as provided for in paragraph (a) of this section.

(2) Requirements relating to inclusion or treatment of providers and suppliers.

(3) Coverage determinations (including related appeal and grievance processes for all benefits included under an M+C contract). Determinations on issues other than whether a service is covered under an M+C contract, and the extent of enrollee liability under the M+C plan for such a service, are not considered coverage determinations for purposes of this paragraph.

(c) Except as provided in paragraphs (a) and (b) of this section, nothing in this section may be construed to affect or modify the provisions of any other law or regulation that imposes or preempts a specific State authority.

§ 422.404 State premium taxes prohibited.

(a) *Basic rule.* No premium tax, fee, or other similar assessment may be imposed by any State, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa, or any of their political subdivision or other governmental authorities with respect to any payment HCFA makes on behalf of M+C enrollees under subpart F of this part.

(b) *Construction.* Nothing in this section shall be construed to exempt any M+C organization from taxes, fees, or other monetary assessments related to the net income or profit that accrues to, or is realized by, the organization from business conducted under this part, if that tax, fee, or payment is applicable to a broad range of business activity.

Subpart J [Reserved]

15. Subpart J is reserved.

16. Subpart K is added as follows:

Subpart K—Contracts With Medicare+Choice Organizations

Sec.
422.500 Definitions.
422.501 General provisions.
422.502 Contract provisions.
422.504 Effective date and term of contract.
422.506 Nonrenewal of contract.
422.508 Modification or termination of contract by mutual consent.
422.510 Termination of contract by HCFA.
422.512 Termination of contract by the M+C organization.
422.514 Minimum enrollment requirements.
422.516 Reporting requirements.
422.520 Prompt payment by M+C organization.
422.524 Special rules for RFB societies.

Subpart K—Contracts With Medicare+Choice Organizations

§ 422.500 Definitions.

For purposes of this subpart, the following definitions apply:

Business transaction means any of the following kinds of transactions:

(1) Sale, exchange, or lease of property.

(2) Loan of money or extension of credit.

(3) Goods, services, or facilities furnished for a monetary consideration, including management services, but not including—

(i) Salaries paid to employees for services performed in the normal course of their employment; or

(ii) Health services furnished to the M+C organization's enrollees by hospitals and other providers, and by M+C organization staff, medical groups, or independent practice associations, or by any combination of those entities.

Clean Claim means a claim that has no defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

Party in interest includes the following:

(1) Any director, officer, partner, or employee responsible for management or administration of an M+C organization.

(2) Any person who is directly or indirectly the beneficial owner of more than 5 percent of the organization's equity; or the beneficial owner of a mortgage, deed of trust, note, or other interest secured by and valuing more than 5 percent of the organization.

(3) In the case of an M+C organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law.

(4) Any entity in which a person described in paragraph (1), (2), or (3) of this definition:

(i) Is an officer, director, or partner; or

(ii) Has the kind of interest described in paragraphs (1), (2), or (3) of this definition.

(5) Any person that directly or indirectly controls, is controlled by, or is under common control with, the M+C organization.

(6) Any spouse, child, or parent of an individual described in paragraph (1), (2), or (3) of this definition.

Related entity means any entity that is related to the M+C organization by common ownership or control and—

(1) Performs some of the M+C 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 M+C organization at a cost of more than $2,500 during a contract period.

Significant business transaction means any business transaction or series of transactions of the kind specified in the above definition of ''business transaction'' that, during any fiscal year of the M+C organization, have a total value that exceeds $25,000 or 5 percent of the M+C organization's total operating expenses, whichever is less.

§ 422.501 General provisions.

(a) *Basic rule.* In order to qualify as an M+C organization, enroll beneficiaries in any M+C plans it offers, and be paid on behalf of Medicare beneficiaries enrolled in those plans, an M+C organization must enter into a contract with HCFA.

(b) *Conditions necessary to contract as an M+C organization.* Any entity seeking to contract as an M+C organization must:

(1) Be licensed by the State as a risk bearing entity in each State in which it seeks to offer an M+C plan as defined in § 422.2.

(2) Meet the minimum enrollment requirements of § 422.514, unless waived under § 422.514(b).

(3) Have administrative and management arrangements satisfactory to HCFA, as demonstrated by at least the following:

(i) A policy making body that exercises oversight and control over the M+C organization's policies and personnel to ensure that management actions are in the best interest of the organization and its enrollees.

(ii) Personnel and systems sufficient for the M+C organization to organize, plan, control, and evaluate financial and marketing activities, the furnishing of services, the quality assurance program, and the administrative and management aspects of the organization.

(iii) At a minimum, an executive manager whose appointment and removal are under the control of the policy making body.

(iv) A fidelity bond or bonds, procured and maintained by the M+C organization, in an amount fixed by its policymaking body but not less than $100,000 per individual, covering each officer and employee entrusted with the handling of its funds. The bond may have reasonable deductibles, based upon the financial strength of the M+C organization.

(v) Insurance policies or other arrangements, secured and maintained by the M+C organization and approved by HCFA to insure the M+C organization against losses arising from professional liability claims, fire, theft, fraud, embezzlement, and other casualty risks.

(vi) A compliance plan that consists of the following:

(A) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable Federal and State standards.

(B) The designation of a compliance officer and compliance committee that are accountable to senior management.

(C) Effective training and education between the compliance officer and organization employees.

(D) Effective lines of communication between the compliance officer and the organization's employees.

(E) Enforcement of standards through well-publicized disciplinary guidelines.

(F) Provision for internal monitoring and auditing.

(G) Ensures prompt response to detected offenses and development of corrective action initiatives.

(H) An adhered-to process for reporting to HCFA and/or the OIG credible information of violations of law by the M+C organization, plan, subcontractors or enrollees for a determination as to whether criminal, civil, or administrative action may be appropriate. With respect to enrollees, this reporting requirement shall be restricted to credible information on violations of law with respect to enrollment in the plan, or the provision of, or payment for, health services.

(4) Not accept new enrollees under a section 1876 reasonable cost contract in any area in which it seeks to offer an M+C plan.

(5) The M+C organization's contract must not have been terminated by HCFA under § 422.510 within the past 5 years.

(c) *Contracting authority.* Under the authority of section 1857(c)(5) of the Act, HCFA may enter into contracts under this part without regard to Federal and Departmental acquisition regulations set forth in title 48 of the CFR and provisions of law or other regulations relating to the making, performance, amendment, or modification of contracts of the United States if HCFA determines that those provisions are inconsistent with the efficient and effective administration of the Medicare program.

(d) *Protection against fraud and beneficiary protections.* (1) HCFA annually audits the financial records (including data relating to Medicare utilization, costs, and computation of the ACR) of at least one-third of the M+C organizations offering M+C plans. These auditing activities are subject to monitoring by the Comptroller General.

(2) Each contract under this section must provide that HCFA, or any person or organization designated by HCFA has the right to:

(i) Inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the M+C contract;

(ii) Inspect or otherwise evaluate the facilities of the organization when there is reasonable evidence of some need for such inspection; and

(iii) Audit and inspect any books, contracts, and records of the M+C organization that pertain to—

(A) The ability of the organization to bear the risk of potential financial losses, or

(B) Services performed or determinations of amounts payable under the contract.

(e) *Severability of contracts.* The contract must provide that, upon HCFA's request—

(1) The contract will be amended to exclude any M+C plan or State-licensed entity specified by HCFA; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

§ 422.502 Contract provisions.

The contract between the M+C organization and HCFA must contain the following provisions:

(a) *Agreement to comply with regulations and instructions.* The M+C organization agrees to comply with all the applicable requirements and conditions set forth in this part and in general instructions. An M+C organization's compliance with paragraphs (a)(1) through (a)(13) of this section is material to performance of the contract. The M+C organization agrees—

(1) To accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of this part.

(2) That it will comply with the prohibition in § 422.108 on discrimination in beneficiary enrollment.

(3) To provide—

(i) The basic benefits as required under § 422.100 and, to the extent applicable, supplemental benefits under § 422.101; and

(ii) Access to benefits as required under subpart C of this part;

(iii) In a manner consistent with professionally recognized standards of health care, all benefits covered by Medicare.

(4) To disclose information to beneficiaries in the manner and the form prescribed by HCFA as required under § 422.110;

(5) To operate a quality assurance and performance improvement program and have an agreement for external quality review as required under subpart D of this part;

(6) To comply with all applicable provider requirements in subpart E of this part, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans;

(7) To comply with all requirements in subpart M of this part governing coverage determinations, grievances, and appeals;

(8) To comply with the reporting requirements in § 422.516 and the requirements in § 422.257 for submitting encounter data to HCFA;

(9) That it will be paid under the contract in accordance with the payment rules in subpart F of this part;

(10) To develop its annual ACR, and submit all required information on premiums, benefits, and cost-sharing by May 1, as provided in subpart G of this part;

(11) That its contract may not be renewed or may be terminated in accordance with this subpart and subpart N of this part.

(12) To comply will all requirements that are specific to a particular type of M+C plan, such as the special rules for private fee-for-service plans in §§ 422.114 and 422.216 and the MSA requirements in §§ 422.56, 422.103, and 422.262; and

(13) To comply with the confidentiality and enrollee record accuracy requirements in § 422.118.

(14) An M+C organization's compliance with paragraphs (a)(1) through (a)(13) and (c) of this section is material to performance of the contract.

(b) *Communication with HCFA.* The M+C organization must have the capacity to communicate with HCFA electronically.

(c) *Prompt payment.* The M+C organization must comply with the prompt payment provisions of § 422.520 and with instructions issued by HCFA, as they apply to each type of plan included in the contract.

(d) *Maintenance of records.* The M+C organization agrees to maintain for 6 years books, records, documents, and other evidence of accounting procedures and practices that—

(1) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the ACR) of M+C organizations.

(ii) Enable HCFA to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the organization.

(iii) Enable HCFA to audit and inspect any books and records of the M+C organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the ACR proposal.

(v) Establish component rates of the ACR for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(2) Include at least records of the following:

(i) Ownership and operation of the M+C organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and six prior periods.

(iii) Federal income tax or informational returns for the current contract period and six prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts, and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the M+C organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities.

(e) *Access to facilities and records.* The M+C organization agrees to the following:

(1) HHS, the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the M+C organization; and

(iii) The enrollment and disenrollment records for the current contract period and six prior periods.

(2) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, patient care documentation, and other records of the M+C organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(3) The M+C organization agrees to make available, for the purposes specified in paragraph (d) of this section, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that HCFA may require.

(4) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 6 years from the final date of the contract period or completion of audit, whichever is later unless—

(i) HCFA determines there is a special need to retain a particular record or group of records for a longer period and notifies the M+C organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the M+C organization, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HCFA determines that there is a reasonable possibility of fraud, in which case it may inspect, evaluate, and audit the M+C organization at any time.

(f) *Disclosure of information.* The M+C organization agrees to submit—

(1) To HCFA, certified financial information that must include the following:

(i) Such information as HCFA may require demonstrating that the organization has a fiscally sound operation.

(ii) Such information as HCFA may require pertaining to the disclosure of ownership and control of the M+C organization.

(2) To HCFA, all information that is necessary for HCFA to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective

beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(i) The benefits covered under an M+C plan;

(ii) The M+C monthly basic beneficiary premium and M+C monthly supplemental beneficiary premium, if any, for the plan or in the case of an MSA plan, the M+C monthly MSA premium.

(iii) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(iv) Plan quality and performance indicators for the benefits under the plan including —

(A) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(B) Information on Medicare enrollee satisfaction;

(C) Information on health outcomes;

(D) The recent record regarding compliance of the plan with requirements of this part, as determined by HCFA; and

(E) Other information determined by HCFA to be necessary to assist beneficiaries in making an informed choice among M+C plans and traditional Medicare;

(v) Information about beneficiary appeals and their disposition;

(vi) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(vii) For M+C organizations offering an MSA plan, information specified by HCFA for HCFA's use in preparing its report to the Congress on the MSA demonstration, including data specified by HCFA in the areas of selection, use of preventative care, and access to services.

(viii) To HCFA, any other information deemed necessary by HCFA for the administration or evaluation of the Medicare program.

(3) To its enrollees all informational requirements under § 422.64 and, upon an enrollee's, request the financial disclosure information required under § 422.516.

(g) *Beneficiary Financial Protection.* The M+C organization agrees to comply with the following requirements:

(1) Each M+C organization must adopt and maintain arrangements satisfactory to HCFA to protect its enrollees from incurring liability for payment of any fee that are the legal obligation of the M+C organization. To meet this requirement the M+C organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the organization's providers from holding any beneficiary enrollee liable for payment of any such fees; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the M+C organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the M+C organization, to provide services to the organization's beneficiary enrollees.

(2) The M+C organization must provide for continuation of enrollee health care benefits—

(i) For all enrollees, for the duration of the contract period for which HCFA payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with HCFA terminates, or, in the event of an insolvency, through discharge.

(3) In meeting the requirements of this paragraph (g), other than the provider contract requirements specified in paragraph (g)(1) of this section, the M+C organization may use—

(i) Contractual arrangements;

(ii) Insurance acceptable to HCFA;

(iii) Financial reserves acceptable to HCFA; or

(iv) Any other arrangement acceptable to HCFA.

(h) *Requirements of other laws and regulations.* (1) The M+C organization agrees to comply with—

(i) Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84;

(ii) The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;

(iii) The Americans With Disabilities Act; and

(iv) Other laws applicable to recipients of Federal funds; and

(v) All other applicable laws and rules.

(2) M+C organizations receiving Federal payments under M+C contracts, and related entities, contractors, and subcontractors paid by an M+C organization to fulfill its obligations under its M+C contract are subject to certain laws that are applicable to individuals and entities receiving Federal funds. M+C organizations must inform all related entities, contractors and subcontractors that payments that they receive are, in whole or in part, from Federal funds.

(i) *M+C organization relationship with related entities, contractors, and subcontractors.* (1) Notwithstanding any relationship(s) that the M+C organization may have with related entities, contractors, or subcontractors, the M+C organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with HCFA.

(2) The M+C organization agrees to require all related entities, contractors, or subcontractors to agree that—

(i) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to the M+C contract; and

(ii) HHS', the Comptroller General's, or their designee's right to inspect, evaluate, and audit any pertinent information for any particular contract period will exist through 6 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

(3) All contracts or written arrangements between M+C organizations and providers, related entities, contractors, or subcontractors must contain the following:

(i) Enrollee protection provisions that provide—

(A) Consistent with paragraph (g)(1) of this section, arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the obligation of the M+C Organization; and

(B) Consistent with paragraph (g)(2) of this section, provision for the continuation of benefits.

(ii) Accountability provisions that indicate that—

(A) The M+C organization oversees and is accountable to HCFA for any functions or responsibilities that are described in these standards; and

(B) The M+C organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph (i)(4) of this section.

(iii) A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement will be consistent and comply with the M+C organization's contractual obligations.

(4) If any of the M+C organizations' activities or responsibilities under its contract with HCFA are delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

(i) Written arrangements must specify delegated activities and reporting responsibilities.

(ii) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where HCFA or the M+C organization determine that such parties have not performed satisfactorily.

(iii) Written arrangements must specify that the performance of the parties is monitored by the M+C organization on an ongoing basis.

(iv) Written arrangements must specify that either—

(A) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the M+C organization; or

(B) The credentialing process will be reviewed and approved by the M+C organization and the M+C organization must audit the credentialing process on an ongoing basis.

(v) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and HCFA instructions.

(5) If the M+C organization delegates selection of the providers, contractors, or subcontractor to another organization, the M+C organization's written arrangements with that organization must state that the HCFA-contracting M+C organization retains the right to approve, suspend, or terminate any such arrangement.

(j) *Additional contract terms.* The M+C organization agrees to include in the contract such other terms and conditions as HCFA may find necessary and appropriate in order to implement requirements in this part.

(k) *Severability of contracts.* The contract must provide that, upon HCFA's request—

(1) The contract will be amended to exclude any M+C plan or State-licensed entity specified by HCFA; and

(2) A separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made.

(l) *Certification of data that determine payment.* As a condition for receiving a monthly payment under subpart F of this part, the M+C organization agrees that its chief executive officer (CEO) or chief financial officer (CFO) must request payment under the contract on a document that certifies the accuracy, completeness, and truthfulness of relevant data that HCFA requests. Such data include specified enrollment information, encounter data, and other information that HCFA may specify.

(1) The CEO or CFO must certify that each enrollee for whom the organization is requesting payment is validly enrolled in an M+C plan offered by the organization and the information relied upon by HCFA in determining payment is accurate.

(2) The CEO or CFO must certify that the encounter data it submits under § 422.257 are accurate, complete, and truthful.

(3) If such encounter data are generated by a related entity, contractor, or subcontractor of an M+C organization, such entity, contractor, or subcontractor must similarly certify the accuracy, completeness, and truthfulness of the data.

(m) *Certification of accuracy of ACR.* The M+C organization agrees, as a condition for retaining (and not providing additional benefits with) payment amounts below the amount of its ACR, that the information in its ACR submission is accurate and fully conforms to the requirements in § 422.310.

§ 422.504 Effective date and term of contract.

(a) *Effective date.* The contract is effective on the date specified in the contract between the M+C organization and HCFA and, for a contract that provides for coverage under an MSA plan, not earlier than January 1999.

(b) *Term of contract.* Except as provided in paragraph (d) of this section, each contract is for a period of 12 months beginning on January 1 and ending on December 31.

(c) *Renewal of contract.* In accordance with § 422.506, contracts are renewed annually only if—

(1) HCFA informs the M+C organization that it authorizes a renewal; and

(2) The M+C organization has not provided HCFA with a notice of intention not to renew.

(d) *Exception.* Prior to January 1, 2002, at HCFA's discretion, a contract may be for a term longer than 12 months and may begin on a date specified by HCFA other than January 1.

§ 422.506 Nonrenewal of contract.

(a) *Nonrenewal by an M+C organization.* (1) An M+C organization may elect not to renew its contract with HCFA as of the end of the term of the contract for any reason provided it meets the timeframes for doing so set forth in paragraphs (a)(2) and (a)(3) of this section.

(2) If an M+C organization does not intend to renew its contract, it must notify—

(i) HCFA in writing, by May 1 of the year in which the contract would end;

(ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative M+C plans, Medigap options, and original Medicare and must receive HCFA approval.

(iii) The general public, at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community located in the M+C organization's service area.

(3) HCFA may accept a nonrenewal notice submitted after May 1 if—

(i) The M+C organization notifies its Medicare enrollees and the public in accordance with paragraph (a)(2)(ii) and (a)(2)(iii) of this section; and

(ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.

(4) If an M+C organization does not renew a contract under this paragraph (a), HCFA will not enter into a contract with the organization for 5 years unless there are special circumstances that warrant special consideration, as determined by HCFA.

(b) *HCFA decision not to renew.* (1) HCFA may elect not to authorize renewal of a contract for any of the following reasons:

(i) The M+C organization has not fully implemented or shown discernable progress in implementing quality improvement projects as defined in § 422.152(d).

(ii) The M+C organization's level of enrollment or growth in enrollment is determined by HCFA to threaten the viability of the organization under the M+C program and or be an indicator of beneficiary dissatisfaction with the M+C plan(s) offered by the organization.

(iii) For any of the reasons listed in § 422.510(a), which would also permit HCFA to terminate the contract.

(iv) The M+C organization has committed any of the acts in § 422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under subpart O of this part.

(2) *Notice.* HCFA provides notice of its decision whether to authorize renewal of the contract as follows:

(i) To the M+C organization by May 1 of the contract year.

(ii) If HCFA decides not to authorize a renewal of the contract, to the M+C organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.

(iii) If HCFA decides not to authorize a renewal of the contract, to the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of

general circulation in each community or county located in the M+C organization's service area.

(3) *Notice of appeal rights.* HCFA gives the M+C organization written notice of its right to appeal the decision not to renew in accordance with § 422.644.

§ 422.508 Modification or termination of contract by mutual consent.

(a) A contract may be modified or terminated at any time by written mutual consent.

(1) If the contract is terminated by mutual consent, except as provided in paragraph (b) of this section, the M+C organization must provide notice to its Medicare enrollees and the general public as provided in § 422.512(b)(2) and (b)(3).

(2) If the contract is modified by mutual consent, the M+C organization must notify its Medicare enrollees of any changes that HCFA determines are appropriate for notification within timeframes specified by HCFA.

(b) If the contract terminated by mutual consent is replaced the day following such termination by a new M+C contract, the M+C organization is not required to provide the notice specified in paragraph (a)(1) of this section.

§ 422.510 Termination of contract by HCFA.

(a) *Termination by HCFA.* HCFA may terminate a contract for any of the following reasons:

(1) The M+C organization has failed substantially to carry out the terms of its contract with HCFA.

(2) The M+C organization is carrying out its contract with HCFA in a manner that is inconsistent with the effective and efficient implementation of this part.

(3) HCFA determines that the M+C organization no longer meets the requirements of this part for being a contracting organization.

(4) The M+C organization commits or participates in fraudulent or abusive activities affecting the Medicare program, including submission of fraudulent data.

(5) The M+C organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(6) The M+C organization substantially fails to comply with the requirements in subpart M of this part relating to grievances and appeals.

(7) The M+C organization fails to provide HCFA with valid encounter data as required under § 422.257.

(8) The M+C organization fails to implement an acceptable quality assessment and performance improvement program as required under subpart D of this part.

(9) The M+C organization substantially fails to comply with the prompt payment requirements in § 422.520.

(10) The M+C organization substantially fails to comply with the service access requirements in § 422.112 or § 422.114.

(11) The M+C organization fails to comply with the requirements of § 422.208 regarding physician incentive plans.

(b) *Notice.* If HCFA decides to terminate a contract for reasons other than the grounds specified in § 422.510(a)(5), it gives notice of the termination as follows:

(1) *Termination of contract by HCFA.* (i) HCFA notifies the M+C organization in writing 90 days before the intended date of the termination.

(ii) The M+C organization notifies its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The M+C organization notifies the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the M+C organization's service area.

(2) *Immediate termination of contract by HCFA.* (i) For terminations based on violations prescribed in § 422.510(a)(5), HCFA notifies the M+C organization in writing that its contract has been terminated effective the date of the termination decision by HCFA. If termination is effective in the middle of a month, HCFA has the right to recover the prorated share of the capitation payments made to the M+C organization covering the period of the month following the contract termination.

(ii) HCFA notifies the M+C organization's Medicare enrollees in writing of HCFA's decision to terminate the M+C organization's contract. This notice occurs no later than 30 days after HCFA notifies the plan of its decision to terminate the M+C contract. HCFA simultaneously informs the Medicare enrollees of alternative options for obtaining Medicare services, including alternative M+C organizations in a similar geographic area and original Medicare.

(iii) HCFA notifies the general public of the termination no later than 30 days after notifying the plan of HCFA's decision to terminate the M+C contract. This notice is published in one or more newspapers of general circulation in each community or county located in the M+C organization's service area.

(c) *Corrective action plan*—(1) *General.* Before terminating a contract for reasons other than the grounds specified in paragraph (a)(5) of this section, HCFA provides the M+C organization with reasonable opportunity, not to exceed timeframes specified at subpart N of this part, to develop and receive HCFA approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(2) *Exception.* If a contract is terminated under § 422.510(a)(5), the M+C organization will not have the opportunity to submit a corrective action plan.

(d) *Appeal rights.* If HCFA decides to terminate a contract, it sends written notice to the M+C organization informing it of its termination appeal rights in accordance with subpart N of this part.

§ 422.512 Termination of contract by the M+C organization.

(a) *Cause for termination.* The M+C organization may terminate the M+C contract if HCFA fails to substantially carry out the terms of the contract.

(b) *Notice.* The M+C organization must give advance notice as follows:

(1) To HCFA, at least 90 days before the intended date of termination. This notice must specify the reasons why the M+C organization is requesting contract termination.

(2) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the services area, including alternative M+C plans, Medigap options, original Medicare and must receive HCFA approval.

(3) To the general public at least 60 days before the termination effective date by publishing an HCFA-approved notice in one or more newspapers of general circulation in each community or county located in the M+C organization's geographic area.

(c) *Effective date of termination.* The effective date of the termination is determined by HCFA and is at least 90 days after the date HCFA receives the M+C organization's notice of intent to terminate.

(d) *HCFA's liability.* HCFA's liability for payment to the M+C organization ends as of the first day of the month

after the last month for which the contract is in effect.

(e) *Effect of termination by the organization.* HCFA does not enter into an agreement with an organization that has terminated its contract within the preceding 5 years unless there are circumstances that warrant special consideration, as determined by HCFA.

§ 422.514 Minimum enrollment requirements.

(a) *Basic rule.* Except as provided in paragraph (b) of this section, HCFA does not enter into a contract under this subpart unless the organization meets the following minimum enrollment requirement—

(1) At least 5,000 individuals (or 1,500 individuals if the organization is a PSO) are enrolled for the purpose of receiving health benefits from the organization; or

(2) At least 1,500 individuals (or 500 individuals if the organization is a PSO) are enrolled for purposes of receiving health benefits from the organization and the organization primarily serves individuals residing outside of urbanized areas as defined in § 412.62(f) (or, in the case of a PSO, the PSO meets the requirements in § 422.352(c)).

(3) Except as provided for in paragraph (b) of this section, an M+C organization must maintain a minimum enrollment as defined in paragraphs (a)(1) and (a)(2) of this section for the duration of its contract.

(b) *Minimum Enrollment Waiver.* (1) For an organization that does not meet the applicable requirement of paragraph (a) of this section at application for an M+C contract or during the first 3 years of such contract, HCFA may waive the minimum enrollment requirement as provided for below. To receive a waiver, an organization must demonstrate to HCFA's satisfaction that it is capable to administering and managing an M+C contract and is able to manage the level of risk required under the contract. Factors that HCFA will take into consideration in making this evaluation include the extent to which—

(i) The organization management and providers have previous experience in managing and providing health care services under a risk-based payment arrangement to at least as many individuals as the applicable minimum enrollment for the entity as described in paragraph (a) of this section, or

(ii) The organization has the financial ability to bear financial risk under an M+C contract. In determining whether an organization is capable of bearing risk, HCFA considers factors such as the organization's management experience as described in paragraph (b)(1)(i) of this section and stop-loss insurance that is adequate and acceptable to HCFA; and,

(iii) The organization is able to establish a marketing and enrollment process that will allow it to meet the applicable enrollment requirement specified in paragraph (a) of this section prior to completion of the third contract year.

(2) If an M+C organization fails to meet the enrollment requirement in the first year, HCFA may waive the minimum requirements for another year provided that the organization—

(i) Requests an additional minimum enrollment waiver no later than 120 days before the end of the first year;

(ii) Continues to demonstrate it is capable of administering and managing an M+C contract and is able to manage the level of risk; and,

(iii) Demonstrates an acceptable marketing and enrollment process. Enrollment projections for the second year of the waiver will become the organization's transitional enrollment standard.

(3) If an M+C organization fails to meet the enrollment requirement in the second year, HCFA may waive the minimum requirements for the third year only if the organization has attained the transitional enrollment standard as described in paragraph (b)(2)(iii) of this section.

(c) Failure to meet enrollment requirements. HCFA may elect not to renew its contract with an M+C organization that fails to meet the applicable enrollment requirement in paragraph (a) of this section

§ 422.516 Reporting requirements.

(a) *Required information.* Each M+C organization must have an effective procedure to develop, compile, evaluate, and report to HCFA, to its enrollees, and to the general public, at the times and in the manner that HCFA requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information with respect to the following:

(1) The cost of its operations.

(2) The patterns of utilization of its services.

(3) The availability, accessibility, and acceptability of its services.

(4) To the extent practical, developments in the health status of its enrollees.

(5) Information demonstrating that the M+C organization has a fiscally sound operation.

(6) Other matters that HCFA may require.

(b) *Significant business transactions.* Each M+C organization must report to HCFA annually, within 120 days of the end of its fiscal year (unless for good cause shown, HCFA authorizes an extension of time), the following:

(1) A description of significant business transactions (as defined in § 422.500) between the M+C organization and a party in interest.

(2) With respect to those transactions—

(i) A showing that the costs of the transactions listed in paragraph (c) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(ii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(3) A combined financial statement for the M+C organization and a party in interest if either of the following conditions is met:

(i) Thirty-five percent or more of the costs of operation of the M+C organization go to a party in interest.

(ii) Thirty-five percent or more of the revenue of a party in interest is from the M+C organization.

(c) *Requirements for combined financial statements.* (1) The combined financial statements required by paragraph (b)(3) of this section must display in separate columns the financial information for the M+C organization and each of the parties in interest.

(2) Inter-entity transactions must be eliminated in the consolidated column.

(3) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(4) Upon written request from an M+C organization showing good cause, HCFA may waive the requirement that the organization's combined financial statement include the financial information required in this paragraph (c) with respect to a particular entity.

(d) *Reporting and disclosure under ERISA.* (1) For any employees' health benefits plan that includes an M+C organization in its offerings, the M+C organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the particular M+C organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(2) The M+C organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term ''administrator'' is defined in ERISA.

(e) *Loan information.* Each organization must notify HCFA of any loans or other special financial arrangements it makes with contractors, subcontractors and related entities.

(f) *Enrollee access to Information.* Each M+C organization must make the information reported to HCFA under § 422.502(f)(1) available to its enrollees upon reasonable request.

§ 422.520 Prompt payment by M+C organization.

(a) *Contract between HCFA and the M+C organization.*

(1) The contract between HCFA and the M+C organization must provide that the M+C organization will pay 95 percent of the ''clean claims'' within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an M+C private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.

(2) The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B).

(3) All other claims must be approved or denied within 60 calendar days from the date of the request.

(b) *Contracts between M+C organizations and providers and suppliers.* Contracts or other written agreements between M+C organizations and providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the M+C organization and the relevant provider.

(c) *Failure to comply.* If HCFA determines, after giving notice and opportunity for hearing, that an M+C organization has failed to make payments in accordance with paragraph (a) of this section, HCFA may provide—

(1) For direct payment of the sums owed to providers, or M+C private fee-for-service plan enrollees; and

(2) For appropriate reduction in the amounts that would otherwise be paid to the organization, to reflect the amounts of the direct payments and the cost of making those payments.

§ 422.524 Special rules for RFB societies.

In order to participate as an M+C organization, an RFB society—

(a) May not impose any limitation on membership based on any factor related to health status; and

(b) Must offer, in addition to the M+C RFB plan, health coverage to individuals who are members of the church or convention or group of churches with which the society is affiliated, but who are not entitled to receive benefits from the Medicare program.

Subpart L—Effect of Change of Ownership or Leasing of Facilities During Term of Contract

17. *Nomenclature change.* Throughout newly designated subpart L, ''HMO or CMP'' is revised to read ''M+C organization'' wherever it appears.

18. *Nomenclature change.* Throughout newly designated subpart L, ''HMO's or CMP's'' are revised to read ''M+C organization'' and ''M+C organization's'' respectively.

§ 422.550 [Amended]

19. In § 422.550, the following changes are made:

a. In paragraph (b), the following sentence is added at the end: ''The M+C organization must also provide updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.''

b. In paragraphs (c)(2) and (e), ''§ 417.522'' is revised to read ''§ 422.552''.

c. In paragraph (d)(2), ''subpart L'' is revised to read ''subpart K''.

§ 422.552 [Amended]

20. In § 422.552, in paragraph (a)(1), the following sentence is added at the end: ''The M+C organization also provides HCFA with updated financial information and a discussion of the financial and solvency impact of the change of ownership on the surviving organization.''

§ 422.553 [Amended]

21. In § 422.553, ''subpart J'' is revised to read ''subpart K''.

22. Subparts M through O are added to read as follows:

Subpart M—Grievances, Organization Determinations and Appeals

Sec.

Subpart N—Medicare Contract Appeals

Subpart O—Intermediate Sanctions

Subpart M—Grievances, Organization Determinations and Appeals

§ 422.560 Basis and scope.

(a) *Statutory basis.* (1) Section 1852(f) of the Act provides that an M+C organization must establish meaningful grievance procedures.

(2) Section 1852(g) of the Act establishes requirements that an M+C organization must meet concerning organization determinations and appeals.

(b) *Scope.* This subpart sets forth—

(1) Requirements for M+C organizations with respect to grievance procedures, organization determinations, and appeal procedures.

(2) The rights of M+C enrollees with respect to organization determinations, and grievance and appeal procedures.

(3) The rules concerning notice of noncoverage of inpatient hospital care.

(4) The rules that apply when an M+C enrollee requests immediate PRO review of a determination that he or she no longer needs inpatient hospital care.

§ 422.561 Definitions.

As used in this subpart, unless the context indicates otherwise—

Appeal means any of the procedures that deal with the review of adverse organization determinations on the health care services an enrollee is entitled to receive or any amounts the enrollee must pay for a service, as defined under § 422.566(b). These procedures include reconsiderations by the M+C organization, and if necessary, an independent review entity, hearings before ALJs, review by the Departmental Appeals Board (DAB), and judicial review.

Authorized representative means an individual authorized by an enrollee to act on his or her behalf in obtaining an organization determination or in dealing with any of the levels of the appeal process, subject to the rules described in 20 CFR part 404, subpart R, unless otherwise stated in this subpart.

Enrollee means an M+C eligible individual who has elected an M+C plan offered by an M+C organization, or his or her authorized representative.

Grievance means any complaint or dispute other than one involving an organization determination, as defined in § 422.566(b).

Physician has the meaning given the term in section 1861(r) of the Act.

§ 422.562 General provisions.

(a) *Responsibilities of the M+C organization.* (1) An M+C organization, with respect to each M+C plan that it offers, must establish and maintain—

(i) A grievance procedure as described in § 422.564 for addressing issues that do not involve organization determinations;

(ii) A procedure for making timely organization determinations; and

(iii) Appeal procedures that meet the requirements of this subpart for issues that involve organization determinations; and

(2) An M+C organization must ensure that all enrollees receive written information about the—

(i) Grievance and appeal procedures that are available to them through the M+C organization; and

(ii) Complaint process available to the enrollee under the PRO process as set forth under section 1154(a)(14) of the Act.

(3) In accordance with subpart K of this part, if the M+C organization delegates any of its responsibilities under this subpart to another entity or individual through which the organization provides health care services, the M+C organization is ultimately responsible for ensuring that the entity or individual satisfies the relevant requirements of this subpart.

(b) *Rights of M+C enrollees.* In accordance with the provisions of this subpart, enrollees have the following rights:

(1) The right to have grievances between the enrollee and the M+C organization heard and resolved, as described in § 422.564.

(2) The right to a timely organization determination, as provided under § 422.566.

(3) The right to request an expedited organization determination, as provided under § 422.570.

(4) If dissatisfied with any part of an organization determination, the following appeal rights:

(i) The right to a reconsideration of the adverse organization determination by the M+C organization, as provided under § 422.578.

(ii) The right to request an expedited reconsideration, as provided under § 422.584.

(iii) If, as a result of a reconsideration, an M+C organization affirms, in whole or in part, its adverse organization determination, the right to an automatic reconsidered determination made by an independent, outside entity contracted by HCFA, as provided in § 422.592.

(iv) The right to an ALJ hearing if the amount in controversy is $100 or more, as provided in § 422.600.

(v) The right to request DAB review of the ALJ hearing decision, as provided in § 422.608.

(vi) The right to judicial review of the hearing decision if the amount in controversy is $1000 or more, as provided in § 422.612.

(c) *Limits on when this subpart applies.* (1) If an enrollee receives immediate PRO review (as provided in § 422.622) of a determination of noncoverage of inpatient hospital care—

(i) The enrollee is not entitled to review of that issue by the M+C organization; and

(ii) The PRO review decision is subject only to the appeal procedures set forth in part 473 of this chapter.

(2) If an enrollee has no further liability to pay for services that were furnished by an M+C organization, a determination regarding these services is not subject to appeal.

(d) *When other regulations apply.* Unless this subpart provides otherwise, the regulations in 20 CFR, part 404, subparts J and R (covering, respectively, the administrative review and hearing process and representation of parties under title II of the Act), apply under this subpart to the extent they are appropriate.

§ 422.564 Grievance procedures.

(a) *General rules.* (1) Each M+C organization must provide meaningful procedures for timely hearing and resolution of grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any M+C plan it offers.

(2) Grievance procedures must meet any guidelines established by HCFA.

(b) *Distinguished from organization determinations and appeals.* Grievance procedures are separate and distinct from organization determinations and appeal procedures, which address organization determinations.

(c) *Distinguished from the PRO complaint process.* Under section 1154(a)(14) of the Act, the PRO must review beneficiaries' written complaints about the quality of services they have received under the Medicare program; this process is separate and distinct from the grievance procedures of the M+C organization.

§ 422.566 Organization determinations.

(a) *Responsibilities of the M+C organization.* Each M+C organization must have a procedure for making timely organization determinations (in accordance with the requirements of this subpart) regarding the benefits an enrollee is entitled to receive under an M+C plan, including basic benefits as described under § 422.100(c)(1) and mandatory and optional supplemental benefits as described under § 422.102, and the amount, if any, that the enrollee is required to pay for a health service. The M+C organization must have a

standard procedure for making determinations, in accordance with § 422.568, and an expedited procedure for situations in which applying the standard procedure could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, in accordance with §§ 422.570 and 422.572.

(b) *Actions that are organization determinations.* An organization determination is any determination made by an M+C organization with respect to any of the following:

(1) Payment for emergency services, post-stabilization care, or urgently needed services.

(2) Payment for any other health services furnished by a provider other than the M+C organization that the enrollee believes—

(i) Are covered under Medicare; or

(ii) If not covered under Medicare, should have been furnished, arranged for, or reimbursed by the M+C organization.

(3) The M+C organization's refusal to provide services that the enrollee believes should be furnished or arranged for by the M+C organization when the enrollee has not received the services outside the M+C organization.

(4) Discontinuation of a service, if the enrollee disagrees with the determination that the service is no longer medically necessary.

(c) *Who can request an organization determination.* Any of the parties listed in § 422.574 can request an organization determination, with the exception that only the parties listed in § 422.570(a) can request an expedited determination.

§ 422.568 Standard timeframes and notice requirements for organization determinations.

(a) *Timeframe for requests for service.* When a party has made a request for a service, the M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(b) *Timeframe for requests for payment.* The M+C organization must process requests for payment according to the ''prompt payment'' provisions set forth in § 422.520.

(c) *Written notification for denials.* If an M+C organization decides to deny service or payment in whole or in part, it must give the enrollee written notice of the determination.

(d) *Content of the notice.* The notice of any denial under paragraph (c) of this section must—

(1) State the specific reasons for the denial in understandable language;

(2) Inform the enrollee of his or her right to a reconsideration;

(3) Describe both the standard and expedited reconsideration processes, including the enrollee's right to and conditions for obtaining an expedited reconsideration for service requests, and the rest of the appeal process; and

(4) Comply with any other requirements specified by HCFA.

(e) *Effect of failure to provide timely notice.* If the M+C organization fails to provide the enrollee with timely notice of an organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

§ 422.570 Expediting certain organization determinations.

(a) *Request for expedited determination.* An enrollee or a physician (regardless of whether the physician is affiliated with the M+C organization) may request that an M+C organization expedite an organization determination involving the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment.)

(b) *How to make a request.* (1) To ask for an expedited determination, an enrollee or a physician must submit an oral or written request directly to the M+C organization or, if applicable, to the entity responsible for making the determination, as directed by the M+C organization.

(2) A physician may provide oral or written support for a request for an expedited determination.

(c) *How the M+C organization must process requests.* The M+C organization must establish and maintain the following procedures for processing requests for expedited determinations:

(1) Establish an efficient and convenient means for individuals to submit oral or written requests. The M+C organization must document all oral requests in writing and maintain the documentation in the case file.

(2) Promptly decide whether to expedite a determination, based on the following requirements:

(i) For a request made by an enrollee the M+C organization must provide an expedited determination if it determines that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) For a request made or supported by a physician, the M+C organization must provide an expedited determination if the physician indicates that applying the standard timeframe for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(d) *Actions following denial.* If an M+C organization denies a request for expedited determination, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 14-day timeframe established in § 422.568 for a standard determination. The 14-day period begins with the day the M+C organization receives the request for expedited determination.

(2) Give the enrollee prompt oral notice of the denial and follow up, within 2 working days, with a written letter that—

(i) Explains that the M+C organization will process the request using the 14-day timeframe for standard determinations;

(ii) Informs the enrollee of the right to file a grievance if he or she disagrees with the M+C organization's decision not to expedite; and

(iii) Provides instructions about the grievance process and its timeframes.

(e) *Action on accepted request for expedited determination.* If an M+C organization grants a request for expedited determination, it must make the determination and give notice in accordance with § 422.572.

(f) *Prohibition of punitive action.* An M+C organization may not take or threaten to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited determination.

§ 422.572 Timeframes and notice requirements for expedited organization determinations.

(a) *Timeframe.* Except as provided in paragraph (b) of this section, an M+C organization that approves a request for expedited determination must make its determination and notify the enrollee (and the physician involved, as appropriate) of its decision, whether

adverse or favorable, as expeditiously as the enrollee's health condition requires, but no later than 72 hours after receiving the request.

(b) *Extensions.* The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(c) *Confirmation of oral notice.* If the M+C organization first notifies an enrollee of its expedited determination orally, it must mail written confirmation to the enrollee within 2 working days of the oral notification.

(d) *How information from noncontract providers affects timeframes for expedited determinations.* If an M+C organization must receive medical information from noncontract providers, the 72-hour period begins when the organization receives that information. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information in order to receive timely payment.

(e) *Content of the notice of expedited determination.* (1) The notice of any expedited determination must state the specific reasons for the determination in understandable language.

(2) If the determination is not completely favorable to the enrollee, the notice must—

(i) Inform the enrollee of his or her right to a reconsideration;

(ii) Describe both the standard and expedited reconsideration processes, including the enrollee's right to request, and conditions for obtaining, an expedited reconsideration, and the rest of the appeal process; and

(iii) Comply with any other requirements specified by HCFA.

(f) *Effect of failure to provide a timely notice.* If the M+C organization fails to provide the enrollee with timely notice of an expedited organization determination as specified in this section, this failure itself constitutes an adverse organization determination and may be appealed.

§ 422.574 Parties to the organization determination.

The parties to the organization determination are—

(a) The enrollee (including his or her authorized representative);

(b) An assignee of the enrollee (that is, a physician or other provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other provider or entity (other than the M+C organization) determined to have an appealable interest in the proceeding.

§ 422.576 Effect of an organization determination.

The organization determination is binding on all parties unless it is reconsidered under §§ 422.578 through 422.596 or is reopened and revised under § 422.616.

§ 422.578 Right to a reconsideration.

Any party to an organization determination (including one that has been reopened and revised as described in § 422.616) may request that the determination be reconsidered under the procedures described in § 422.582, which address requests for a standard reconsideration. An enrollee or physician (acting on behalf of an enrollee) may request an expedited reconsideration as described in § 422.584.

§ 422.580 Reconsideration defined.

A reconsideration consists of a review of an adverse organization determination, the evidence and findings upon which it was based, and any other evidence the parties submit or the M+C organization or HCFA obtains.

§ 422.582 Request for a standard reconsideration.

(a) *Method and place for filing a request.* A party to an organization determination must ask for a reconsideration of the determination by filing a written request with—

(1) The M+C organization that made the organization determination;

(2) An SSA office; or

(3) In the case of a qualified railroad retirement beneficiary, an RRB office.

(b) *Timeframe for filing a request.* Except as provided in paragraph (c) of this section, a party must file a request for a reconsideration within 60 calendar days from the date of the notice of the organization determination. If the SSA or RRB receives a request, it forwards the request to the M+C organization for its reconsideration. The timeframe within which the organization must conduct its review begins when it receives the request.

(c) *Extending the time for filing a request.*

(1) *General rule.* If a party shows good cause, the M+C organization may extend the timeframe for filing a request for reconsideration.

(2) *How to request an extension of timeframe.* If the 60-day period in which to file a request for a reconsideration has expired, a party to the organization determination may file a request for reconsideration with the M+C organization, SSA, or an RRB office. If SSA or RRB receives a request, it forwards the request to the M+C organization for its reconsideration. The request for reconsideration and to extend the timeframe must—

(i) Be in writing; and

(ii) State why the request for reconsideration was not filed on time.

(d) *Parties to the reconsideration.* The parties to the reconsideration are the parties to the organization determination, as described in § 422.574, and any other provider or entity (other than the M+C organization) whose rights with respect to the organization determination may be affected by the reconsideration, as determined by the entity that conducts the reconsideration.

(e) *Withdrawing a request.* The party who files a request for reconsideration may withdraw it by filing a written request for withdrawal at one of the places listed in paragraph (a) of this section.

§ 422.584 Expediting certain reconsiderations.

(a) *Who may request an expedited reconsideration.* An enrollee or a physician (regardless of whether he or she is affiliated with the M+C organization) may request that an M+C organization expedite a reconsideration of a determination that involves the issues described in § 422.566(b)(3) and (b)(4). (This does not include requests for payment.) A physician that requests an expedited reconsideration must be acting on behalf of the enrollee as an authorized representative.

(b) *How to make a request.* (1) To ask for an expedited reconsideration, an enrollee or a physician acting on behalf of an enrollee must submit an oral or written request directly to the M+C organization or, if applicable, to the entity responsible for making the reconsideration, as directed by the M+C organization.

(2) A physician may provide oral or written support for a request for an expedited reconsideration.

(c) *How the M+C organization must process requests.* The M+C organization must establish and maintain the

following procedures for processing requests for expedited reconsiderations:

(1) *Handling of requests.* The M+C organization must establish an efficient and convenient means for individuals to submit oral or written requests, document all oral requests in writing, and maintain the documentation in the case file.

(2) *Prompt decision.* Promptly decide on whether to expedite the reconsideration or follow the timeframe for standard reconsideration based on the following requirements:

(i) For a request made by an enrollee, the M+C organization must provide an expedited reconsideration if it determines that applying the standard timeframe for reconsidering a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) For a request made or supported by a physician, the M+C organization must provide an expedited reconsideration if the physician indicates that applying the standard timeframe for conducting a reconsideration could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(d) *Actions following denial.* If an M+C organization denies a request for expedited reconsideration, it must take the following actions:

(1) Automatically transfer a request to the standard timeframe and make the determination within the 30-day timeframe established in § 422.590(a). The 30-day period begins the day the M+C organization receives the request for expedited reconsideration.

(2) Give the enrollee prompt oral notice, and follow up, within 2 working days, with a written letter that—

(i) Explains that the M+C organization will process the enrollee's request using the 30-day timeframe for standard reconsiderations;

(ii) Informs the enrollee of the right to file a grievance if he or she disagrees with the organization's decision not to expedite; and

(iii) Provides instructions about the grievance process and its timeframes.

(e) *Action following acceptance of a request.* If an M+C organization grants a request for expedited reconsideration, it must conduct the reconsideration and give notice in accordance with § 422.590(d).

(f) *Prohibition of punitive action.* An M+C organization may not take or threaten to take any punitive action against a physician acting on behalf or in support of an enrollee in requesting an expedited reconsideration.

§ 422.586 Opportunity to submit evidence.

The M+C organization must provide the parties to the reconsideration with a reasonable opportunity to present evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing. In the case of an expedited reconsideration, the opportunity to present evidence is limited by the short timeframe for making a decision. Therefore, the M+C organization must inform the parties of the conditions for submitting the evidence.

§ 422.590 Timeframes and responsibility for reconsiderations.

(a) *Standard reconsideration: Request for services.*

(1) If the M+C organization makes a reconsidered determination that is completely favorable to the enrollee, the M+C organization must issue the determination (and effectuate it in accordance with § 422.618(a)) as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration. The M+C organization may extend the timeframe by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). For extensions, the M+C organization must issue and effectuate its determination as expeditiously as the enrollee's health condition requires, but no later than upon expiration of the extension.

(2) If the M+C organization makes a reconsidered determination that affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by HCFA as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days from the date it receives the request for a standard reconsideration (or no later than the expiration of an extension described in paragraph (a)(1) of this section). The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

(b) *Standard reconsideration: Request for payment.* (1) If the M+C organization makes a reconsidered determination that is completely favorable to the enrollee, the M+C organization must issue its reconsidered determination to the enrollee (and effectuate it in accordance with § 422.618(a)) no later than 60 calendar days from the date it receives the request for a standard reconsideration.

(2) If the M+C organization affirms, in whole or in part, its adverse organization determination, it must prepare a written explanation and send the case file to the independent entity contracted by HCFA no later than 60 calendar days from the date it receives the request for a standard reconsideration. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

(c) *Effect of failure to meet timeframe for standard reconsideration.* If the M+C organization fails to provide the enrollee with a reconsidered determination within the timeframes specified in paragraph (a) or paragraph (b) of this section, this failure constitutes an affirmation of its adverse organization determination, and the M+C organization must submit the file to the independent entity in the same manner as described under paragraphs (a)(2) and (b)(2) of this section.

(d) *Expedited reconsideration*—(1) *Timeframe.* Except as provided in paragraph (d)(2) of this section, an M+C organization that approves a request for expedited reconsideration must complete its reconsideration and give the enrollee (and the physician involved, as appropriate) notice of its decision as expeditiously as the enrollee's health condition requires but no later than 72 hours after receiving the request.

(2) *Extensions.* The M+C organization may extend the 72-hour deadline by up to 14 calendar days if the enrollee requests the extension or if the organization justifies a need for additional information and how the delay is in the interest of the enrollee (for example, the receipt of additional medical evidence from noncontract providers may change an M+C organization's decision to deny). The M+C organization must notify the enrollee of its determination as expeditiously as the enrollee's health condition requires but no later than upon expiration of the extension.

(3) *Confirmation of oral notice.* If the M+C organization first notifies an enrollee orally of a completely favorable expedited reconsideration, it must mail written confirmation to the enrollee within 2 working days.

(4) *How information from noncontract providers affects timeframes for expedited reconsiderations.* If the M+C organization must receive medical information from noncontract providers, the 72-hour period begins when the

organization receives the information. Noncontract providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information in order to receive timely payment.

(5) *Affirmation of an adverse expedited organization determination.* If, as a result of its reconsideration, the M+C organization affirms, in whole or in part, its adverse expedited organization determination, the M+C organization must submit a written explanation and the case file to the independent entity contracted by HCFA as expeditiously as the enrollee's health condition requires, but not later than within 24 hours of its affirmation. The organization must make reasonable and diligent efforts to assist in gathering and forwarding information to the independent entity.

(e) *Notification of enrollee.* If the M+C organization refers the matter to the independent entity as described under this section, it must concurrently notify the enrollee of that action.

(f) *Failure to meet timeframe for expedited reconsideration.* If the M+C organization fails to provide the enrollee with the results of its reconsideration within the timeframe described in paragraph (d) of this section, this failure constitutes an adverse reconsidered determination, and the M+C organization must submit the file to the independent entity within 24 hours of expiration of the timeframe set forth in paragraph (d) of this section.

(g) *Who must reconsider an adverse organization determination.* (1) A person or persons who were not involved in making the organization determination must conduct the reconsideration.

(2) When the issue is the M+C organization's denial of coverage based on a lack of medical necessity, the reconsidered determination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue.

§ 422.592 Reconsideration by an independent entity.

(a) When the M+C organization affirms, in whole or in part, its adverse organization determination, the issues that remain in dispute must be reviewed and resolved by an independent, outside entity that contracts with HCFA.

(b) The independent outside entity must conduct the review as expeditiously as the enrollee's health condition requires but must not exceed the deadlines specified in the contract.

(c) When the independent entity conducts a reconsideration, the parties to the reconsideration are the same parties listed in § 422.582(d) who qualified during the M+C organization's reconsideration, with the addition of the M+C organization.

§ 422.594 Notice of reconsidered determination by the independent entity.

(a) *Responsibility for the notice.* When the independent entity makes the reconsidered determination, it is responsible for mailing a notice of its reconsidered determination to the parties and for sending a copy to HCFA.

(b) *Content of the notice.* The notice must—

(1) State the specific reasons for the entity's decisions;

(2) If the reconsidered determination is adverse (that is, does not completely reverse the M+C organization's adverse organization determination), inform the parties of their right to an ALJ hearing if the amount in controversy is $100 or more;

(3) Describe the procedures that a party must follow to obtain an ALJ hearing; and

(4) Comply with any other requirements specified by HCFA.

§ 422.596 Effect of a reconsidered determination.

A reconsidered determination is final and binding on all parties unless a party files a request for a hearing under the provisions of § 422.602, or unless the reconsidered determination is revised under § 422.616.

§ 422.600 Right to a hearing.

(a) If the amount remaining in controversy is $100 or more, any party to the reconsideration (except the M+C organization) who is dissatisfied with the reconsidered determination has a right to a hearing before an ALJ. The M+C organization does not have the right to request a hearing before an ALJ.

(b) The amount remaining in controversy, which can include any combination of Part A and Part B services, is computed in accordance with § 405.740 of this chapter for Part A services and § 405.817 of this chapter for Part B services.

(c) If the basis for the appeal is the M+C organization's refusal to provide services, HCFA uses the projected value of those services to compute the amount remaining in controversy.

§ 422.602 Request for an ALJ hearing.

(a) *How and where to file a request.* A party must file a written request for a hearing at one of the places listed in § 422.582(a) or with the independent, outside entity. The organizations listed in § 422.582(a) forward the request to the independent, outside entity, which is responsible for transferring the case to the appropriate ALJ hearing office.

(b) *When to file a request.* Except when an ALJ extends the timeframe as provided in 20 CFR 404.933(c), a party must file a request for a hearing within 60 days of the date of the notice of a reconsidered determination.

(c) *Parties to a hearing.* The parties to a hearing are the parties to the reconsideration, the M+C organization, and any other person or entity whose rights with respect to the reconsideration may be affected by the hearing, as determined by the ALJ.

(d) *When the amount in controversy is less than $100.* (1) If a request for a hearing clearly shows that the amount in controversy is less than $100, the ALJ dismisses the request.

(2) If, after a hearing is initiated, the ALJ finds that the amount in controversy is less than $100, he or she discontinues the hearing and does not rule on the substantive issues raised in the appeal.

§ 422.608 Departmental Appeals Board (DAB) review.

Any party to the hearing, including the M+C organization, who is dissatisfied with the ALJ hearing decision, may request that the DAB review the ALJ's decision or dismissal. Regulations located at 20 CFR 404.967 through 404.984 regarding SSA Appeals Council Review apply to DAB review for matters addressed by this subpart.

§ 422.612 Judicial review.

(a) *Review of ALJ's decision.* Any party, including the M+C organization, may request judicial review (upon notifying the other parties) of an ALJ's decision if—

(1) The DAB denied the party's request for review; and

(2) The amount in controversy is $1,000 or more.

(b) *Review of DAB decision.* Any party, including the M+C organization, may request judicial review (upon notifying the other parties) of the DAB decision if—

(1) It is the final decision of HCFA; and

(2) The amount in controversy is $1,000 or more.

(c) *How to request judicial review.* A party must file a civil action 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).

§ 422.616 Reopening and revising determinations and decisions.

(a) An organization or reconsidered determination made by an M+C

organization, a reconsidered determination made by the independent entity described in § 422.592, or the decision of an ALJ or the DAB that is otherwise final and binding may be reopened and revised by the entity that made the determination or decision, under the rules in § 405.750 of this chapter.

(b) Reopening may be at the instigation of any party.

(c) The filing of a request for reopening does not relieve the M+C organization of its obligation to make payment or provide services as specified in § 422.618.

(d) Once an entity issues a revised determination or decision, any party may file an appeal.

§ 422.618 How an M+C organization must effectuate reconsidered determinations or decisions.

(a) *Reversals by the M+C organization*—(1) *Requests for service.* If, on reconsideration of a request for service, the M+C organization completely reverses its organization determination, the organization must authorize or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 30 calendar days after the date the M+C organization receives the request for reconsideration (or no later than upon expiration of an extension described in § 422.590(a)(1)).

(2) *Requests for payment.* If, on reconsideration of a request for payment, the M+C organization completely reverses its organization determination, the organization must pay for the service no later than 60 calendar days after the date the M+C organization receives the request for reconsideration.

(b) *Reversals other than by the M+C organization.* If the M+C organization's organization determination is reversed in whole or in part by the independent outside entity or at a higher level of appeal, the M+C organization must pay for, authorize, or provide the service under dispute as expeditiously as the enrollee's health condition requires, but no later than 60 calendar days from the date it receives notice reversing the organization determination. The M+C organization must also inform the independent, outside entity that the organization has effectuated the decision.

§ 422.620 How M+C organizations must notify enrollees of noncoverage of inpatient hospital care.

(a) *Enrollee's entitlement.* Where an M+C organization has authorized coverage of the inpatient admission of an enrollee, either directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.112(b)), the enrollee remains entitled to inpatient hospital care until he or she receives notice of noncoverage of that care.

(b) *Physician concurrence required.* Before the M+C organization gives notice of noncoverage as described in paragraph (c) of this section, the physician who is responsible for the enrollee's hospital care must concur.

(c) *Notice to the enrollee.* The M+C organization must give the enrollee written notice that includes the following:

(1) The reason why inpatient hospital care is no longer needed.

(2) The effective date of the enrollee's liability for continued inpatient care.

(3) The enrollee's appeal rights.

(4) Comply with any other requirements specified by HCFA.

(d) *Physician concurrence when a hospital determines if care is necessary.* If the M+C organization allows the hospital to determine whether inpatient care is necessary, the hospital obtains the concurrence of the contracting physician responsible for the enrollee's hospital care or of another physician as authorized by the M+C organization, and notifies the enrollee, following the procedures set forth in § 412.42(c)(3) of this chapter.

§ 422.622 Requesting immediate PRO review of noncoverage of inpatient hospital care.

(a) *Enrollee's right to review or reconsideration.* (1) An enrollee who wishes to appeal a determination by an M+C organization or hospital that inpatient care is no longer necessary must request immediate PRO review of the determination in accordance with paragraph (b) of this section. An enrollee who requests immediate PRO review may remain in the hospital with no additional financial liability as specified in paragraph (c) of this section.

(2) An enrollee who fails to request immediate PRO review in accordance with the procedures in paragraph (b) of this section may request expedited reconsideration by the M+C organization as described in § 422.584, but the financial liability rules of paragraph (c) of this section do not apply.

(b) *Procedures enrollee must follow.* For the immediate PRO review process, the following rules apply:

(1) The enrollee must submit the request for immediate review—

(i) To the PRO that has an agreement with the hospital under § 466.78 of this chapter;

(ii) In writing or by telephone; and

(iii) By noon of the first working day after he or she receives written notice that the M+C organization or hospital has determined that the hospital stay is no longer necessary.

(2) On the date it receives the enrollee's request, the PRO must notify the M+C organization that the enrollee has filed a request for immediate review.

(3) The M+C organization must supply any information that the PRO requires to conduct its review and must make it available, by phone or in writing, by the close of business of the first full working day immediately following the day the enrollee submits the request for review.

(4) In response to a request from the M+C organization, the hospital must submit medical records and other pertinent information to the PRO by close of business of the first full working day immediately following the day the organization makes its request.

(5) The PRO must solicit the views of the enrollee who requested the immediate PRO review.

(6) The PRO must make a determination and notify the enrollee, the hospital, and the M+C organization by close of business of the first working day after it receives all necessary information from the hospital, or the organization, or both.

(c) *Liability for hospital costs*—(1) *When the M+C organization determines that hospital services are not, or are no longer, covered.* (i) Except as provided in paragraph (c)(1)(ii) of this section, if the M+C organization authorized coverage of the inpatient admission directly or by delegation (or the admission constitutes emergency or urgently needed care, as described in §§ 422.2 and 422.112(b)), the organization continues to be financially responsible for the costs of the hospital stay when a timely appeal is filed under paragraph (a)(1) of this section until noon of the calendar day following the day the PRO notifies the enrollee of its review determination. If coverage of the hospital admission was never approved by the M+C organization (or the admission does not constitute emergency or urgently needed care, as described in §§ 422.2 and 422.112(b)), the M+C organization is liable for the hospital costs only if it is determined on appeal that the hospital stay should have been covered under the M+C plan.

(ii) The hospital may not charge the M+C organization (or the enrollee) if—

(A) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate PRO review; and

(B) The PRO upholds the noncoverage determination made by the M+C organization.

(2) *When the hospital determines that hospital services are no longer required.* If the hospital determines that inpatient hospital services are no longer necessary, and the enrollee could not reasonably be expected to know that the services would not be covered, the hospital may not charge the enrollee for inpatient services received before noon of the calendar day following the day the PRO notifies the enrollee of its review determination.

Subpart N—Medicare Contract Determinations and Appeals

§ 422.641 Contract determinations.

This subpart establishes the procedures for making and reviewing the following contract determinations:

(a) A determination that an entity is not qualified to enter into a contract with HCFA under Part C of title XVIII of the Act.

(b) A determination to terminate a contract with an M+C organization in accordance with § 422.510(a).

(c) A determination not to authorize a renewal of a contract with an M+C organization in accordance with § 422.506(b).

§ 422.644 Notice of contract determination.

(a) When HCFA makes a contract determination, it gives the M+C organization written notice.

(b) The notice specifies—

(1) The reasons for the determination; and

(2) The M+C organization's right to request reconsideration.

(c) For HCFA-initiated terminations, HCFA mails notice 90 days before the anticipated effective date of the termination. For terminations based on initial determinations described at § 422.510(a)(5), HCFA immediately notifies the M+C organization of its decision to terminate the organization's M+C contract.

(d) When HCFA determines that it will not authorize a contract renewal, HCFA mails the notice to the M+C organization by May 1 of the current contract year.

§ 422.646 Effect of contract determination.

The contract determination is final and binding unless—

(a) The determination is reconsidered in accordance with §§ 422.648 through 422.658;

(b) A timely request for a hearing is filed under § 422.662; or

(c) The reconsideration decision is revised as a result of a reopening under § 422.696.

§ 422.648 Reconsideration: Applicability.

(a) Reconsideration is the first step for appealing a contract determination specified in § 422.641.

(b) HCFA reconsiders the specified determinations if the M+C organization files a written request in accordance with § 422.650.

§ 422.650 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.* The request for reconsideration must be filed within 15 days from the date of the notice of the initial determination.

(c) *Proper party to file a request.* Only an authorized official of the entity or M+C organization that was the subject of a contract determination may file the request for reconsideration.

(d) *Withdrawal of a request.* The M+C organization or M+C contract applicant who filed the request for a reconsideration may withdraw it at any time before the notice of the reconsidered determination is mailed. The request for withdrawal must be in writing and filed with HCFA.

§ 422.652 Opportunity to submit evidence.

HCFA provides the M+C organization or M+C contract applicant and the HCFA official or officials who made the contract determination reasonable opportunity to present as evidence any documents or written statements that are relevant and material to the matters at issue.

§ 422.654 Reconsidered determination.

A reconsidered determination is a new determination that—

(a) Is based on a review of the contract 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 M+C organization subsequent to the contract determination; and

(b) Affirms, reverses, or modifies the initial determination.

§ 422.656 Notice of reconsidered determination.

(a) HCFA gives the M+C organization or M+C contract applicant written notice of the reconsidered determination.

(b) The notice—

(1) Contains findings with respect to the M+C organization's qualifications to enter into or remain under a contract with HCFA pursuant to Part C of title XVIII of the Act;

(2) States the specific reasons for the reconsidered determination; and

(3) Informs the M+C organization or M+C contract applicant of its right to a hearing if it is dissatisfied with the determination.

§ 422.658 Effect of reconsidered determination.

A reconsidered determination is final and binding unless a request for a hearing is filed in accordance with § 422.662 or it is revised in accordance with § 422.696.

§ 422.660 Right to a hearing.

The following parties are entitled to a hearing:

(a) An applicant entity that has been determined in a reconsidered determination to be unqualified to enter into a contract with HCFA under Part C of the Act.

(b) An M+C organization whose contract with HCFA has been terminated or has not been renewed as a result of a contract determination as provided in § 422.641.

§ 422.662 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 applicant entity or M+C 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.* A request for a hearing must be filed within 15 days after the date of the notice of contract or reconsidered determination.

(c) *Parties to a hearing.* The parties to a hearing must be—

(1) The parties described in § 422.660;

(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.

§ 422.664 Postponement of effective date of a contract determination when a request for a hearing with respect to a contract determination is filed timely.

(a) HCFA postpones the proposed effective date of the contract determination to terminate a contract with an M+C organization until a hearing decision is reached and affirmed by the Administrator following review under § 422.692 in instances where an M+C organization requests review by the Administrator; and

(b) HCFA extends the current contract 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 this part; and

(2) For such period as HCFA and the M+C organization agree.

(c) Exception: A contract terminated in accordance with § 422.510(a)(5) will be immediately terminated and will not be postponed if a hearing is requested.

§ 422.666 Designation of hearing officer.

HCFA designates a hearing officer to conduct the hearing. The hearing officer need not be an ALJ.

§ 422.668 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 objections, and may, at his or her discretion, either proceed with the hearing or withdraw.

(1) If the hearing officer withdraws, HCFA designates 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 in writing to HCFA.

§ 422.670 Time and place of hearing.

(a) The hearing officer fixes a time and place for the hearing, which is not to exceed 30 days from the receipt of the request for the hearing, and sends written notice to the parties. The notice also informs 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 hearing, or of adjournment or postponement.

§ 422.672 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.

§ 422.674 Authority of representatives.

(a) A representative appointed and qualified in accordance with § 422.672 may, on behalf of the represented party—

(1) Gives or accepts any notice or request pertinent to the proceedings set forth in this subpart;

(2) Presents evidence and allegations as to facts and law in any proceedings affecting that party; and

(3) Obtains 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.

§ 422.676 Conduct of hearing.

(a) The hearing is open to the parties and to the public.

(b) The hearing officer inquires fully into all the matters at issue and receives in evidence the testimony of witnesses and any documents that are relevant and material.

(c) The hearing officer provides the parties an opportunity to enter any objection to the inclusion of any document.

(d) The hearing officer decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing.

§ 422.678 Evidence.

The hearing officer rules on the admissibility of evidence and may admit evidence that would be inadmissible under rules applicable to court procedures.

§ 422.680 Witnesses.

(a) The hearing officer may examine the witnesses.

(b) The parties or their representatives are permitted to examine their witnesses and cross-examine witnesses of other parties.

§ 422.682 Discovery.

(a) Prehearing discovery is 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 is provided by order of the hearing officer.

(d) The hearing officer's order on all discovery matters is final.

§ 422.684 Prehearing.

The hearing officer may schedule a prehearing conference if he or she believes that a conference would more clearly define the issues.

§ 422.686 Record of hearing.

(a) A complete record of the proceedings at the hearing is 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.

§ 422.688 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 the Act.

§ 422.690 Notice and effect of hearing decision.

(a) As soon as practical after the close of the hearing, the hearing officer issues 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 provides a copy of the hearing decision to each party.

(c) The hearing decision is final and binding unless it is reversed or modified by the Administrator following review under § 422.692, or reopened and revised in accordance with § 422.696.

§ 422.692 Review by the Administrator.

(a) *Request for Review by Administrator.* An M+C organization that has received a hearing decision upholding a contract termination determination may request review by the Administrator within 15 days of receiving the hearing decision as provided under § 422.690(b).

(b) *Review by the Administrator.* The Administrator shall review the hearing officer's decision, and determine, based upon this decision, the hearing record, and any written arguments submitted by the M+C organization, whether the termination decision should be upheld, reversed, or modified.

(c) *Decision by the Administrator.* The Administrator issues a written decision, and furnishes the decision to the M+C organization requesting review.

§ 422.694 Effect of Administrator's decision.

A decision by the Administrator under section 422.692 is final and binding unless it is reopened and revised in accordance with § 422.696.

§ 422.696 Reopening of contract or reconsidered determination or decision of a hearing officer or the Administrator.

(a) *Initial or reconsidered determination.* HCFA may reopen and revise an initial or reconsidered determination 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. Another hearing officer designated by HCFA may reopen and revise the decision if the hearing officer who issued the decision is unavailable.

(c) *Decision of Administrator.* A decision by the Administrator that is otherwise final may be reopened and revised by the Administrator upon the Administrator's own motion within one year of the notice of the Administrator's decision.

(d) *Notices.* (1) The notice of reopening and of any revisions following the reopening is mailed to the parties.

(2) The notice of revision specifies the reasons for revisions.

§ 422.698 Effect of revised determination.

The revision of a contract or reconsidered determination is binding unless a party files a written request for hearing of the revised determination in accordance with § 422.662.

Subpart O—Intermediate Sanctions

§ 422.750 Kinds of sanctions.

(a) The following intermediate sanctions and civil money penalties may be imposed:

(1) Civil money penalties ranging from $10,000 to $100,000 depending upon the violation.

(2) Suspension of enrollment of Medicare beneficiaries.

(3) Suspension of payment to the M+C organization for Medicare beneficiaries who enroll.

(4) Require the M+C organization to suspend all marketing activities to Medicare beneficiaries for the M+C plan subject to the intermediate sanctions.

(b) The enrollment, payment, and marketing sanctions continue in effect until HCFA is satisfied that the deficiency on which the determination was based has been corrected and is not likely to recur.

§ 422.752 Basis for imposing sanctions.

(a) *All intermediate sanctions.* For the violations listed below, HCFA may impose any of the sanctions specified in § 422.750 on any M+C organization that has a contract in effect. The M+C organization may also be subject to other applicable remedies available under law.

(1) Fails substantially to provide, to an M+C enrollee, medically necessary services that the organization is required to provide (under law or under the contract) to an M+C enrollee, and that failure adversely affects (or is substantially likely to adversely affect) the enrollee.

(2) Imposes on M+C enrollees premiums in excess of the monthly basic and supplemental beneficiary premiums permitted under section 1854 of the Act and Subpart G of this part.

(3) Expels or refuses to reenroll a beneficiary in violation of the provisions of this part.

(4) Engages in any practice that could reasonably be expected to have the effect of denying or discouraging enrollment of individuals whose medical condition or history indicates a need for substantial future medical services.

(5) Misrepresents or falsifies information that it furnishes—

(i) To HCFA; or

(ii) To an individual or to any other entity.

(6) Fails to comply with the requirements of § 422.204, which prohibits interference with practitioners' advice to enrollees.

(7) Fails to comply with § 422.216, which requires the organization to enforce the limit on balance billing under a private fee-for service plan.

(8) Employs or contracts with an individual who is excluded from participation in Medicare under section 1128 or 1128A of the Act (or with an entity that employs or contracts with such an individual) for the provision of any of the following:

(i) Health care.

(ii) Utilization review.

(iii) Medical social work.

(iv) Administrative services.

(b) *Suspension of enrollment and marketing.* If HCFA makes a determination under § 422.510(a), HCFA may impose the intermediate sanctions in § 422.756(c)(1) and (c)(3).

§ 422.756 Procedures for imposing sanctions.

(a) *Notice of Sanction and opportunity to respond*—(1) *Notice of sanction.* Before imposing the intermediate sanctions specified in paragraph (c) of this section HCFA—

(i) Sends a written notice to the M+C organization stating the nature and basis of the proposed sanction; and

(ii) Sends the OIG a copy of the notice.

(2) *Opportunity to respond.* HCFA allows the M+C organization 15 days from receipt of the notice to provide evidence that it has not committed an act or failed to comply with the requirements described in § 422.752, as applicable. HCFA may allow a 15-day addition to the original 15 days upon receipt of a written request from the M+C organization. To be approved, the request must provide a credible explanation of why additional time is necessary and be received by HCFA before the end of the 15-day period following the date of receipt of the sanction notice. HCFA does not grant an extension if it determines that the M+C organization's conduct poses a threat to an enrollee's health and safety.

(b) *Informal reconsideration.* If, consistent with paragraph (a)(2) of this section the M+C organization submits a timely response to HCFA's notice of sanction, HCFA conducts an informal reconsideration that:

(1) Consists of a review of the evidence by an HCFA official who did not participate in the initial decision to impose a sanction; and

(2) Gives the M+C organization a concise written decision setting forth the factual and legal basis for the decision that affirms or rescinds the original determination.

(c) *Specific sanctions.* If HCFA determines that an M+C organization has acted or failed to act as specified in § 422.752 and affirms this determination in accordance with paragraph (b) of this section, HCFA may—

(1) Require the M+C organization to suspend acceptance of applications made by Medicare beneficiaries for enrollment in the sanctioned M+C plan during the sanction period;

(2) In the case of a violation under § 422.752(a), suspend payments to the M+C organization for Medicare beneficiaries enrolled in the sanctioned M+C plan during the sanction period; and

(3) Require the M+C organization to suspend all marketing activities for the sanctioned M+C plan to Medicare enrollees.

(d) Effective date and duration of sanctions—(1) *Effective date.* Except as provided in paragraph (d)(2) of this section, a sanction is effective 15 days after the date that the organization is notified of the decision to impose the sanction or, if the M+C organization timely seeks reconsideration under paragraph (b) of this section, on the date specified in the notice of HCFA's reconsidered determination.

(2) *Exception.* If HCFA determines that the M+C organization's conduct poses a serious threat to an enrollee's health and safety, HCFA may make the sanction effective on a date before issuance of HCFA's reconsidered determination.

(3) *Duration of sanction.* The sanction remains in effect until HCFA notifies the M+C organization that HCFA is satisfied that the basis for imposing the

sanction has been corrected and is not likely to recur.

(e) *Termination by HCFA.* In addition to or as an alternative to the sanctions described in paragraph (c) of this section, HCFA may decline to authorize the renewal of an organization's contract in accordance with § 422.506(b)(2) and (b)(3), or terminate the contract in accordance with § 422.510.

(f) *Civil Money Penalties.* (1) If HCFA determines that an M+C organization has committed an act or failed to comply with a requirement described in § 422.752, HCFA notifies the OIG of this determination, and also notifies OIG when HCFA reverses or terminates a sanction imposed under this part.

(2) In the case of a violation described in paragraph (a) of § 422.752, or a determination under paragraph (b) of § 422.752 based upon a violation under § 422.510(a)(4) (involving fraudulent or abusive activities), in accordance with the provisions of 42 CFR parts 1003 and 1005, the OIG may impose civil money penalties on the M+C organization in accordance with parts 1003 and 1005 of this title in addition to, or in place of, the sanctions that HCFA may impose under paragraph (c) of this section.

(3) In the case of a determination under paragraph (b) of § 422.752 other than a determination based upon a violation under § 422.510(a)(4), in accordance with the provisions of 42 CFR parts 1003 and 1005, HCFA may impose civil money penalties on the M+C organization in the amounts specified in § 422.758 in addition to, or in place of, the sanctions that HCFA may impose under paragraph (c) of this section.

§ 422.758 Maximum amount of civil money penalties imposed by HCFA.

If HCFA makes a determination under § 422.752(b), based on any determination under § 422.510(a) except a determination under § 422.510(a)(4), HCFA may impose civil money penalties in the following amounts:

(a) If the deficiency on which the determination is based has directly adversely affected (or has the substantial likelihood of adversely affecting) one or more M+C enrollees—$25,000 for each determination.

(b) For each week that a deficiency remains uncorrected after the week in which the M+C organization receives HCFA's notice of the determination—$10,000.

§ 422.760 Other applicable provisions.

The provisions of section 1128A of the Act (except subsections (a) and (b)) apply to civil money penalties under this subpart to the same extent that they apply to a civil money penalty or procedure under section 1128A of the Act.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare—Hospital Insurance; and Program No. 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: June 17, 1998.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: June 18, 1998.

Donna E. Shalala,

Secretary.

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The items in this list were editorially compiled as an aid to Federal Register users. Inclusion or exclusion from this list has no legal significance.

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LIST OF PUBLIC LAWS

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The text of laws is not published in the **Federal Register** but may be ordered in ''slip law'' (individual pamphlet) form from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402 (phone, 202–512–1808). The text will also be made available on the Internet from GPO Access at http://www.access.gpo.gov/su_docs/. Some laws may not yet be available.

H.R. 1847/P.L. 105–184

Telemarketing Fraud Prevention Act of 1998 (June 23, 1998; 112 Stat. 520)

S. 1150/P.L. 105–185

Agricultural Research, Extension, and Education Reform Act of 1998 (June 23, 1998; 112 Stat. 523)

S. 1900/P.L. 105–186

U.S. Holocaust Assets Commission Act of 1998 (June 23, 1998; 112 Stat. 611)

H.R. 3811/P.L. 105–187

Deadbeat Parents Punishment Act of 1998 (June 24, 1998; 112 Stat. 618)

Last List June 24, 1998

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