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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: November 14, 2000, at 9:00 a.m.

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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Rules and Regulations

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

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

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR part 25

[Docket No. NM178; Special Conditions No. 25–167–SC]

Special Conditions: Bombardier Model CL–600–2C10 Airplane; Automatic Takeoff Thrust Control System

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Final special conditions; request for comments.

SUMMARY: These special conditions are issued for the Bombardier Model CL–600–2C10 series airplanes. This new airplane will have a novel or unusual design feature associated with an Automatic Takeoff Thrust Control System (ATTCS). The applicable airworthiness regulations do not contain appropriate safety standards for approach climb performance using an ATTCS. These special conditions contain the additional safety standards the Administrator considers necessary to establish a level of safety equivalent to that established by the existing airworthiness standards.

DATES: The effective date of these special conditions is October 24, 2000.

Send your comments on or before December 18, 2000.

ADDRESSES: Mail your comments on these special conditions in duplicate to: Federal Aviation Administration, Transport Airplane Directorate, Attention: Rules Docket (ANM–114), Docket No. NM178, 1601 Lind Avenue SW., Renton, Washington 98055–4056; or deliver them to the Transport Airplane Directorate at that address. You must mark your comments: Docket No. NM178. You may inspect all comments at that address on weekdays, except Federal holidays, between 7:30 a.m. and 4 p.m.

FOR FURTHER INFORMATION CONTACT: Gerry Lakin, FAA, Transport Airplane Directorate, Aircraft Certification Office, Standardization Branch, ANM–113, 1601 Lind Avenue SW., Renton, Washington, telephone (425) 227–1187; fax (425) 227–1149.

SUPPLEMENTARY INFORMATION: The FAA has determined that notice and opportunity for prior public comment hereon are impracticable because those procedures would significantly delay issuance of the approval design and thus delivery of the affected aircraft. In addition, 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 these special conditions 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 notice number and be submitted in duplicate to the address specified above. All communications received by the closing date for comments will be considered by the Administrator. These special conditions 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 notice must include a self-addressed, stamped postcard on which the following statement is made: ''Comments to Docket No. NM178.'' The postcard will be date stamped and returned to the commenter.

Background

On May 6, 1996, Bombardier Aerospace applied for an amendment to U.S. Type Certificate (TC) A21EA, through Transport Canada, to include the Bombardier Model CL600–2C10 series airplane (Regional Jet Series 700). The Model CL600–2C10 is a medium-sized transport category airplane powered by two General Electric Aircraft Engines (GEAE) CF34–8C1 turbofan engines mounted on the aft fuselage. Each engine can deliver up to 13,790 pounds of thrust at takeoff. The airplane will be capable of operating with 5 flight crewmembers and up to 78 passengers.

The Model CL600–2C10 will incorporate an unusual design feature to show compliance with the approach climb requirements of § 25.121(d) (''Climb: One-engine-inoperative''). This design feature is the Automatic Takeoff Thrust Control System (ATTCS), referred to by Bombardier as Automatic Power Reserve (APR). Appendix I to Title 14, Code of Federal Regulations (CFR), part 25, limits the application of performance credit for ATTCS to takeoff only. Since the airworthiness regulations do not contain appropriate safety standards for approach climb performance using ATTCS, special conditions are required to ensure a level of safety equivalent to that established in the regulations.

Type Certification Basis

Under the provisions of § 21.17 (''Designation of applicable regulations''), Bombardier must show that the Model CL600–2C10 meets the applicable provisions of:

- 14 CFR part 25, effective February 1, 1965, including amendments 25–1 through 25–86; and
- § 25.109 (''Accelerate-stop distance''), as amended by amendment 25–92.

The certification basis also may include later amendments to part 25 that are not relevant to these special conditions. In addition, the certification basis for the Model CL600–2C10 includes:

- 14 CFR part 34, effective September 10, 1990, including amendment 34–3, effective February 3, 1999, as well as any amendments in effect at the time of certification; and
- 14 CFR part 36, effective December 1, 1969, including amendments 36–1 through 36–22, and any following amendments that will be applicable on the date the type certificate is issued.

These special conditions form an additional part of the type certification basis. The certification basis also may include other special conditions that are not relevant to these specific special conditions.

If the Administrator finds that the applicable airworthiness regulations (in this case, part 25) do not contain adequate or appropriate safety standards for the Bombardier Model CL600–2C10 because of a novel or unusual design feature, the FAA may prescribe special conditions under the provisions of § 21.16 (''Special conditions''). The special conditions become part of the type certification basis in accordance with § 21.101(b)(2) (''Designation of applicable regulations'').

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

As stated previously, the Model CL600–2C10 will incorporate an unusual design feature, the ATTCS (referred to by Bombardier as APR), to show compliance with the approach climb requirements of § 25.121(d). The Model CL600–2C10 is powered by two GEAE CF34–8C1 turbofan engines mounted on the aft fuselage of the airplane, and equipped with Full Authority Digital Engine Controls (FADEC) that, in part, protect against exceeding engine limits. Further, the airplane incorporates a non-moving throttle system that functions by placing the throttle levers in detents for the takeoff and climb phases of flight; this allows the FADEC to schedule the power setting based on the phase of flight. With the APR and associated systems functioning normally as designed, all applicable requirements of part 25 will be met without requiring any action by the flight crew to increase power.

Automatic takeoff power control on the Model CL600–2C10 involves uptrimming the operating engine to maximum takeoff power (APR). These actions will be controlled by the FADEC. At takeoff, when the power levers are set to the Takeoff Go-Around (TOGA) detent, if there are no FADEC fault or failure messages displayed, the system is armed and APR will occur without any further action by the crew if an engine fails. During go-around, the uptrim is automatically armed.

Engine power is set to TOGA to initiate the takeoff roll. The value of TOGA for the current ambient conditions will be calculated and set by the FADEC. Following an engine failure during takeoff or go-around, the ATTCS will change the power reference on the operating engine to achieve the maximum takeoff power rating if the engine power was originally set to normal takeoff power. If the reduced power takeoff option is being used, the ATTCS will increase the power of the operating engine to the maximum takeoff rating, although the aircraft performance will be based on a 10% power increase only.

The engine operating limits (turbine temperature and N_1) for TOGA are set and displayed to the pilot when that rating is selected. These limits are set in such a way that the engine redline limits are not exceeded when an APR is engaged. When the maximum takeoff power rating is selected or triggered, the engine limits are reset automatically to reflect the engine redline limits.

The system is armed during all phases of the flight. The power levers will continue to function normally if the ATTCS should fail. Full takeoff power is available if the pilot elects to push the power levers past the takeoff power detent into the overtravel range.

Operations of all systems and equipment will be designed to function within the engine power range. Thrust increase from the initial to the maximum approved takeoff power level will be free of hazardous engine response characteristics.

The APR function, as described above, is part of the powerplant control system. The APR is always armed whenever power levers are above the idle detent. The system is verified before each flight via the FADEC built-in test feature. When the APR is triggered following an engine failure, an ''APR'' message will appear on the engine display.

The FADEC installed on the Model CL600–2C10 will ensure that inherent flight characteristics of the airplane do provide adequate warning if an engine failure occurs during takeoff. The natural yawing tendency of the airplane, coupled with flashing master warning and master caution lights, will provide the pilot with a clear indication of any engine failure during takeoff.

The part 25 standards for ATTCS, contained in § 25.904 (Automatic takeoff thrust control system (ATTCS)'') and Appendix I, specifically restrict performance credit for ATTCS to takeoff only. Expanding the scope of the standards to include other phases of flight, such as go-around, was considered at the time the standards were issued, but flight crew workload issues precluded further consideration. As stated in the preamble to amendment 25–62:

> ''In regard to ATTCS credit for approach climb and go-around maneuvers, current regulations preclude a higher thrust for the approach climb [§ 25.121(d)] than for the landing climb (§ 25.119). The workload required for the flightcrew to monitor and select from multiple in-flight thrust settings in the event of an engine failure during a critical point in the approach, landing, or go-around operations is excessive. Therefore, the FAA does not agree that the scope of the amendment should be changed to include the use of ATTCS for anything except the takeoff phase.'' (Refer to 52 FR 43153, November 9, 1987.)

The ATTCS incorporated on the Model CL600–2C10 allows the pilot to use the same power setting procedure during a go-around, regardless of whether or not an engine fails. In either case, the pilot obtains go-around power by moving the throttles into the forward (takeoff/go-around) throttle detent. Since the ATTCS is permanently armed, it will function automatically following an engine failure, and advance the remaining engine to the ATTCS thrust level. Therefore, this design adequately addresses the pilot workload concerns identified in the preamble to amendment 25–62.

Accordingly, these special conditions would require a showing of compliance with those provisions of § 25.904 and Appendix I that are applicable to the approach climb and go-around maneuvers.

The definition of a critical time interval for the approach climb case, during which time it must be extremely improbable to violate a flight path based on the gradient requirement of § 25.121(d), is of primary importance. That gradient requirement implies a minimum one-engine-inoperative flight path capability with the airplane in the approach configuration. The engine may have been inoperative before initiating the go-around, or it may become inoperative during the go-around. The definition of the critical time interval must consider both possibilities.

Applicability

As discussed above, these special conditions would be applicable to the Bombardier Model CL600–2C10. Should Bombardier apply at a later date for a change to the type certificate to include another model incorporating the same novel or unusual design feature, these special conditions 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 the

Bombardier Model CL600–2C10 airplane. 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 airplane.

The substance of these special conditions has been subjected to the notice and public comment process in several prior instances, and has been derived without substantive change from those special conditions previously issued. It is unlikely that prior public comment on this action would result in a significant change from the substance contained in this document. For this reason, and because a delay would significantly affect the certification of the airplane, which is imminent, the FAA has determined that prior public notice and comment are unnecessary and impracticable. 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 25

Aircraft, Aviation safety, Reporting and recordkeeping requirements.

The authority citation for these special conditions is as follows:

Authority: 49 U.S.C. 106(g), 40113, 44701, 44702, 44704.

The Special Conditions

Accordingly, pursuant to the authority delegated to me by the Administrator, the following special conditions are issued as part of the type certification basis for the Bombardier Model CL600–2C10 airplane.

1. *General.* An Automatic Takeoff Thrust Control System (ATTCS) is defined as the entire automatic system, including all devices, both mechanical and electrical that sense engine failure, transmit signals, actuate fuel controls or power levers, or increase engine power by other means on operating engines to achieve scheduled thrust or power increases and furnish cockpit information on system operation.

2. *ATTCS.* The engine power control system that automatically resets the power or thrust on the operating engine (following engine failure during the approach for landing) must comply with the following requirements stated in paragraphs 2.a, 2.b, and 2.c:

a. *Performance and System Reliability Requirements.* The probability analysis must include consideration of ATTCS failure occurring after the time at which the flightcrew last verifies that the ATTCS is in a condition to operate until the beginning of the critical time interval.

b. *Thrust or Power Setting.*

(1) The initial thrust or power setting on each engine at the beginning of the takeoff roll or go-around may not be less than any of the following:

(i) That required to permit normal operation of all safety-related systems and equipment dependent upon engine thrust or power lever position; or

(ii) That shown to be free of hazardous engine response characteristics and not to result in any unsafe aircraft operating or handling characteristics when thrust or power is increased from the initial takeoff or go-around thrust or power to the maximum approved takeoff thrust or power.

(2) For approval of an ATTCS system for go-around, the thrust or power setting procedure must be the same for go-arounds initiated with all engines operating as for go-arounds initiated with one engine inoperative.

c. *Powerplant Controls.* In addition to the requirements of § 25.1141, no single failure or malfunction, or probable combination thereof, of the ATTCS, including associated systems, may cause the failure of any powerplant function necessary for safety. The ATTCS must be designed to:

(1) Apply thrust or power on the operating engine(s), following any one engine failure during takeoff or go-around, to achieve the maximum approved takeoff thrust or power without exceeding engine operating limits; and

(2) Provide a means to verify to the flightcrew before takeoff and before beginning an approach for landing that the ATTCS is in a condition to operate.

3. *Critical Time Interval.* The definition of the Critical Time Interval in appendix I, § I25.2(b) shall be expanded to include the following:

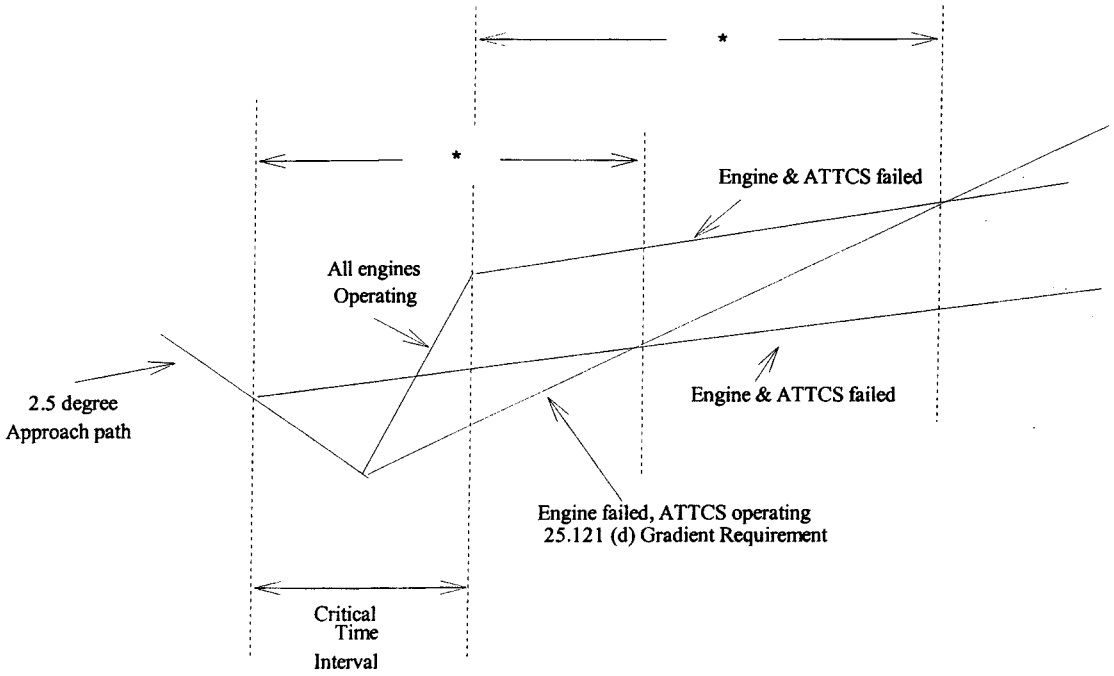
a. When conducting an approach for landing using ATTCS, the critical time interval is defined as follows:

(1) The critical time interval *begins* at a point on a 2.5 degree approach glide path from which, assuming a simultaneous engine and ATTCS failure, the resulting approach climb flight path intersects a flight path originating at a later point on the same approach path corresponding to the part 25 one-engine-inoperative approach climb gradient. The period of time from the point of simultaneous engine and ATTCS failure to the intersection of these flight paths must be no shorter than the time interval used in evaluating the critical time interval for takeoff beginning from the point of simultaneous engine and ATTCS failure and ending upon reaching a height of 400 feet.

(2) The critical time interval *ends* at the point on a minimum performance, all-engines-operating go-around flight path from which, assuming a simultaneous engine and ATTCS failure, the resulting minimum approach climb flight path intersects a flight path corresponding to the part 25 minimum one-engine-inoperative approach climb gradient. The all-engines-operating go-around flight path and the part 25 one-engine-inoperative approach climb gradient flight path originate from a common point on a 2.5 degree approach path. The period of time from the point of simultaneous engine and ATTCS failure to the intersection of these flight paths must be no shorter than the time interval used in evaluating the critical time interval for the takeoff beginning from the point of simultaneous engine and ATTCS failure and ending upon reaching a height of 400 feet.

b. The critical time interval must be determined at the altitude resulting in the longest critical time interval for which one-engine-inoperative approach climb performance data are presented in the Airplane Flight Manual (AFM).

c. The critical time interval is illustrated in the following figure:



* The engine and ATTCS failed time interval must be no shorter than the time interval from the point of simultaneous engine and ATTCS failure to a height of 400 feet used to comply with I25.2(b) for ATTCS use during takeoff.

Issued in Renton, Washington, on October 24, 2000.

D. L. Riggin,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 00–28294 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 2000–ASW–17]

Revision of Class E Airspace, Fayetteville, AR

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: This notice confirms the effective date of a direct final rule which revises the Class E Airspace at Fayetteville, AR.

EFFECTIVE DATE: The direct final rule published at 65 FR 54953 is effective 0901 UTC, November 30, 2000.

FOR FURTHER INFORMATION CONTACT: Donald J. Day, Airspace Branch, Air Traffic Division, Southwest Region, Federal Aviation Administration, Fort Worth, TX 76193–0520, telephone: 817–222–5593.

SUPPLEMENTARY INFORMATION: The FAA published this direct final rule with a request for comments in the **Federal Register** on September 12, 2000, (65 FR 54953). The FAA uses the direct final rulemaking procedure for a noncontroversial rule where the FAA believes that there will be no adverse public comment. This direct final rule advised the public that no adverse comments were anticipated, and that unless a written adverse comment, or a written notice of intent to submit such an adverse comment, were received within the comment period, the regulation would become effective on November 30, 2000. No adverse comments were received, and, thus, this action confirms that this direct final rule will be effective on that date.

Issued in Fort Worth, TX, on October 27, 2000.

Robert N. Stevens,

Acting Manager, Air Traffic Division, Southwest Region.

[FR Doc. 00–28292 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 2000–ASW–18]

Revision of Class D Airspace, Robert Gray Army Airfield, TX; and Revocation of Class D Airspace, Hood Army Airfield, TX

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: This notice confirms the effective date of a direct final rule which revises the Class D Airspace at Robert Gray Army Airfield, TX. and revokes the Class D Airspace at Hood Army Airfield, TX.

EFFECTIVE DATE: The direct final rule published at 65 FR 54950 is effective 0901 UTC, November 30, 2000.

FOR FURTHER INFORMATION CONTACT: Donald J. Day, Airspace Branch, Air Traffic Division, Southwest Region, Federal Aviation Administration, Fort Worth, TX 76193–0520, telephone: 817–222–5593.

SUPPLEMENTARY INFORMATION: The FAA published this direct final rule with a request for comments in the **Federal Register** on September 12, 2000, (65 FR 54950). The FAA uses the direct final rulemaking procedure for a noncontroversial rule where the FAA believes that there will be no adverse public comment. This direct final rule advised the public that no adverse comments were anticipated, and that unless a written adverse comment, or a written notice of intent to submit such an adverse comment, were received within the comment period, the regulation would become effective on November 30, 2000. No adverse comments were received and, thus, this action confirms that this direct final rule will be effective on that date.

Issued in Fort Worth, TX, on October 27, 2000.

Robert N. Stevens,

Acting Manager, Air Traffic Division, Southwest Region.

[FR Doc. 00–28291 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 71

[Airspace Docket No. 2000–ASW–15]

Revision of Class E Airspace, Tulsa, OK

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: This notice confirms the effective date of a direct final rule which revises the Class E Airspace at Tulsa, OK.

EFFECTIVE DATE: The direct final rule published at 65 FR 54952 is effective 0901 UTC, November 30, 2000.

FOR FURTHER INFORMATION CONTACT: Donald J. Day, Airspace Branch, Air Traffic Division, Southwest Region, Federal Aviation Administration, Fort Worth, TX 76193–0520, telephone: 817–222–5593.

SUPPLEMENTARY INFORMATION: The FAA published this direct final rule with a request for comments in the **Federal Register** on September 12, 2000, (65 FR 54952). The FAA uses the direct final rulemaking procedure for a noncontroversial rule where the FAA believes that there will be no adverse public comment. This direct final rule advised the public that no adverse comments were anticipated, and that unless a written adverse comment, or a written notice of intent to submit such an adverse comment, were received within the comment period, the regulation would become effective on November 30, 2000. No adverse comments were received, and, thus, this action confirms that this direct final rule will be effective on that date.

Issued in Fort Worth, TX, on October 27, 2000.

Robert N. Stevens,

Acting Manager, Air Traffic Division, Southwest Region.

[FR Doc. 00–28293 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF COMMERCE

Bureau of Export Administration

15 CFR Parts 740 and 774

[Docket No. 000204027–0266–02]

RIN 0694–AC14

Revisions to License Exception CTP; Corrections

AGENCY: Bureau of Export Administration, Commerce.

ACTION: Final rule.

SUMMARY: On October 13, 2000 the Bureau of Export Administration published a final rule (65 FR 60852) revising License Exception CTP. This rule corrects inadvertent errors or omissions in the October 13 rule. This rule revises regulations to show the correct effective date that Estonia becomes a Tier 2 country (December 28, 2000). This rule also revises the License Requirements section of Export Control Classification Number (ECCN) 4D002 consistent with previously agreed to changes in the Wassenaar List of Dual-Use Goods and Technologies. In addition, this rule corrects a typographical error that appeared in the regulations. Finally, this preamble clarifies that the preambular text in the October 13 rule incorrectly described changes to ECCNS 4D003 and 4E003. These changes were to ECCNS 4D001 and 4E001 and were correctly set forth in the regulatory text of the October 13 rule.

DATES: This rule is effective October 13, 2000.

FOR FURTHER INFORMATION CONTACT: Kirsten Mortimer, Regulatory Policy Division, Bureau of Export Administration, at (202) 482–2440.

SUPPLEMENTARY INFORMATION: Although the Export Administration Act (EAA) expired on August 20, 1994, the President invoked the International Emergency Economic Powers Act and continued in effect the EAR, and to the extent permitted by law, the provisions of the EAA, as amended, in Executive Order 12924 of August 19, 1994, as extended by the President's notices of August 15, 1995 (60 FR 42767), August 14, 1996 (61 FR 42527), August 13, 1997 (62 FR 43629), August 13, 1998 (63 FR 44121), August 10, 1999 (64 FR 44101), and August 8, 2000 (65 FR 48347).

Rulemaking Requirements

1. This final rule has been determined to be not significant for purposes of E.O. 12866.

2. Notwithstanding any other provision of law, no person is required to respond to nor be subject to a penalty for failure to comply with a collection of information subject to the requirements of the Paperwork Reduction Act unless that collection of information displays a current valid OMB Control Number. This regulation involves collections previously approved by the Office of Management and Budget under control numbers 0694–0088, ''Multi-Purpose Application,'' which carries a burden hour estimate of 45 minutes per manual submission and 40 minutes per electronic submission. Miscellaneous and recordkeeping activities account for 12 minutes per submission. Information is also collected under OMB control number 0694–0107, ''National Defense Authorization Act,'' Advance Notifications and Post-Shipment Verification Reports, which carries a burden hour estimate of 15 minutes per report. This rule also involves collections of information under OMB control number 0694–0073, ''Export Controls of High Performance Computers'' and OMB control number 0694–0093, ''Import Certificates and End-User Certificates''.

3. This rule does not contain policies with Federalism implications sufficient to warrant preparation of a Federalism

assessment under Executive Order 13132.

4. The provisions of the Administrative Procedure Act (5 U.S.C. 553) requiring notice of proposed rulemaking, the opportunity for public participation, and a delay in effective date, are inapplicable because this regulation involves a military and foreign affairs function of the United States (Sec. 5 U.S.C. 553(a)(1)). Further, no other law requires that a notice of proposed rulemaking and an opportunity for public comment be given for this rule. Accordingly, it is issued in final form.

List of Subjects

15 CFR Part 740

Administrative practice and procedure, Exports, Foreign trade, Reporting and recordkeeping requirements.

15 CFR Part 774

Exports, Foreign trade.

Accordingly, parts 740 and 774 of the Export Administration Regulations (15 CFR Parts 730–799) are amended to read as follows:

1. The authority citation for 15 CFR part 740 continues to read as follows:

Authority: 50 U.S.C. app. 2401 *et seq.*; 50 U.S.C. 1701 *et seq.*; E.O. 12924, 59 FR 43437, 3 CFR, 1994 Comp., p. 917; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; Notice of August 3, 2000 (65 FR 48347, August 8, 2000).

2. The authority citation for 15 CFR part 774 continues to read as follows:

Authority: 50 U.S.C. app. 2401 *et seq.*; 50 U.S.C. 1701 *et seq.*; 10 U.S.C. 7420; 10 U.S.C. 7430(e); 18 U.S.C. 2510 *et seq.*; 22 U.S.C. 287c, 22 U.S.C. 3201 *et seq.*, 22 U.S.C. 6004; 30 U.S.C. 185(s), 185(u); 42 U.S.C. 2139a; 42 U.S.C. 6212; 43 U.S.C. 1354; 46 U.S.C. app. 466c; 50 U.S.C. app. 5; E.O. 12924, 59 FR 43437, 3 CFR, 1994 Comp., p. 917; E.O. 13026, 61 FR 58767, 3 CFR, 1996 Comp., p. 228; Notice of August 3, 2000 (65 FR 48347, August 8, 2000).

PART 740—CORRECTED

3. Section 740.7 is amended by revising the phrase ''As of December 26, 2000'' in the last sentence of paragraphs (c)(1) and (d)(1) to read ''As of December 28, 2000'', and by revising the phrase ''greater that 12,500 MTOPS'' in paragraph (d)(4) to read ''greater than 12,500 MTOPS''.

PART 774—CORRECTED

4. In Supplement No. 1 to part 774 (the Commerce Control List), Category 4—Computers is amended by revising the License Requirements section of Export Control Classification Number (ECCN) 4D002, to read as follows:

4D002 ''Software'' specially designed or modified to support ''technology'' controlled by 4E (except 4E980, 4E992, and 4E993).

License Requirements

REASON FOR CONTROL: NS, MT, AT, NP, XP

Control(s)	Country chart
NS applies to entire entry	NS Column 1.
MT applies to ''software'' for equipment controlled by 4E for MT reasons	MT Column 1.
AT applies to entire entry	AT Column 1.

NP applies to ''software'' for computers with a CTP greater than 6,500 Mtops, unless a License Exception is available. See § 742.3(b) of the EAR for information on applicable licensing review policies.

XP applies to ''software'' for computers with a CTP greater than 6,500 Mtops, unless a License Exception is available. See § 742.3(b) of the EAR for information on applicable licensing review policies.

* * * * *

Dated: October 27, 2000.

Steven C. Goldman,

Acting Assistant Secretary for Export Administration.

[FR Doc. 00–28307 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–33–P

DEPARTMENT OF THE INTERIOR

Office of Surface Mining Reclamation and Enforcement

30 CFR Part 938

[PA–126–FOR]

Pennsylvania Regulatory Program

AGENCY: Office of Surface Mining Reclamation and Enforcement (OSM), Interior.

ACTION: Final rule; approval of amendment.

SUMMARY: OSM is approving an amendment to the Pennsylvania regulatory program (Pennsylvania program) under the Surface Mining Control and Reclamation Act of 1977 (SMCRA), 30 U.S.C. 1201 *et seq.*, as amended. The amendment revises certain portions of 25 Pennsylvania Code Chapter 86, Surface and Underground Mining: General, pertaining to ownership and control, bonding, civil penalties and areas unsuitable for mining. The amendments are intended to revise the Pennsylvania program to be consistent with the corresponding Federal regulations.

EFFECTIVE DATE: November 3, 2000.

FOR FURTHER INFORMATION CONTACT: Mr. Robert J. Biggi, Office of Surface Mining Reclamation and Enforcement, Harrisburg Field Office, Third Floor, Suite 3C, Harrisburg Transportation Center (Amtrack), 415 Market Street, Harrisburg, Pennsylvania 17101, Telephone: (717) 782–4036.

SUPPLEMENTARY INFORMATION:

I. Background on the Pennsylvania Program

On July 30, 1982, the Secretary of the Interior conditionally approved the Pennsylvania program. Background on the Pennsylvania program, including the Secretary's findings and the disposition of comments can be found in the July 30, 1982 **Federal Register** (47 FR 33079). Subsequent actions concerning the regulatory program amendments are identified at 30 CFR 938.11, 938.15 and 938.16.

II. Submission of the Amendment

By letter dated November 2, 1999 (Administrative Record No. PA–845.02),

the Pennsylvania Department of Environmental Protection (PADEP) submitted an amendment to its approved regulatory program pertaining to ownership and control, bonding, civil penalties and areas unsuitable for mining pursuant to the Federal regulations at 30 CFR 732.17(b). Pennsylvania did so as a result of its Regulatory Basics Initiative (RBI) intended to revise regulations considered to be unclear, unnecessary or more stringent than the corresponding Federal regulation. The proposed rulemaking was published in the November 29, 1999 **Federal Register** (64 FR 66595). The public comment period closed on December 29, 1999. No one requested an opportunity to speak at a public hearing, so no hearing was held.

III. Director's Findings

Set forth below, pursuant to SMCRA and the Federal regulations at 30 CFR 732.15 and 732.17, are the Director's findings concerning the amendments to the Pennsylvania permanent regulatory program. Revisions not specifically discussed below concern paragraph notations to reflect organizational changes resulting from this amendment.

Section 86.1. Definitions

1. *Owned or controlled or owns or controls.* PADEP modifies the title to the definition by substituting the word ''and'' for the second ''or'' so it now reads ''Owned or controlled and owns or controls.'' This change renders the title substantively identical to, and therefore no less effective than, the title to the Federal counterpart definition at 30 CFR 773.5. PADEP also modifies subparagraph (iii)(E) by deleting the specified percentages (10–50%) of instruments of ownership of a corporate entity necessary to establish a presumption of ownership or control, and by substituting a reference to percentages in the corresponding Federal regulations at 30 CFR 773.5(b)(5). This provision of the Federal regulations was vacated by the United States Court of Appeals for the District of Columbia Circuit in *National Mining Ass'n.* v. *United States Dep't. of the Interior,* 177 F.3d 1, 7 (D.C. Cir. 1999). However, while the vacated Federal regulation cannot be implemented in a Federal program, the text of the regulation has not been deleted from the Code of Federal Regulations.

Moreover, pursuant to section 505(b) of SMCRA, 30 U.S.C. 1255(b), any state law or regulation ''which provides for more stringent land use and environmental controls and regulations of surface coal mining operations than do the provisions' of SMCRA ''or any regulations issued pursuant thereto shall not be construed to be inconsistent'' with SMCRA. As such, state programs may still choose to employ this criterion in defining ownership and control. Therefore, we are approving subparagraph (iii)(E) because it provides a basis for establishing a rebuttable presumption of ownership and control that is in addition to those contained in the Federal regulations.

2. *Related party.* PADEP is excluding from this definition persons who are excluded as owners or controllers based on a percentage of ownership under the definition of ''owned or controlled and owns or controls.'' The term ''related party'' does not exist in the Federal regulations, but it has previously been approved by OSM, and remains part of Pennsylvania's approved program. We are approving this change to the definition because it makes it clear that the term ''related party'' is consistent with the term ''owned or controlled and owns or controls,'' and because it does not render the Pennsylvania program inconsistent with SMCRA or the Federal regulations.

3. *Willful violation.* PADEP is adding this definition which states that a willful violation is an act or omission which violates the acts, this chapter, Chapter 87, 88, 89, or 90, or a permit condition required by them, committed by a person who intends the result which actually occurs.

The Director finds that this definition is substantively identical to, and therefore no less effective than the definition found in the Federal rules at 30 CFR 701.5.

Section 86.124(a)(6) Areas Unsuitable for Mining

PADEP is removing current language and substituting the following statement:

> The Department may determine not to process any petition for a designation under § 86.122 (relating to criteria for designating lands as unsuitable) insofar as it pertains to an area for which an administratively complete surface mining operation permit application has been filed and the first newspaper notice has been published. The Department will provide written notice to the petitioner with a statement of its findings.

The Director finds that the revised language is substantively identical to and therefore no less effective than the corresponding portion of the Federal regulation at 30 CFR 764.15(a)(6).

Section 86.152(d) Adjustments (Bond Amount)

PADEP is adding section (d) to require notification of proposed adjustments to bond amounts to the permittee, the surety and any person with a property interest in collateral who has requested such notification. PADEP also adds language providing the permittee an opportunity for informal conference on the adjustment. The Director finds that the changes described above are substantively identical to and therefore no less effective than the Federal Regulations at 30 CFR 800.15(b).

Section 86.156 Form of the Bond

PADEP is adding, in new subsection (3), a self bond to the type of bonds the Department may accept. Existing subsection (3) is re-numbered as (4) and modified to state that the Department will accept ''[a] combination of bonding instruments as provided in § 86.160 (relating to combination of bonding instruments) for coal surface mining activities.'' Existing subsections (4) and (5) are re-numbered as (5) and (6), respectively. The Director finds that the changes described above are substantively identical to and therefore no less effective than the Federal Regulations at 30 CFR 800.12.

Section 86.160 Combination of Bonding Instruments

PADEP is changing the title of this section from ''Surety/collateral combination bond'' to ''Combination of Bonding Instruments,'' and is further modifying the section to include self bonds as part of the combination of bonds that may be accepted. The Director finds that the changes described above are substantively identical to and therefore no less effective than the Federal Regulations at 30 CFR 800.12(d).

Section 86.171 Procedures for Seeking Release of Bond

PADEP is modifying subsection (d) of this section, which currently requires the Department to inspect a site that has applied for bond release within 30 days of receipt of the complete application, or as soon thereafter as possible, to require inspection within 30 days of receipt of the completed application for bond release ''or as soon thereafter as weather conditions permit.'' The Director finds that the changes described above are substantively identical to and therefore no less effective than corresponding language in the Federal Regulations at 30 CFR 800.40(b).

Section 86.182 Procedures

PADEP is adding a new subsection (a) which requires the Department to notify the permittee and surety of its intent to forfeit the bond. Existing subsections regarding bond forfeiture currently lettered as (a) through (g) are re-lettered as (b) through (h) without modification. The Director finds that the changes described above are substantively identical to and therefore no less effective than the Federal Regulations at 30 CFR 800.50(a)(1).

Section 86.193 Assessment of Penalty

PADEP is increasing the threshold for assessment of a civil penalty from $1000 to $1100 in subsections (b) and (c). PADEP also eliminates mandatory penalty amounts for violations of conducting surface mining activities off the permitted area by deleting subsections (d) through (g). The deleted provisions in subsections (d) through (g) have no Federal counterparts. The Department is retaining the requirement, in subsection 86.193(a), that it assess a civil penalty for each violation included as a basis for a cessation order. The Director notes that the Pennsylvania provision, as amended, imposes a lower threshold for mandatory assessment of a civil penalty ($1,100) than the threshold ($1,210) prescribed in the Federal regulations at 30 CFR 845.12(b). Otherwise, the amendments render the Pennsylvania provision substantively identical to its Federal counterparts. Therefore, the Director finds that the changes described above are consistent with the civil penalty provisions in the Federal Regulations at 30 CFR 845.12.

Section 86.194 System for Assessment of Penalties

PADEP is adding language in subsection (b)(1)(vi) allowing an additional civil penalty amount up to the statutory limit to be assessed in extraordinary circumstances.

PADEP also specifies $3,000 as the upper limit to be assessed based on seriousness in subsection (b)(1).

PADEP also modifies subsection (b)(2), ''Culpability,'' by lowering the maximum limit from $1500 to $1200. Also, the minimum amount for violations of willful or reckless conduct was lowered from $2,000 to $260.

PADEP is also changing the criteria for credit to be given for speed of compliance in subsection (b)(3).

PADEP deletes the phrase ''without limitation'' in subsection (b)(4), pertaining to penalties for costs expended by the Commonwealth as a result of the violation. The presumed effect of this deletion is that costs are now limited to those listed in subdivisions (i) through (iv) of subsection (b)(4).

PADEP also reduces the review period for the history of previous violations from two years to one in subsection (b)(6).

PADEP is also adding new subsection (f) entitled ''Revision of civil penalty.'' Subsection (1) is added and explains that the Department may revise a civil penalty calculated in accordance with dollar limits included in subsection (b) and that the basis for revision would be fully explained and documented. New subsection (2) is added to explain that if the Department revises the civil penalty, the Department will use the general criteria in subsection (b) and will give a written explanation of the basis for the revision to the person to whom the order was issued.

The Director finds that the changes described above are consistent with the Federal regulations at 30 CFR 845.13 and 845.16, except as follows. Subsection (f) contains language that is substantively identical to its Federal counterpart at 30 CFR 845.16(a), but it is punctuated differently, with the result that its meaning differs from the Federal regulation. In order to clarify the meaning of this provision, so that it can be interpreted to be no less effective than its Federal counterpart, the period after the first sentence, ending with ''subsection (b),'' must be changed to a comma, and the comma after the term ''demonstrably unjust'' must be changed to a period. Pennsylvania was informed of this in a teleconference by the Harrisburg, PA OSM Office, and agreed to make the change. The change was published in the Pennsylvania Bulletin dated September 23, 2000. (Administrative Record No. Pa. 845.09) The Director thus finds that the changes described render this provision substantively identical to and therefore consistent with the Federal regulations at 30 CFR 845.16(a).

Section 86.195(c) Penalties Against Corporate Officers

PADEP is adding new subsection (c) which allows a corporate officer to postpone payment of an individual civil penalty where the officer or permittee has agreed in writing on a plan for abatement of or compliance with a failure to abate order. The Director finds that the changes described above are substantively identical to and therefore consistent with the Federal Regulations at 30 CFR 846.18(c).

Section 86.201 Procedures for Assessment of Civil Penalties

PADEP is adding new subsection (a) to allow operators to submit information to the Department and the inspector concerning violations within 15 days of service of a notice of violation or order. Existing subsections (a) through (d) are re-lettered (b) through (e), respectively. PADEP is adding new subsection (f) to bar the use of evidence obtained in an assessment conference in formal review proceedings. Existing subsection (f) is re-lettered as (g). The Director finds that the changes described above are substantively identical to and therefore consistent with the Federal Regulations at 30 CFR 845.17(a) and 845.18(f).

Section 86.202 Final Action

PADEP is changing the title of this section from ''Appeal Procedures'' to ''Final Action.'' The change is non-substantive in nature and does not render this provision inconsistent with its Federal counterpart at 30 CFR 845.19.

IV. Summary and Disposition of Comments

Federal Agency Comments

On November 3, 1999, we asked for comments from various Federal agencies who may have an interest in the Pennsylvania amendment (Administrative Record Number 845.03). We solicited comments in accordance with section 503(b) of SMCRA and 30 CFR 732.17(h)(11)(i) of the Federal regulations. The Federal Mine Safety and Health Administration responded that it did not have any comments in letters dated November 19, 1999 (Administrative Records Numbers PA–845.04 and PA–845.05.)

Environmental Protection Agency (EPA)

Pursuant to 30 CFR 732.17(h)(11)(i) and (ii), OSM is required to solicit comments and obtain the written concurrence of the EPA with respect to those provisions of the proposed program amendment that relate to air or water quality standards promulgated under the authority of the Clean Water Act (33 U.S.C. 1251 *et seq.*) or the Clean Air Act (42 U.S.C. 7401 *et seq.*). The Director has determined that this amendment contains no such provisions and that EPA concurrence is therefore unnecessary. However, by letter dated November 3, 1999, we requested comments from EPA on the State's proposed amendment of November 2, 1999 (Administrative Record Number 845.02), and EPA responded in its letter dated November 29, 1999 (Administrative Record Number PA–

845.07) that it did not have any comments.

Public Comments

No comments were received in response to our request for public comments.

V. Director's Decision

Based on the above findings, we are approving the amendments to the Pennsylvania program. The Federal regulations at 30 CFR Part 938, codifying decisions concerning the Pennsylvania program, are being amended to implement this decision. This final rule is being made effective immediately (November 3, 2000) to expedite the State program amendment process and to encourage States to bring their programs into conformity with the Federal standards without undue delay. Consistency of State and Federal standards is required by SMCRA.

Section 503 of SMCRA provides that a State may not exercise jurisdiction under SMCRA unless the State program is approved by the Secretary. Similarly, 30 CFR 732.17(a) requires that any alteration of an approved State program be submitted to OSM for review as a program amendment. Thus, any changes to the State program are not enforceable until approved by OSM. The Federal regulations at 30 CFR 732.17(g) prohibit any unilateral changes to approved State programs. In the oversight of the Pennsylvania program, we will recognize only the statutes, regulations, and other materials approved by OSM, together with any consistent implementing policies, directives, and other materials. We will require that Pennsylvania enforce only such provisions.

VI. Procedural Determinations

Executive Order 12866—Regulatory Planning and Review

This rule is exempted from review by the Office of Management and Budget under Executive Order 12866.

Executive Order 12630—Takings

This rule does not have takings implications. This determination is based on the analysis performed for the counterpart federal regulation.

Executive Order 13132—Federalism

This rule does not have federalism implications. SMCRA delineates the roles of the federal and State governments with regard to the regulation of surface coal mining and reclamation operations. One of the purposes of SMCRA is to ''establish a nationwide program to protect society and the environment from the adverse effects of surface coal mining operations.'' Section 503(a)(1) of SMCRA requires that State laws regulating surface coal mining and reclamation operations be ''in accordance with'' the requirements of SMCRA, and section 503(a)(7) requires that State programs contain rules and regulations ''consistent with'' regulations issued by the Secretary pursuant to SMCRA.

Executive Order 12988—Civil Justice Reform

The Department of the Interior has conducted the reviews required by section 3 of Executive Order 12988 and has determined that, to the extent allowed by law, this rule meets the applicable standards of subsections (a) and (b) of that section. However, these standards are not applicable to the actual language of State regulatory programs and program amendments since each such program is drafted and promulgated by a specific State, not by OSM. Under sections 503 and 505 of SMCRA (30 U.S.C. 1253 and 1255) and 30 CFR 730.11, 732.15, and 732.17(h)(10), decisions on proposed State regulatory programs and program amendments submitted by the States must be based solely on a determination of whether the submittal is consistent with SMCRA and its implementing federal regulations and whether the other requirements of 30 CFR parts 730, 731, and 732 have been met.

National Environmental Policy Act

Section 702(d) of SMCRA (30 U.S.C. 1292(d)) provides that a decision on a proposed State regulatory program provision does not constitute a major federal action within the meaning of section 102(2)(C) of the National Environmental Policy Act (NEPA) (42 U.S.C. 4332(2)(C)). A determination has been made that such decisions are categorically excluded from the NEPA process (516 DM 8.4.A).

Paperwork Reduction Act

This rule does not contain information collection requirements that require approval by the Office of Management and Budget under the Paperwork Reduction Act (44 U.S.C. 3507 *et seq.*).

Regulatory Flexibility Act

The Department of the Interior has determined that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). The State submittal which is the subject of this rule is based upon counterpart federal regulations for which an economic analysis was prepared and certification made that such regulations would not have a significant economic effect upon a substantial number of small entities.

Accordingly, this rule will ensure that existing requirements previously promulgated by OSM will be implemented by the State. In making the determination as to whether this rule would have a significant economic impact, the Department relied upon the data and assumptions for the counterpart federal regulation.

Small Business Regulatory Enforcement Fairness Act

This rule is not a major rule under 5 U.S.C. 804(2), the Small Business Regulatory Enforcement Fairness Act. This rule:

a. Does not have an annual effect on the economy of $100 million.

b. Will not cause a major increase in costs or prices for consumers, individual industries, federal, State, or local government agencies, or geographic regions.

c. Does not have significant adverse effects on competition, employment, investment, productivity, innovation, or the ability of U.S. based enterprises to compete with foreign-based enterprises.

This determination is based upon the fact that the State submittal which is the subject of this rule is based upon counterpart federal regulations for which an analysis was prepared and a determination made that the federal regulation was not considered a major rule.

Unfunded Mandates

This rule will not impose a cost of $100 million or more in any given year on any governmental entity or the private sector.

List of Subjects in 30 CFR Part 938

Intergovernmental relations, Surface mining, Underground mining.

Dated: October 11, 2000.

Allen D. Klein,

Regional Director, Appalachian Regional Coordinating Center.

For the reasons set out in the preamble, Title 30, Chapter VII, Subchapter T of the Code of Federal Regulations is amended as set forth below:

PART 938—PENNSYLVANIA

1. The authority citation for part 938 continues to read as follows:

Authority: 30 U.S.C. 1201 *et seq.*

2. Section 938.15 is amended in the table by adding a new entry in

chronological order by ''Date of Final Publication'' to read as follows:

§ 938.15 Approval of Pennsylvania regulatory program amendments.

* * * * *

Original amendment submission date	Date of final publication	Citation/description
*	*	*
November 2, 1999	November 3, 2000	25 Pa. Code 86.1, 86.124, 86.152, 86.156, 86.160, 86.171, 86.182, 86.193, 86.194, 86.195, 86.201, and 86.202.

[FR Doc. 00–28268 Filed 11–2–00; 8:45 am]
BILLING CODE 4310–05–P

DEPARTMENT OF THE TREASURY

Fiscal Service

31 CFR Parts 306 and 356

[Department of the Treasury Circular, Public Debt Series No. 1–93]

Marketable Book-Entry Treasury Bills, Notes, and Bonds; Minimum Par Amounts Required for STRIPS

AGENCY: Bureau of Public Debt, Fiscal Service, Department of Treasury.

ACTION: Final rule.

SUMMARY: The Department of the Treasury (''Treasury,'' ''We,'' or ''Us'' is issuing in final form amendments to 31 CFR part 306 (General Regulations Governing U.S. Securities) and 31 CFR part 356 (Uniform Offering Circular for the Sale and Issue of Marketable Book-Entry Treasury Bills, Notes, and Bonds). The purpose of these amendments is to simplify and enhance market participants' ability to strip Treasury fixed-principal securities. ''Stripping'' a security means to separate it into its principal and interest components. The amendment modifies the minimum and multiple amounts that are required to strip Treasury fixed-principal securities by setting them each at $1,000. It also eliminates the multiple requirement for the interest components that result from stripping, in effect making Treasury fixed-principal securities strippable ''to the penny.'' Further, the amendment eliminates Exhibit C of this part, ''Minimum Par Amounts for Fixed-Principal STRIPS,'' since this table will no longer be necessary. Finally, the amendment provides us the flexibility to designate a Treasury note or bond as strippable even if the note or bond was not originally designated as strippable by its offering announcement. This flexibility will allow us to make eligible for stripping outstanding five-year Treasury notes issued prior to September 30, 1997.

EFFECTIVE DATE: March 1, 2001, except for the amendment of § 356.31(a), which is effective November 3, 2000.

ADDRESSES: You may download this final rule from the Bureau of the Public Debt's Internet site at the following address: www.publicdebt.treas.gov. It is also available for public inspection and copying at the Treasury Department Library, Room 1428, Main Treasury Building, 1500 Pennsylvania Avenue, NW., Washington, DC, 20220. To visit the library, call (202) 622–0990 for an appointment.

FOR FURTHER INFORMATION CONTACT: Lori Santamorena (Executive Director) or Chuck Andreatta (Senior Financial Advisory), Bureau of the Public Debt, Government Securities Regulations Staff, (202) 691–3632, or e-mail us at govsecreg@bpd.treas.gov.

SUPPLEMENTARY INFORMATION: 31 CFR part 356, also referred to as the uniform offering circular, sets out the terms and conditions for the sale and issuance to the public of marketable Treasury bills, notes, and bonds.[1] The uniform offering circular, in conjunction with offering announcements, represents a comprehensive statement of these terms and conditions.[2] This final rule modifies § 356.31, which pertains to STRIPS (Separate Trading of Registered Interest and Principal of Securities). It also eliminates Exhibit C (''Minimum Par Amounts for Fixed-Principal STRIPS''). In addition, this rule amends 31 CFR 306.128, which pertains to Treasury's discretion to supplement, amend, or revise regulations governing U.S. securities.

Stripping Treasury Securities ''To the Penny''

The STRIPS program, which began in January 1985, allows holders of book-entry (electronic) Treasury notes and bonds to separate those securities into their separate principal and interest components. These components can then be held and traded separately as zero-coupon securities. The interest components (''TINTs''), but not the principal components, are fungible (interchangeable). This means that TINTs with the same maturity date have the same identifying CUSIP number regardless of the underlying security from which they were stripped. Securities with the same CUSIP number are considered to be the same security.

Since its implementation, the STRIPS program has required that the par amount of a fully constituted Treasury fixed-principal[3] security to be stripped must be an amount that, based on the stated interest rate of the security, will produce a TINT of $1,000 or a multiples of $1,000. Any amount greater than this par amount must be in a multiple of that amount. Once a book-entry security has been separated, each interest and principal component can then be maintained and transferred in multiples of $1,000. This $1,0000 minimum and multiple requirement conforms with the minimum and multiple requirement of fully constituted Treasury notes and bonds.

The $1,000 multiple requirement for the TINTs, however, results in a wide disparity in the par amounts of fully constituted (unstripped) securities with different interest rates that are needed to produce TINTs in multiples of $1,000. For example, a note or bond with an interest rate of 6⅛ percent requires a minimum of $1,600,000 of the fully constituted security for stripping in order for the resulting TINTs to be in a multiple of $1,000. In this example, the resulting TINTs have payment amounts of $49,000. By contrast, a note or bond with an interest rate of 6¼ percent requires only a minimum par amount of $32,000 to be stripped, with resulting TINTs of $1,000, which is the minimum amounts for TINTs.

When we implemented a process to make TINTs from inflation-indexed securities fungible on March 31, 1999,[4]

[1] Includes both fixed-principal and inflation-indexed Treasury securities.

[2] The uniform offering circular was published as a final rule on January 5, 1993 (58 FR 412). The circular, as amended, is codified at 31 CFR part 356.

[3] We use the term ''fixed-principal'' to distinguish such securities from Treasury ''inflated-indexed'' securities, whose principal amounts are adjusted periodically for inflation.

[4] 63 FR 35782 (June 30, 1998).

it was necessary for us to convert the payment values of the TINTs to ''adjust values,'' which could be maintained and transferred ''to the penny.'' At that time, we stated that we would ''consider at a later date the desirability of making changes to the minimum and multiple requirements for fixed-principal TINTs, * * * and permitting fixed-principal TINTs to be held in amounts to the penny.'' [5]

On November 1, 2000, we announced that, effective March 1, 2001, we will be changing the minimum and multiple requirements for stripping Treasury fixed-principal securities. We have decided to make these changes because elimination of the $1,000 minimum and multiple requirements will make stripping easier. Market participants will no longer be required to deliver fully constituted securities in widely different amounts depending on the interest rate of the underlying security. By simplifying the requirements for STRIPS, our goal is to enhance the liquidity and efficiency of the STRIPS market.

Increasing the Number of Strippable Securities

Enhancing the liquidity of the STRIPS market is also our objective in modifying the STRIPS rules to permit us to designate a note or bond as strippable even if the note or bond was not originally designated as strippable by its offering announcement. When the STRIPS program was first implemented in 1985, only Treasury notes and bonds with maturities of 10 years or longer were eligible for stripping. At that time there was little market interest in stripping securities with maturities less than 10 years.

By 1997, however, interest in stripping shorter-term Treasury notes had developed. Consequently, on September 17, 1997, we announced that all Treasury notes issued on or after September 30, 1997, were eligible for STRIPS.

Because Treasury securities currently can be made eligible for STRIPS only by being designated as such in their offering announcements, we have not been able to make eligible for stripping outstanding shorter-term (five-year) notes that were issued prior to September 30, 1997. This amendment to the uniform offering circular will allow us to do so. As a result, we plan to announce that we are making eligible for stripping five-year notes issued prior to September 30, 1997, thereby allowing for an increase in the supply of TINTs that mature in the next two years.

[5] 63 FR 35783 (June 30, 1998).

Amendments, Revisions, and Deletions

Accordingly, we are amending the uniform offering circular's general paragraph on STRIPS, 356.31(a), so that we may designate Treasury notes and bonds as being eligible for stripping at a later date if they were not designated as being eligible in their offering announcement. We are also amending paragraph 356.31(b)(1), which provides the minimum par amount and multiple requirements for stripping Treasury fixed-principal securities, so that they may be stripped to the penny. We are also amending 31 CFR 306.128 in order to allow outstanding Treasury notes and bonds that we issued prior to the effective date of the uniform offering circular, March 1, 1993, to also be stripped to the penny. As a result of these amendments, we are removing Exhibit C to the uniform offering circular because this table is no longer necessary.

We are issuing this amendment in final form rather than proposed form in order to more quickly simplify and expand the STRIPS market. In addition, there is no negative impact on the holders of the issues of the securities affected. This change provides an additional feature that should enhance the marketability of these issues.

Procedural Requirements

This final rule is not a ''significant regulatory action'' under Executive Order 12866. The notice and public procedures and delayed effective date requirements of the Administrative Procedure Act also do not apply, under 5 U.S.C. 553(a)(2).

Since no notice of proposed rulemaking is required, the provisions of the Regulatory Flexibility Act (5 U.S.C. 601, *et seq.*) do not apply.

List of Subjects

Bonds, Federal Reserve System, Government securities, Securities.

For the reasons stated in the preamble, we amend 31 CFR Chapter II, Subchapter B, as follows:

PART 306—GENERAL REGULATIONS GOVERNING U.S. SECURITIES

1. The authority citation for part 306 continues to read as follows:

Authority: 31 U.S.C. Chapter 31; 5 U.S.C. 301; 12 U.S.C. 391.

2. Revise § 306.128 to read as follows:

§ 306.128 Supplements, amendments or revisions.

The Secretary of the Treasury may at any time, or from time to time, prescribe additional supplemental, amendatory or revised regulations with respect to U.S. securities. The Secretary also may lower the minimum and multiple requirements for stripping marketable Treasury notes and bonds issued prior to March 1, 1993, through an announcement as provided in § 356.31 of this title.

PART 356—SALE AND ISSUE OF MARKETABLE BOOK-ENTRY TREASURY BILLS, NOTES, AND BONDS (DEPARTMENT OF THE TREASURY CIRCULAR, PUBLIC DEBT SERIES NO. 1–93)

3. The authority citation for part 356 continues to read as follows:

Authority: 5 U.S.C. 301; 31 U.S.C. 3102, *et seq.*; 12 U.S.C. 391.

4. Amend § 356.31 as set forth below:

a. Revise the first sentence in paragraph (a), and

b. Revise paragraph (b)(1) to read as follows:

§ 356.31 STRIPS.

(a) *General.* A note or bond may be designated in the offering announcement, or later by announcement by Treasury, as eligible for the STRIPS program. * * *

(b) *Treasury fixed-principal securities—(1) Minimum par amounts required for STRIPS.* The minimum par amount of a fixed-principal security that may be stripped into the components described in paragraph (a) of this section is $1,000. Any par amount to be stripped above $1,000 must be in a multiple of $1,000.

* * * * *

Exhibit C to Part 356 [Removed]

5. Remove Exhibit C to Part 356.

Dated: October 31, 2000.

Donald V. Hammond,

Fiscal Assistant Secretary.

[FR Doc. 00–28280 Filed 11–1–00; 8:45 am]

BILLING CODE 4810–39–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[CA 241–0244a; FRL–6893–1]

Revisions to the California State Implementation Plan, Antelope Valley Air Pollution Control District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Direct final rule.

SUMMARY: EPA is taking direct final action to approve revisions to the Antelope Valley Air Pollution Control

District portion of the California State Implementation Plan (SIP). These revisions concern the recission of rules and associated negative declarations for one volatile organic compound (VOC) source category and one oxides of nitrogen (NO_X) source category for the Antelope Valley Air Pollution Control District (AVAPCD). We are approving these local rule recissions and negative declarations under the Clean Air Act as amended in 1990 (CAA or the Act).

DATES: This rule is effective on January 2, 2001, without further notice, unless EPA receives adverse comments by December 4, 2000. If we receive such comment, we will publish a timely withdrawal in the **Federal Register** to notify the public that this rule will not take effect.

ADDRESSES: Mail comments to Andy Steckel, Rulemaking Office Chief (AIR–4), U.S. Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

You can inspect copies of the submitted SIP revisions and EPA's technical support documents (TSDs) at our Region IX office during normal business hours. You may also see copies of the submitted SIP revisions at the following locations:

Environmental Protection Agency, Air Docket (6102), Ariel Rios Building, 1200 Pennsylvania Avenue, NW., Washington DC 20460.
California Air Resources Board, Stationary Source Division, Rule Evaluation Section, 2020 ''L'' Street, Sacramento, CA 95812.
Antelope Valley Air Pollution Control District, 43301 Division Street, Suite 206, Lancaster, CA 93539–4409

FOR FURTHER INFORMATION CONTACT: Julie A. Rose, Rulemaking Office (AIR–4), U.S. Environmental Protection Agency, Region IX, (415) 744–1184.

SUPPLEMENTARY INFORMATION: Throughout this document, ''we,'' ''us'' and ''our'' refer to EPA.

Table of Contents

I. The State's Submittal

A. What Rules Did the State Submit?

Table 1 lists the rule recissions and negative declarations we are approving with the dates that they were adopted by the local air agency and submitted by the California Air Resources Board (CARB).

TABLE 1.—SUBMITTED RULE RECISSIONS AND NEGATIVE DECLARATIONS

Local agency	Rule No.	Rule title	Adopted	Submitted
AVAPCD	1103 & Negative Declaration	Pharmaceuticals and Cosmetic Manufacturing Operations.	01–18–00	03–28–00
AVAPCD	1159 & Negative Declaration	Nitric Acid Units—Oxides of Nitrogen	01–18–00	03–28–00

On May 19, 2000, these rule submittals were found to meet the completeness criteria in 40 CFR part 51, appendix V, which must be met before formal EPA review.

B. Are There Other Versions of These Rules?

The current versions of Rules 1103 and 1159 were approved in the SIP for the South Coast Air Quality Management District (SCAQMD) on July 2, 1982 and July 12, 1990, respectively. At that time, these rules applied in all of SCAQMD, including the Antelope Valley region of Los Angeles County. [1] The AVAPCD was created pursuant to California Health and Safety Code (CHSC) section 40106 and assumed all air pollution control responsibilities of the SCAQMD in the Antelope Valley region effective July 1, 1997, including responsibility for implementing Rules 1103 and 1159.

C. What Is the Purpose of the Submitted Rules?

Rule 1103 establishes limits for VOC emissions produced by Pharmaceuticals and Cosmetics Manufacturing Operations. Rule 1159 establishes limits for oxides of nitrogen (NO_X) emissions produced by Nitric Acid Plants. The recissions and associated negative declarations were submitted because there are no applicable manufacturing or nitric acid facilities within AVAPCD jurisdiction.

II. EPA's Evaluation and Action

A. How Is EPA Evaluating the Rule Recissions?

These SIP revisions must be consistent with Clean Air Act applicable manufacturing or nitric acid facilites within AVAPCD jurisdiction.

II. EPA's Evaluation and Action

A. How Is EPA Evaluating the Rule Recissions?

These SIP revisions must be consistent with Clean Air Act requirements for RACT (see sections 182(a)(A) and 182(F)) and SIP relaxations (see sections 110(l) and 193.) To do so, the submittal should provide reasonable assurance that no sources subject to Rules 1103 or 1159 currently exist or are planned for the AVAPCD.

B. Do the Rules Meet the Evaluation Criteria?

We believe these rule recissions and associated negative declarations are consistent with the relevant policy and guidance regarding RACT and SIP relaxations. The TSD has more information on our evaluation.

C. Public Comment and Final Action

As authorized in section 110(k)(3) of the Act, EPA is fully approving the submitted rule recissions because we believe they fulfill all relevant requirements. We do not think anyone will object to this, so we are finalizing the approval without proposing it in advance. However, in the Proposed Rules section of this **Federal Register**, we are simultaneously proposing approval of the same submitted rule recissions. If we receive timely adverse comments, the direct final approval will be effective without further notice on January 2, 2001. This will incorporate these rule recissions into the federally enforceable SIP.

III. Background Information

Why Were These Rules Submitted Initially?

VOCs and NO_X help produce ground-level ozone and smog, which harm

[1] The Antelope Valley region of Los Angeles County is contained within the Federal area known as the southeast Desert Modified Air Quality Management Area and the region identified by the State of California as the Mojave Desert Air Basin.

human health and the environment. Section 110(a) of the CAA requires states to submit regulations that control VOC and NO_X emissions. Table 2 lists some of the national milestones leading to the submittal of these local agency VOC and NO_X rules.

TABLE 2.—OZONE NONATTAINMENT MILESTONES

Date	Event
March 3, 1978	EPA promulgated a list of ozone nonattainment areas under the Clean Air Act as amended in 1977. 43 FR 8964; 40 CFR 81.305.
May 26, 1988	EPA notified Governors that parts of their SIPs were inadequate to attain and maintain the ozone standard and requested that they correct the deficiencies (EPA's SIP-Call). See section 110(a)(2)(H) of the pre-amended Act.
November 15, 1990.	Clean Air Act Amendments of 1990 were enacted. Public Law 101–549, 104 Stat. 2399, codified at 42 U.S.C. 7401–7671q.
May 15, 1991	Section 182(a)(2)(A) requires that ozone nonattainment areas correct deficient RACT rules by this date.

IV. Administrative Requirements

Under Executive Order 12866 (58 FR 51735, October 4, 1993), this action is not a ''significant regulatory action'' and therefore is not subject to review by the Office of Management and Budget. This action merely approves state law as meeting federal requirements and imposes no additional requirements beyond those imposed by state law. Accordingly, the Administrator certifies that this rule will not have a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*). Because this rule approves pre-existing requirements under state law and does not impose any additional enforceable duty beyond that required by state law, it does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Public Law 104–4). For the same reason, this rule also does not significantly or uniquely affect the communities of tribal governments, as specified by Executive Order 13084 (63 FR 27655, May 10, 1998). This rule 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, as specified in Executive Order 13132 (64 FR 43255, August 10, 1999), because it merely approves a state rule implementing a federal standard, and does not alter the relationship or the distribution of power and responsibilities established in the Clean Air Act. This rule also is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997), because it is not economically significant.

In reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the Clean Air Act. In this context, in the absence of a prior existing requirement for the State to use voluntary consensus standards (VCS), EPA has no authority to disapprove a SIP submission for failure to use VCS. It would thus be inconsistent with applicable law for EPA, when it reviews a SIP submission, to use VCS in place of a SIP submission that otherwise satisfies the provisions of the Clean Air Act. Thus, the requirements of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) do not apply. As required by section 3 of Executive Order 12988 (61 FR 4729, February 7, 1996), in issuing this rule, EPA has taken the necessary steps to eliminate drafting errors and ambiguity, minimize potential litigation, and provide a clear legal standard for affected conduct. EPA has complied with Executive Order 12630 (53 FR 8859, March 15, 1988) by examining the takings implications of the rule in accordance with the ''Attorney General's Supplemental Guidelines for the Evaluation of Risk and Avoidance of Unanticipated Takings'' issued under the executive order. This rule does not impose an information collection burden under the provisions of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*).

The Congressional Review Act, 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. EPA will submit a report containing this rule and other required information to the U.S. Senate, the U.S. House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. A major rule cannot take effect until 60 days after it is published in the **Federal Register**. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

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 January 2, 2001. 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).).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Hydrocarbons, Intergovernmental relations, Oxides of nitrogen, Ozone, Reporting and recordkeeping requirements, Volatile organic compounds.

Dated: October 4, 2000.

Felicia Marcus,

Regional Administrator, Region IX.

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

PART 52—[AMENDED]

1. The authority citation for Part 52 continues to read as follows:

Authority: 42 U.S.C. 7401 *et seq.*

Subpart F—California

2. Section 52.220 is amended by adding paragraphs (c)(69)(v) and (c)(168)(i)(H)(*3*) to read as follows:

§ 52.220 Identification of plan.

* * * * *

(c) * * *

(69) * * *

(v) Previously approved on July 8, 1982 in paragraph (c)(69)(iii) of this section and now deleted without replacement for implementation in the Antelope Valley Air Pollution Control District Rule 1103.

* * * * *

(168) * * *

(i) * * *

(H) * * *

(*3*) Previously approved on July 12, 1990 in paragraph (i)(H)(*1*) of this section and now deleted without replacement for implementation in the Antelope Valley Air Pollution Control District Rule 1159.

* * * * *

3. Section 52.222 is amended by adding paragraphs (a)(6)(iv) and (b)(4)(iii) to read as follows:

§ 52.222 Negative declarations.

(a) * * *

(6) * * *

(iv) Pharmaceuticals and Cosmetic Manufacturing Operations submitted on March 28, 2000 and adopted on January 18, 2000.

* * * * *

(b) * * *

(4) * * *

(iii) Nitric Acid Units submitted on March 28, 2000 and adopted on January 18, 2000.

* * * * *

[FR Doc. 00–27659 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–U

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 180

[OPP–301043; FRL–6740–9]

RIN 2070–AB78

Sodium *o*-nitophenolate, sodium *p*-nitrophenolate, sodium 5-nitroguaiacolate, and the End–Use Product Atonik® Exemption From the Requirement of a Tolerance and Temporary Exemption From the Requirement of a Tolerance

AGENCY: Environmental Protection Agency (EPA).

ACTION: Final rule.

SUMMARY: This regulation establishes an exemption from the requirement of a tolerance for residues of the active ingredients (a.i.) sodium *o*-nitophenolate, sodium *p*-nitrophenolate, sodium 5-nitroguaiacolate, on all food commodities when used as Plant Growth Regulators on growing crops. These three a.i. comprise the end–use product ATONIK®, ASAHI Manufacturing Company, Ltd., c/o Chemical Consultants International, Inc., West 98th Terrace, Suite 100, Overland Park, KS, 66212, submitted a petition to EPA under the Federal Food, Drug, and Cosmetic Act (FFDCA), as amended by the Food Quality Protection Act (FQPA) of 1996, requesting an exemption from the requirement of a tolerance. This regulation eliminates the need to establish a maximum permissible level for residues of sodium *o*-nitophenolate, sodium *p*-nitrophenolate, and sodium 5-nitroguaiacolate and reassess the three existing tolerances for those three a.i..

DATES: This regulation is effective November 3, 2000. Objections and requests for hearings, identified by docket control number OPP–301043, must be received by EPA on or before January 2, 2001.

ADDRESSES: Written objections and hearing requests may be submitted by mail, in person, or by courier. Please follow the detailed instructions for each method as provided in Unit VIII. of the **SUPPLEMENTARY INFORMATION.** To ensure proper receipt by EPA, your objections and hearing requests must identify docket control number OPP–301043 in the subject line on the first page of your response.

FOR FURTHER INFORMATION CONTACT: By mail: Richard King, c/o Product Manager (PM) 90, Biopesticides and Pollution Prevention Division (7511C), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: (703) 308–8052; e-mail address: king.richard@epa.gov.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

You may be affected by this action if you are an agricultural producer, food manufacturer, or pesticide manufacturer. Potentially affected categories and entities may include, but are not limited to:

Categories	NAICS codes	Examples of potentially affected entities
Industry	111 112 311 32532	Crop production Animal production Food manufacturing Pesticide manufacturing

This listing is not intended to be exhaustive, but rather provides a guide for readers regarding entities likely to be affected by this action. Other types of entities not listed in the table could also be affected. The North American Industrial Classification System (NAICS) codes have been provided to assist you and others in determining whether or not this action might apply to certain entities. If you have questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT.**

B. How Can I Get Additional Information, Including Copies of this Document and Other Related Documents?

1. *Electronically.* You may obtain electronic copies of this document, and certain other related documents that might be available electronically, from the EPA Internet Home Page at http://www.epa.gov/. To access this document, on the Home Page select ''Laws and Regulations,'' ''Regulations and Proposed Rules,'' and then look up the entry for this document under the ''**Federal Register**—Environmental Documents.'' You can also go directly to the **Federal Register** listings at http://www.epa.gov/fedrgstr/.

2. *In person.* The Agency has established an official record for this action under docket control number OPP–301043. The official record consists of the documents specifically referenced in this action, and other information related to this action, including any information claimed as Confidential Business Information (CBI). This official record includes the documents that are physically located in the docket, as well as the documents that are referenced in those documents. The public version of the official record does not include any information claimed as CBI. The public version of the official record, which includes printed, paper versions of any electronic comments submitted during an applicable comment period is available for inspection in the Public Information and Records Integrity Branch (PIRIB), Rm. 119, Crystal Mall #2, 1921 Jefferson Davis Hwy., Arlington, VA, from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The PIRIB telephone number is (703) 305–5805.

II. Background and Statutory Findings

In the **Federal Register** of July 8, 1998 (63 FR 36901) (FRL–5791–6), EPA issued a notice pursuant to section 408 of the FFDCA, 21 U.S.C. 346a(e), as amended by the FQPA (Public Law 104–170) announcing the filing of a pesticide tolerance petition by ASAHI Manufacturing Company, Ltd., c/o Chemical Consultants International, Inc., West 98th Terrace, Suite 100, Overland Park, KS, 66212. This notice included a summary of the petition prepared by the petitioner ASAHI Manufacturing Company, Ltd. There were no comments received in response to the notice of filing.

New section 408(c)(2)(A)(i) of the FFDCA allows EPA to establish an exemption from the requirement for a tolerance (the legal limit for a pesticide chemical residue in or on a food) only if EPA determines that the exemption is ''safe.'' Section 408(c)(2)(A)(ii) defines ''safe '' to mean that ''there is a reasonable certainty that no harm will result from aggregate exposure to the pesticide chemical residue, including all anticipated dietary exposures and all other exposures for which there is reliable information.'' This includes exposure through drinking water and in

residential settings, but does not include occupational exposure. Section 408(b)(2)(C) requires EPA to give special consideration to exposure of infants and children to the pesticide chemical residue in establishing a tolerance and to ''ensure that there is a reasonable certainty that no harm will result to infants and children from aggregate exposure to the pesticide chemical residue....'' Additionally, section 408(b)(2)(D) requires that the Agency consider ''available information concerning the cumulative effects of a particular pesticide's residues'' and ''other substances that have a common mechanism of toxicity.''

EPA performs a number of analyses to determine the risks from aggregate exposure to pesticide residues. First, EPA determines the toxicity of pesticides. Second, EPA examines exposure to the pesticide through food, drinking water, and through other exposures that occur as a result of pesticide use in residential settings.

III. Toxicological Profile

Consistent with section 408(b)(2)(D) of the FFDCA, EPA has reviewed the available scientific data and other relevant information in support of this action and considered its validity, completeness and reliability and the relationship of this information to human risk. EPA has also considered available information concerning the variability of the sensitivities of major identifiable subgroups of consumers, including infants and children.

The Biopesticide and Pollution Prevention Division (BPPD) has reviewed submitted data to assess the potential hazards and exposures that might result from the proposed use of ATONIK® in or on all food commodities. The plant growth regulator will be formulated into an End–Use product containing a mixture of 0.6% a.i. sodium 5-nitroguaiacolate (1%), sodium *o*-nitophenolate (0.2%), and sodium *p*-nitrophenolate (0.3%) by weight and applied to all crops at rates of less than 20 grams a.i. (g a.i.) per acre. Based on the review of submitted information, dose levels and toxicity end–points were evaluated for the use of exposure estimates to characterize potential risks.

The Tier I data was submitted on the end–use product, ATONIK®, each of the three a.i., sodium *o*-nitrophenolate, sodium *p*-nitrophenolate, sodium 5-nitoguaiacolate, and a manufacturing use product (a mixture of the components). No toxicity endpoints for dietary, occupational or non–occupational risk charaterizations were indicated because:

1. The no–observed–adverse–effect levels (N0AEL) from dietary administration of the a.i. are 5–6 times higher than that of the developmental toxicity study (1,589 and 1,723 milligrams/kilograms/day (mg/kg/day) for males and females compared with 300 mg/kg/day in pregant rats).

2. The acute toxicity of the end–use product is classified into Toxicity Category IV for the oral (LD_{50} > 5,000 mg/kg) and inhalation (LC_{50} > 5.8 mg/L) routes and Toxicity Category III for the dermal route (LD_{50} > 2,000 mg/kg).

3. No developmental effects were noted at dose up to 600 mg/kg/day highest dose tested (HDT).

4. Studies on the three components of the manufacturing use product (MUP) showed no mutagentic activity.

5. The low concentration of the a.i. in the end use product (0.6%).

6. There is a low application rate (< 20 g a.i. per acre).

IV. Aggregate Exposures

In examining aggregate exposure, section 408 of the FFDCA directs EPA to consider available information concerning exposures from the pesticide residue in food and all other non–occupational exposures, including drinking water from ground water or surface water and exposure through pesticide use in gardens, lawns, or buildings (residential and other indoor uses).

A. Dietary Exposure

No toxicity endpoints for dietary, occupational or non–occupational risk characterizations were indicated in subchronic toxicity, developmental toxicity or mutagenicity studies on ATONIK® or its three a.i.. The application rate is so low (< 20 g/acre) that negligible or nonexistent residues would be available for risk characterization. Therefore, considering the lack of toxicity and low exposure no risk characterizations have been conducted for ATONIK®.

1. *Food*. The end–use product, ATONIK®, contains three a.i. (sodium 5-nitroguaiacolate, sodium *o*-nitophenolate, and sodium *p*-nitrophenolate) in very low concentrations. At the application rates employed, the level of each a.i. which may be present in any of the food or feed items would be far below the levels which demonstrated any effects in the subchronic oral feeding study, the developmental toxicity study or the mutagenicity studies. It can be shown that in order to reach a dose rate comparable to the LOAEL of 1,600 mg/kg/day obtained in the subchronic oral feeding study, a person weighing 50 kg (100 lbs.) would have to consume all of the produce from 4 acres of crop every day.

Further, due to the rapid uptake and metabolism of the three a.i. in plants, it is unlikely that any of the residue would be available for potential exposure.

2. *Drinking water exposure*. Similarly, exposure to humans from consumption of water would be equally unlikely.

B. Other Non-Occupational Exposure

Using the previously mentioned criteria, the Agency believes that non–occupational exposures via other routes would be highly unlikely. There is no allowed use of the product containing the three a.i. on lawns, rights–of–way, golf courses, or other areas where human exposure is likely to occur. Therefore, for all practical purposes, exposure from these areas would be non–existent.

V. Cumulative Effects

Exposure through other pesticides and substances with the same mode of toxicity is not likely. What little toxicity that was observed is only detected at extremely high concentrations of these a.i..

VI. Determination of Safety for U.S. Population, Infants and Children

The three a.i. in the End–Use Product, ATONIK®, are all classified as biochemicals. The low toxicity of each of these alone and in combination, as discussed above, demonstrates that these chemicals, at the rates established, will not pose any known risk to human health, either as children or as adults. These three a.i. are already exempted from the requirement of a tolerance for use on cotton, rice, and soybeans.

VII. Other Considerations

A. Endocrine Disruptors

EPA is required under the FFDCA, as amended by FQPA, to develop a screening program to determine whether certain substances (including all pesticide active and other ingredients) ''may have an effect in humans that is similar to an effect produced by a naturally occurring estrogen, or other such endocrine effects as the Administrator may designate.'' Following the recommendations of its Endocrine Disruptor Screening and Testing Advisory Committee (EDSTAC), EPA determined that there was scientific basis for including, as part of the program, androgen and thyroid hormone systems, in addition to the estrogen hormone system. EPA also adopted EDSTAC's recommendation that the program include evaluations of potential effects in wildlife. For

pesticide chemicals, EPA will use FIFRA and, to the extent that effects in wildlife may help determine whether a substance may have an effect in humans, FFDCA authority to require the wildlife evaluations. As the science develops and resources allow, screening of additional hormone systems may be added to the Endocrine Disruptor Screening Program (EDSP).

When the appropriate screening and/or testing protocols being considered under the EDSP have been developed, sodium *o*-nitrophenolate, sodium *p*-nitrophenolate, and sodium 5-nitoguaiacolate, may be subjected to additional screening an/or testing to better characterize effects related to endocrine disruption. Based on the weight of the evidence of available data, no endocrine system–related effect have been identified.

B. Analytical Method(s)

Adequate data for the end–use product, ATONIK®, and each of the three components: sodium *o*-nitrophenolate, sodium *p*-nitrophenolate, and sodium 5-nitoguaiacolate, were submitted with the initial registration and petition for tolerances.

C. Tolerance Reassessment

The foregoing is a reassessment of the tolerances for § 180.1139 Sodium 5-nitoguaiacolate, and § 180.1140 Sodium o-nitrophenolate, and § 180.1141 Sodium p-nitrophenolate. This reassessment revises these tolerances to include all food commodities when used as plant growth regulators.

D. Codex Maximum Residue Level

No known international tolerances have been granted for this pesticide. Therefore, based on the completeness and reliability of the toxicity data from the published literature and conservative exposure assessment, the Agency concludes that there is a reasonable certainty that no harm will result from aggregate exposure to residues of ATONIK® including all anticipated dietary exposure and all non–occupational exposures.

VIII. Objections and Hearing Requests

Under section 408(g) of the FFDCA, as amended by the FQPA, any person may file an objection to any aspect of this regulation and may also request a hearing on those objections. The EPA procedural regulations which govern the submission of objections and requests for hearings appear in 40 CFR part 178. Although the procedures in those regulations require some modification to reflect the amendments made to the FFDCA by the FQPA of 1996, EPA will continue to use those procedures, with appropriate adjustments, until the necessary modifications can be made. The new section 408(g) provides essentially the same process for persons to ''object'' to a regulation for an exemption from the requirement of a tolerance issued by EPA under new section 408(d), as was provided in the old FFDCA sections 408 and 409. However, the period for filing objections is now 60 days, rather than 30 days.

A. What Do I Need to Do to File an Objection or Request a Hearing?

You must file your objection or request a hearing on this regulation in accordance with the instructions provided in this unit and in 40 CFR part 178. To ensure proper receipt by EPA, you must identify docket control number OPP–301043 in the subject line on the first page of your submission. All requests must be in writing, and must be mailed or delivered to the Hearing Clerk on or before January 2, 2001.

1. *Filing the request.* Your objection must specify the specific provisions in the regulation that you object to, and the grounds for the objections (40 CFR 178.25). If a hearing is requested, the objections must include a statement of the factual issues(s) on which a hearing is requested, the requestor's contentions on such issues, and a summary of any evidence relied upon by the objector (40 CFR 178.27). Information submitted in connection with an objection or hearing request may be claimed confidential by marking any part or all of that information as CBI. Information so marked will not be disclosed except in accordance with procedures set forth in 40 CFR part 2. A copy of the information that does not contain CBI must be submitted for inclusion in the public record. Information not marked confidential may be disclosed publicly by EPA without prior notice.

Mail your written request to: Office of the Hearing Clerk (1900), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460. You may also deliver your request to the Office of the Hearing Clerk in Rm. C400, Waterside Mall, 401 M St., SW., Washington, DC 20460. The Office of the Hearing Clerk is open from 8 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The telephone number for the Office of the Hearing Clerk is (202) 260–4865.

2. *Tolerance fee payment.* If you file an objection or request a hearing, you must also pay the fee prescribed by 40 CFR 180.33(i) or request a waiver of that fee pursuant to 40 CFR 180.33(m). You must mail the fee to: EPA Headquarters Accounting Operations Branch, Office of Pesticide Programs, P.O. Box 360277M, Pittsburgh, PA 15251. Please identify the fee submission by labeling it ''Tolerance Petition Fees.''

EPA is authorized to waive any fee requirement ''when in the judgement of the Administrator such a waiver or refund is equitable and not contrary to the purpose of this subsection.'' For additional information regarding the waiver of these fees, you may contact James Tompkins by phone at (703) 305–5697, by e-mail at tompkins.jim@epa.gov, or by mailing a request for information to Mr. Tompkins at Registration Division (7505C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460.

If you would like to request a waiver of the tolerance objection fees, you must mail your request for such a waiver to: James Hollins, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460.

3. *Copies for the docket.* In addition to filing an objection or hearing request with the Hearing Clerk as described in Unit VIII.A., you should also send a copy of your request to the PIRIB for its inclusion in the official record that is described in Unit I.B.2. Mail your copies, identified by docket control number OPP–301043, to: Public Information and Records Integrity Branch, Information Resources and Services Division (7502C), Office of Pesticide Programs, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460. In person or by courier, bring a copy to the location of the PIRIB described in Unit I.B.2. You may also send an electronic copy of your request via e-mail to: opp–docket@epa.gov. Please use an ASCII file format and avoid the use of special characters and any form of encryption. Copies of electronic objections and hearing requests will also be accepted on disks in WordPerfect 6.1/8.0 file format or ASCII file format. Do not include any CBI in your electronic copy. You may also submit an electronic copy of your request at many Federal Depository Libraries.

B. When Will the Agency Grant a Request for a Hearing?

A request for a hearing will be granted if the Administrator determines that the material submitted shows the following: There is a genuine and substantial issue of fact; there is a reasonable possibility that available evidence identified by the requestor would, if established resolve one or more of such issues in favor of

the requestor, taking into account uncontested claims or facts to the contrary; and resolution of the factual issues(s) in the manner sought by the requestor would be adequate to justify the action requested (40 CFR 178.32).

IX. Regulatory Assessment Requirements

This final rule establishes an exemption from the tolerance requirement under FFDCA section 408(d) in response to a petition submitted to the Agency. The Office of Management and Budget (OMB) has exempted these types of actions from review under Executive Order 12866, entitled *Regulatory Planning and Review* October 4, 1993 (58 FR 51735). This final rule does not contain any information collections subject to OMB approval under the Paperwork Reduction Act (PRA), 44 U.S.C. 3501 *et seq.*, or impose any enforceable duty or contain any unfunded mandate as described under Title II of the Unfunded Mandates Reform Act of 1995 (UMRA) (Public Law 104–4). Nor does it require any prior consultation as specified by Executive Order 13084, entitled *Consultation and Coordination with Indian Tribal Governments* May 19, 1998 (63 FR 27655); special considerations as required by Executive Order 12898, entitled *Federal Actions to Address Environmental Justice in Minority Populations and Low-Income Populations* February 16, 1994 (59 FR 7629); or require OMB review or any Agency action under Executive Order 13045, entitled *Protection of Children from Environmental Health Risks and Safety Risks* April 23, 1997 (62 FR 19885). This action does not involve any technical standards that would require Agency consideration of voluntary consensus standards pursuant to section 12(d) of the National Technology Transfer and Advancement Act of 1995 (NTTAA), Public Law 104–113, section 12(d)(15 U.S.C. 272 note). Since tolerances and exemptions that are established on the basis of a petition under FFDCA section 408(d), such as the exemption in this final rule, do not require the issuance of a proposed rule, the requirements of the Regulatory Flexibility Act (RFA) (5 U.S.C. 601 *et seq.*) do not apply. In addition, the Agency has determined that this action will not have a substantial direct effect on 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, as specified in Executive Order 13132, entitled *Federalism* August 10, 1999 (64 FR 43255). Executive Order 13132 requires EPA to develop an accountable process to ensure ''meaningful and timely input by State and local officials in the development of regulatory policies that have federalism implications.'' ''Policies that have federalism implications'' is defined in the Executive Order to include regulations that 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.'' This final rule directly regulates growers, food processors, food handlers and food retailers, not States. This action does not alter the relationships or distribution of power and responsibilities established by Congress in the preemption provisions of FFDCA section 408(n)(4).

X. Submission to Congress and the Comptroller General

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

List of Subjects in 40 CFR Part 180

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

Dated: October 6, 2000.

Janet L. Andersen,

Director, Biopesticides and Pollution Prevention Division.

Therefore, 40 CFR chapter I is amended as follows:

PART 180—[AMENDED]

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

Authority: 21 U.S.C. 321(q), 346(a) and 374.

2. In subpart D §180.1139, 180.1140, and 180.1141 are revised to read as follows:

§ 180.1139 Sodium 5-nitroguaiacolate; exemption from the requirements of a tolerance.

The biochemical sodium 5-nitroguiacolate is exempted from the requirement of a tolerance when used as a plant growth regulator in end–use products at a concentration of 0.1% by weight and applied at an application rate of 20 g of a.i. per acre or less per application, in or on all food commodities.

§ 180.1140 Sodium *o*-nitrophenolate; exemption from the requirement of a tolerance.

The biochemical sodium *o*-nitrophenolate is exempted from the requirement of a tolerance when used as a plant growth regulator in end–use products at a concentration of 0.2% by weight and applied at an application rate of 20 g of a.i. per acre or less per application, in or on all food commodities.

§ 180.1141 Sodium *p*-nitrophenolate; exemption from the requirement of a tolerance.

The biochemical sodium *p*-nitrophenolate is exempted from the requirement of a tolerance when used as a plant growth regulator in end–use product at a concentration of 0.3% by weight and applied at an application rate of 20 g of a.i. per acre or less per application, in or on all food commodities.

[FR Doc. 00–28277 Filed 11–2–00; 8:45 am]
BILLING CODE 6560–50–S

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 65

[Docket No. FEMA–D–7503]

Changes in Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency, FEMA.

ACTION: Interim rule.

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

DATES: These modified base flood elevations are currently in effect on the dates listed in the table and revise the Flood Insurance Rate Map(s) (FIRMs) in

effect prior to this determination for each listed community.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

List of Subjects in 44 CFR Part 65

Flood insurance, Floodplains, Reporting and recordkeeping requirements.

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

PART 65—[AMENDED]

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

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

§ 65.4 [Amended]

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

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Alabama:					
Talladega	City of Sylacauga	October 1, 1999, October 8, 1999, *Daily Home*.	The Honorable Jesse L. Cleveland, Mayor of the City of Sylacauga, P.O. Box 390, Sylacauga, Alabama 35150.	September 21, 1999.	010199 C
Florida:					
Broward	Unincorporated areas.	September 27, 2000, October 3, 2000, *Sun-Sentinel*.	Mr. Roger J. Desjarlais, Broward County Administrator, 115 South Andrews Avenue, Room 409, Fort Lauderdale, Florida 33301.	April 20, 2000	125093 F
Alachua	City of Gainesville	October 11, 1999, October 18, 1999, *The Gainesville Sun*.	Mr. Wayne Bowers, City of Gainesville Manager, P.O. Box 490, Gainesville, Florida 32602.	January 16, 2000	125107 D
Broward	City of Hollywood	September 27, 2000, October 3, 2000, *Sun-Sentinel*.	Mr. Samuel Finz, Manager of the City of Hollywood, P.O. Box 229045, Hollywood, Florida 33022–9045.	April 20, 2000	125113 F
Manatee	Unincorporated areas.	July 13, 2000, July 20, 2000, *Bradenton Herald*.	Mr. Ernie Padgett, Manatee County Administrator, P.O. Box 1000, Bradenton, Florida 34206.	July 5, 2000	120153 B
Illinois:					
Cook	Unincorporated areas.	August 3, 2000, August 10, 2000, *Daily Southtown*.	Mr. John H. Stroger, President of the Cook County, Board of Commissioners, 118 North Clark Street, Room 537, Chicago, Illinois 60602.	November 7, 2000	170054 F

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Kane	City of Geneva	August 8, 2000, August 15, 2000, *Kane County Chronicle*.	The Honorable Thomas Coughlin, Mayor of the City of Geneva, 22 South First Street, Geneva, Illinois 60134.	November 13, 2000.	170325 B
McHenry	Village of Huntley	July 13, 2000, July 20, 2000, *The Huntley Farmside*.	Mr. Charles Becker, President of the Village of Huntley, Village Hall, 11704 Coral Street, Huntley, Illinois 60142.	June 29, 2000	170480 C
McHenry	Unincorporated areas.	July 14, 2000, July 21, 2000, *The Northwest Herald*.	Mr. Michael Tryon, Chairperson, McHenry County Board, McHenry County Government Center, 2200 North Seminary Avenue, Woodstock, Illinois 60098.	June 29, 2000	170732 C
Cook	Village of Orland Park.	August 3, 2000, August 10, 2000, *Daily Southtown*.	The Honorable Daniel J. McLaughlin, Mayor of the Village of Orland Park, 14700 South Ravinier Avenue, Orland Park, Illinois 60462.	November 7, 2000	170140 F
Indiana:					
Madison	City of Anderson	June 28, 2000, July 5, 2000, *The Herald Bulletin*.	The Honorable J. Mark Lawler, Mayor of the City of Anderson, 120 East Eighth Street, Anderson, Indiana 46016.	October 4, 2000	180150 B
Allen	City of Fort Wayne	July 12, 2000, July 19, 2000, *The Journal Gazette*.	The Honorable Graham Richard, Mayor of the City of Fort Wayne, 1 Main Street, Room 900, Fort Wayne, Indiana 46802–1804.	July 3, 2000	180003 D
Massachusetts: Bristol.	Town of Easton	August 11, 2000, August 18, 2000, *The Enterprise*.	Mr. Kevin Paicos, Town of Easton Administrator, 136 Elm Street, Easton, Massachusetts 02356.	August 10, 2000	250053
Michigan:					
Macomb	Town of Chesterfield.	October 11, 1999, October 18, 1999, *Macomb Daily*.	Mr. Elbert James Tharp, Chesterfield Township Supervisor, 47275 Sugar Bush Road, Chesterfield, Michigan 48047.	October 5, 1999	260120 D
Macomb	City of Sterling Heights.	June 14, 2000, June 21, 2000, *The Macomb Daily*.	The Honorable Richard J. Notte, Mayor of the City of Sterling Heights, 40555 Utica Road, P.O. Box 8009, Sterling Heights, Michigan 48311.	September 5, 2000.	260128 F
New Hampshire:					
Cheshire	City of Keene	April 28, 2000, May 5, 2000, *The Keene Sentinel*.	The Honorable Michael Blastos, Mayor of the City of Keene, City Hall 3 Washington Street, Keene, New Hampshire 03431.	April 21, 2000	330023 D
North Carolina:					
Wake	Town of Cary	July 19, 2000, July 26, 2000, *The Cary News*.	The Honorable Glenn D. Lang, Mayor of the Town of Cary, 318 North Academy Street, P.O. Box 8005, Cary, North Carolina 27512.	October 24, 2000	370238 E
Dare	Unincorporated areas.	August 24, 2000, August 31, 2000, *The Coastline Times*.	Mr. Stan White, Chairman of the Dare County Board of Commissioners, P.O. Box 1000, Manteo, North Carolina 27954.	August 18, 2000	375348 D
Ohio:					
Greene	City of Beavercreek.	July 3, 2000, July 10, 2000, *Beavercreek News-Current*.	The Honorable Robert Glaser, Mayor of the City of Beavercreek, 1368 Research Park Drive, Beavercreek, Ohio 45432.	October 9, 2000	390876 B
Cuyahoga	City of Cleveland	June 22, 2000, June 29, 2000, *The Plain Dealer*.	The Honorable Michael R. White, Mayor of the City of Cleveland, Cleveland City Hall 601 Lakeside Avenue, Room 202, Cleveland, Ohio 44114.	September 28, 2000.	390104 B
Greene	City of Fairborn	July 3, 2000, July 10, 2000, *Fairborn Daily Herald*.	The Honorable Larry L. Long, Mayor of the City of Fairborn, 44 West Hebble Avenue, Fairborn, Ohio 45324.	October 9, 2000	390195 C
Cuyahoga	City of Highland Heights.	June 22, 2000, June 29, 2000, *The Plain Dealer*.	The Honorable Francine G. Hogg, Mayor of the City of Highland Heights, 5827 Highland Road, Highland Heights, Ohio 44143.	August 28, 2000	390110 D
Pennsylvania:					

State and county	Location	Dates and name of newspaper where notice was published	Chief executive officer of community	Effective date of modification	Community No.
Lancaster	City of Lancaster ..	July 25, 2000, August 1, 2000, *Intelligencer Journal*.	The Honorable Charles W. Smithgall, Mayor of the City of Lancaster, P.O. Box 1599, 120 North Duke Street, Lancaster, Pennsylvania 17603–1599.	July 5, 2000	420552 B
Lancaster	Township of Manheim.	July 25, 2000, August 1, 2000, *Intelligencer Journal*.	Mr. Thomas Woodland, President, Manheim Township Board of Commissioners, 1840 Municipal Drive, Lancaster, Pennsylvania 17601–4162.	July 5, 2000	420556 C
Montgomery ..	Township of Plymouth.	July 18, 2000, July 25, 2000, *Times Herald*.	Ms. Joan Mower, Township of Plymouth Manager, 700 Belvoir Road, Plymouth Meeting, Pennsylvania 19462.	July 7, 2000	420955 E
Rhode Island:					
Kent	City of Warwick	August 18, 2000, August 25, 2000, *The Kent County Daily Times*.	The Honorable Scott Avedisian, Mayor of the City of Warwick, 3275 Post Road, Warwick, Rhode Island 02886.	November 24, 2000.	445409
Virginia:					
Brunswick	Unincorporated areas.	September 13, 2000, September 20, 2000, *Lake Gaston Gazette*.	Mr. J. Grady Martin, Chairman of the Brunswick County Board of Supervisors, County Courthouse, P.O. Box 399, Lawrenceville, Virginia 23868.	September 6, 2000.	510236 B
Independent City.	City of Winchester	August 30, 2000, September 5, 2000, *Winchester Star*.	Mr. Edwin C. Daley, City of Winchester Manager, Rouss City Hall, 15 North Cameron Street, Winchester, Virginia 22601.	November 20, 2000.	510173 B
Independent City.	City of Winchester	July 5, 2000, July 12, 2000, *Winchester Star*.	Mr. Edwin C. Daley, City of Winchester Manager, Rouss City Hall, 15 North Cameron Street, Winchester, Virginia 22601.	June 23, 2000	510173 B
Wisconsin:					
Calumet	City of Brillion	June 8, 2000, June 15, 2000, *The Brillion News*.	The Honorable Robert Mathiebe, Mayor of the City of Brillion, 130 Calumet Street, City Hall, Brillion, Wisconsin 54110.	September 14, 2000.	550036 C
Calumet	Unincorporated areas.	June 8, 2000, June 15, 2000, *Chilton Times-Journal*.	Ms. Allison Blackmer, Calumet County Board of Commissioners, Courthouse, 206 Court Street, Chilton, Wisconsin 53014.	September 14, 2000.	550035 B

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

Dated: October 30, 2000.

Margaret E. Lawless,

Deputy Associate Director for Mitigation.

[FR Doc. 00–28257 Filed 11–2–00; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 0 and 19

[FCC 00–365]

Nonpublic Information

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: The Commission is amending its rules to establish a procedure to deal with the improper release of nonpublic information. The current rules prohibit the unauthorized release of nonpublic information by Commission officials. The revised rules add language requiring persons regulated by or practicing before the Commission who receive written nonpublic information to return it to the Commission's Office of the Inspector General without further distribution or use of the material. The amended rules also highlight the sanctions available to the Commission to address willful violation of the rules by either employees of the Commission or individuals who are regulated by or practicing before it.

DATES: Effective December 4, 2000.

FOR FURTHER INFORMATION CONTACT: Patrick J. Carney, Office of General Counsel, (202) 418–1720.

SUPPLEMENTARY INFORMATION:

1. Recent unauthorized disclosures of nonpublic internal Commission draft orders and documents in market-sensitive proceedings prompt us to adopt this order to amend § 19.735–203 of our rules, 47 CFR 19.735–203. Section 19.735–203 currently governs the disclosure and misuse by Commission personnel of nonpublic information that is contained in Commission records or obtained in connection with Commission employment. The purpose of the amendment is to emphasize the responsibilities of Commission employees in this area and to provide guidance to persons who receive nonpublic documents under circumstances where it appears that the release of the documents was either inadvertent or otherwise unauthorized.

2. Currently, § 19.735–203 prohibits the unauthorized release of nonpublic information, including documents, by Commission officials. Specifically, § 19.735–203(a) states that ''[e]xcept as authorized in writing by the Chairman

* * *, or otherwise as authorized by the Commission or its rules, nonpublic information shall not be disclosed, directly or indirectly, to any person outside the commission.'' Such nonpublic information clearly includes drafts of Commission orders, memoranda and other documents (such as e-mail) containing internal staff recommendations. See 5 CFR 2635.703 (''nonpublic information is information that * * * has not been made available to the general public'' including documents that are ''designated as confidential by an agency.''). We take this opportunity to emphasize that, pursuant to § 19.735–107 of our rules, employees that disclose such documents (or their contents) are subject to significant disciplinary action up to and including removal for cause, in addition to any other penalty prescribed by law. See 47 CFR 19.735–107. Our amendment of § 19.735–203 cross-references this rule governing the Commission's disciplinary and remedial authority.

3. Our rules prohibiting the disclosure of nonpublic information serve to protect the integrity of the Commission's deliberative processes. Disclosure by Commission staff of draft orders, internal confidential memoranda and nonpublic information violates these rules, and we will vigorously investigate and address violations of these rules by Commission personnel.

4. While our existing rules and our guidance in this order make clear our commitment to ensure that Commission personnel do not disclose nonpublic documents, the existing rules do not address the steps that are to be taken by persons regulated by or practicing before the Commission who receive such documents. The revision to § 19.735–203 adds language requiring such persons who come into possession of written nonpublic information (including written material transmitted in electronic form), the release of which they know or reasonably should know was either inadvertent or otherwise unauthorized, to promptly return such written nonpublic information to the Commission's Office of the Inspector General, without further distribution or use of the material.

5. Persons regulated by or practicing before the FCC may be subject to appropriate sanctions for willful violation of this section. In the case of attorneys practicing before the Commission such sanctions may include disciplinary action under the provisions of § 1.24 of the Commission's rules. (Cf., D.C. Rules of Professional Conduct, Rule 1.15 and Opinion no. 256, adopted May 16, 1995. See also: ABA Formal Opinion 92–368, Nov. 10, 1992; Florida Bar Op. 93–3, Feb. 1, 1994; and Oregon Bar Formal Op. No. 1998–150, approved Apr. 1998).

6. The revision also adds a cross reference to § 19.735–203 in a new § 0.458 of the Commission's rules, 47 CFR 0.458. New § 0.458 is within the Commission's part 0 rules dealing with public and nonpublic information.

7. The requirements set forth in 5 U.S.C. 553(b) and (d) pertaining to notice and comment and the effective date in rulemaking proceedings do not apply to this amendment because it concerns matters of agency organization, procedure or practice. See 5 U.S.C. 553(b)(A); 553(d).

8. Accordingly, pursuant to sections 4(i), 4(j), 303(r), 47 U.S.C. 4(i), 4(j), 303(r), parts 0 and 19 of the Commission's rules, 47 CFR part 19, ARE AMENDED as set forth, and is effective December 4, 2000.

List of Subjects

47 CFR Part 0

Classified information.

47 CFR Part 19

Conflict of interests, Nonpublic information.

Federal Communications Commission.

Magalie Roman Salas,

Secretary.

Rule Changes

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR parts 0 and 19 as follows:

PART 0—COMMISSION ORGANIZATION

1. The authority citation for part 0 continues to read as follows:

Authority: Sec. 5, 48 Stat. 1068, as amended; 47 U.S.C. 155.

2. Section 0.458 is added to read as follows:

§ 0.458 Nonpublic information.

Any person regulated by or practicing before the Commission coming into possession of written nonpublic information (including written material transmitted in electronic form) as described in § 19.735–203(a) of this chapter under circumstances where it appears that its release was inadvertent or otherwise unauthorized shall be obligated to return the information to the Commission's Office of Inspector General pursuant to that section. See 47 CFR 19.735–203.

PART 19—EMPLOYEE RESPONSIBILITIES AND CONDUCT

3. The authority citation for part 19 continues to read as follows:

Authority: 5 U.S.C. 7301; 47 U.S.C. 154 (b), (i), (j) and 303 (r).

4. Section 19.735–203 is amended by adding paragraph (d) and a new sentence immediately preceding the second sentence of the note to the section to read as follows:

§ 19.735–203 Nonpublic information.

* * * * *

(d) Any person regulated by or practicing before the Commission coming into possession of written nonpublic information (including written material transmitted in electronic form) as described in paragraph (a) of this section under circumstances where it appears that its release was inadvertent or otherwise unauthorized shall promptly return the written information to the Commission's Office of the Inspector General without further distribution or use of the written nonpublic information. Any person regulated by or practicing before the Commission who willfully violates this section by failing to promptly notify the Commission's Office of the Inspector General of the receipt of written nonpublic information (including written material transmitted in electronic form) that he knew or should have known was released inadvertently or in any otherwise unauthorized manner may be subject to appropriate sanctions by the Commission. In the case of attorneys practicing before the Commission, such sanctions may include disciplinary action under the provisions of § 1.24 of this chapter.

Note: * * * Additionally, employees should refer to § 19.735–107 of this part, which provides that employees of the Commission who violate this part may be subject to disciplinary action which may be in addition to any other penalty prescribed by law.

* * * * *

[FR Doc. 00–28061 Filed 11–2–00; 8:45 am]

BILLING CODE 6712–01–U

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 660

[Docket No. 000822244-0291-02; I.D. 082100B]

RIN 0648-AO66

Fisheries off West Coast States and in the Western Pacific; Western Pacific Pelagic Fisheries; Hawaii-based Pelagic Longline Area Closure

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Emergency interim rule; request for comments.

SUMMARY: NMFS makes changes to an emergency interim rule published on August 25, 2000, governing the Hawaii-based pelagic longline fishery. The changes, which are only applicable to the Hawaii-based pelagic longline fishery when fishing in Area C, as designated under that rule, expressly prohibit directing longline fishing effort toward the harvest of swordfish. The changes require vessels to set their main longline so that the deepest point between any two floats is greater than 100 m (328.1 ft), prohibit the possession of lightsticks on board vessels, require permit holders or operators to donate to charity at least 30 percent of their gross revenues from the sale of incidentally caught swordfish, and require each longline vessel operator to have aboard the vessel an observer waiver form issued by NMFS if the vessel fishes without an observer. The intent of this action is to ensure that swordfish are not targeted by the Hawaii longline fishery in Area C and to reduce adverse impacts on sea turtles while NMFS prepares a comprehensive environmental impact statement (EIS) that analyzes the environmental effects of fishing activities conducted under the Fishery Management Plan for the Pelagic Fisheries of the Western Pacific Region (FMP).

DATES: This emergency interim rule is effective from November 3, 2000, through February 21, 2001, except for the suspension of § 660.22 (hh) and § 660.33 (d)(4), and for the addition of §660.22 (kk) and § 660.33 (d)(7), which are effective December 4, 2000 through February 21, 2001. Comments must be received no later than 5 p.m., local time, on December 18, 2000.

ADDRESSES: Written comments on this action must be mailed to Dr. Charles Karnella, Administrator, NMFS, Pacific Islands Area Office (PIAO), 1601 Kapiolani Blvd., Suite 1110, Honolulu, HI 96814-4700; or faxed to 808-973-2941. Comments will not be accepted if submitted via e-mail or the Internet. Copies of the regulatory impact review (RIR) may be obtained from Dr. Charles Karnella, PIAO. Send comments regarding any ambiguity or unnecessary complexity arising from the language used in this rule to Dr. Charles Karnella.

FOR FURTHER INFORMATION CONTACT: Alvin Katekaru at 808-973-2937.

SUPPLEMENTARY INFORMATION: By this action, NMFS changes an emergency interim rule (65 FR 51992) published on August 25, 2000, governing the Hawaii-based pelagic longline fishery. These changes apply only to the Hawaii-based longline fishery operating in Area C, one of the three designated longline fishing restricted areas established by the August 25, 2000, emergency interim rule. Area C, which encompasses the main and Northwestern Hawaiian Islands, is defined as all waters bounded on the south by 0° lat., on the north by 28° N. lat., on the east by 137° W. long., and on the west by 173° E. long.. NMFS makes these changes in response to allegations made by Plaintiffs in *Center for Marine Conservation* v. *NMFS*, Civ. No. 99-00152 (DAE) that NMFS did not adequately comply with the August 4, 2000, Order Further Amending Order Modifying Provisions of Order of Injunction (August 4, 2000, Order) issued by the U.S. District Court for the District of Hawaii (Court). Plaintiffs complained to the Court that the August 25, 2000, emergency interim rule did not ensure that swordfish would not be targeted by the Hawaii-based longline fishery in Area C. Further, Plaintiffs alleged that the 20-percent standard that NMFS used to implement the Court's requirement that any ''profits'' from the landing and sale of swordfish incidentally caught in Area C be ''donated to charity'', did not ensure that all profits would be donated to charity.

The intent of the August 25, 2000, emergency interim rule was to prohibit any fishing activity by the Hawaii-based longline fishery in Area C that targeted swordfish. To clarify that intent, NMFS is hereby revising that rule to expressly prohibit directing any longline fishing effort toward the harvest of swordfish in Area C. NMFS also is revising that rule to require vessels registered for use with a Hawaii longline limited access permit and fishing for pelagic management unit species in Area C, to deploy longline gear so that the deepest point of the longline between any two floats reaches a depth greater than 100 m (328.1 ft) below the sea surface. This change is intended to ensure that hooks are not set at shallow depths where they would target swordfish. Longline sets are identified as shallow or deep depending on how deep the main longline sags between floats. In a study conducted by NMFS on longline gear sag depths in the Hawaii pelagic longline fishery, it was found that 95 percent of the shallow sets had mainline sag depths shallower than 101 m (331.4 ft), with an average of 52.2 m (171.3 ft). Nearly 90 percent of the swordfish harvested in Area C were caught in shallow sets. On the other hand, 95 percent of the deep longline sets targeting bigeye tuna had a mainline sag depth deeper than 109 m (357.6 ft), with an average of 221 m (725.1 ft). NMFS has determined that requiring vessels to deploy their longlines so that the deepest part of the mainline between any two floats is at a depth greater than 100 m (328.1 ft) will effectively prevent them from targeting swordfish.

Finally, NMFS is changing the provision in the August 25, 2000, emergency interim rule requiring that 20 percent of the gross revenue from the sale of swordfish caught incidentally in Area C be donated to IRS-approved charitable organizations to a provision requiring that at least 30 percent of the gross revenue from the sale of all such swordfish be donated to IRS-approved charitable organizations. This change will ensure that fishery participants have no economic incentive to target swordfish in Area C. The 30 percent of gross revenues standard is much higher then the 3.7–percent profit margin for the average tuna longline vessel based on total revenue less all operating and fixed costs. Moreover, it is also substantially higher than the average tuna longline vessel's 20.6–percent annual return on operating and repair costs.

In addition to the changes made in response to the Plaintiff's complaint, NMFS is changing other provisions of the August 25, 2000, emergency interim rule to facilitate enforcement of the longline fishing restrictions in Area C. First, the measure prohibiting the use of lightsticks is changed to a prohibition on the possession of lightsticks. This provision has the same effect on the targeting of swordfish as a use prohibition but is easier to enforce since it relies on evidence of possession at any time in Area C, rather than evidence of actual fishing with lightsticks in Area C. Second, NMFS is adding a provision to require all longline vessels exempted from carrying NMFS-approved observers for specific fishing trips to

have on board the vessel a valid observer waiver form issued by NMFS. This requirement will enable U.S. Coast Guard and NMFS enforcement agents to monitor compliance of the observer requirements during at-sea inspections of longline vessels operating in Area C.

Criteria for Issuing an Emergency Interim Rule

This emergency interim rule meets NMFS policy guidelines for the use of emergency interim rules (62 FR 44421, August 21, 1997). Also, it realizes benefits that outweigh the value of prior notice, opportunity for public comment, and deliberative consideration expected under the normal rulemaking process.

Recent, Unforeseen Events or Recently Discovered Circumstances

Emergency action is necessary to address, in a timely manner, concerns regarding NMFS's August 25, 2000 emergency interim rule implementing the Court's August 4, 2000 Order. Emergency action is also necessary to facilitate enforcement of the emergency interim rule.

Immediate Benefits

Although there are many variables that make it difficult to predict the effects of this fishery upon different sea turtle populations, NMFS anticipates this action will have a positive benefit sea turtles by further reducing the potential for turtles being caught by Hawaii-based longline vessels.

Classification

The Assistant Administrator for Fisheries, NOAA (AA) has also determined that this emergency interim rule is consistent with the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) and other applicable laws. NMFS prepared an environmental assessment (EA) for the August 25, 2000, emergency interim rule that describes the impact on the human environment of that rule and found that no significant impact would result from the implementation of it. The changes made by the present action clarify the intent of that rule and will facilitate its enforcement. The changes will not cause any significant impact on the human environment.

NMFS also prepared a regulatory impact review for the August 25, 2000, action which assessed its economic costs and benefits. That assessment used calculations from an input-output model of the Hawaii commercial fishery (Sharma, 1999), and showed that in 1998 the Hawaii longline fishery (valued at $46.7 million in ex-vessel revenues) had a total impact on Hawaii business sales of $113 million. The changes made by the present action to the emergency interim rule are expected to have an additional impact on vessel operators who have customarily targeted species other than bigeye tuna, as the requirement that longline gear must be deployed at a depth greater than 100 m (328.1 ft) effectively bans the targeting, in Area C, of yellowfin tuna as well as swordfish. Due to the lack of detailed data, the precise economic impact of the new longline set depth requirement cannot be calculated. However NMFS longline logbook data for 1998-1999 show that approximately 10 percent of the sets in Area C (1,739 of 19,964) targeted yellowfin tuna. This includes sets taken by 74 vessels over the 2-year period, i.e., roughly half of all the vessels that were active during the 2 years.

Nonetheless, the impact of this emergency interim rule is expected to be relatively small because the yellowfin tuna fishery is primarily a summer fishery and has ended for this year and the bigeye tuna fishery, a winter and spring fishery, is about to commence. This emergency interim rule does, however, further reduce the ability of swordfish fishermen to utilize similar gear-setting techniques in Area C and will increasingly require purchase of a line-shooter. Some vessels, however, will operate out of California until NMFS completes the EIS and the emergency interim rule is replaced by final rule.

The Assistant Administrator for Fisheries (AA) finds, for good cause, that under 5 U.S.C. 553(b)(B) providing prior notice and opportunity for public comment for this action is unnecessary given that the Court ordered the actions in the August 25, 2000 emergency interim rule, and that this action is necessary to clarify the intent of the August 25, 2000 rule and to facilitate its enforcement, and the delay associated with providing prior notice and opportunity for public comment would be contrary to the public interest.

Similarly, the AA finds, for good cause, under 5 U.S.C. 553(d)(3), that delaying the effectiveness of this rule for 30 days would be contrary to the public interest. Accordingly, the AA is making this rule effective upon publication in the **Federal Register**, except for the lightstick provisions. The AA is delaying the effectiveness of the provisions prohibiting the possession of lightsicks for 30 days to allow time for any vessel which has a lightstick on board during a current fishing trip to off-load the lightsticks when the vessel returns to port. This delay will not compromise the regulation's effect on the targeting of swordfish since the prohibition on the use of lightsticks will remain in effect.

Under section 305(c) of the Magnuson-Stevens Act, this emergency interim rule will remain in effect for not more than 180 days (until February 21, 2001, based on the effective date of the emergency interim rule published on August 25, 2000). It may be extended for one additional period of not more than 180 days.

Because this emergency interim rule is not required to be published with prior notice and opportunity for public comment under 5 U.S.C. 553, or any other law, the analytical requirements of the Regulatory Flexibility Act do not apply.

This emergency interim rule has been determined to be not significant for purposes of Executive Order 12866.

The President has directed Federal agencies to use plain language in their communications with the public, including regulations. To comply with this directive, we seek public comment on any ambiguity or unnecessary complexity arising from the language used in this rule (see **ADDRESSES**).

List of Subjects in 50 CFR Part 660

Administrative practice and procedure, American Samoa, Fisheries, Fishing, Guam, Hawaiian Natives, Indians, Northern Mariana Islands, Reporting and recordkeeping requirements.

Dated: October 30, 2000.

William T. Hogarth,

Deputy Assistant Administrator for Fisheries, National Marine Fisheries Service.

For the reasons set out in the preamble, 50 CFR part 660 is amended as follows:

PART 660—FISHERIES OFF WEST COAST STATES AND IN THE WESTERN PACIFIC

1. The authority citation for part 660 continues to read as follows:

Authority: 16 U.S.C. 1801 *et seq.*

2. In § 660.22, paragraph (hh) is suspended and new paragraphs (kk), (ll), and (mm) are added to read as follows:

§ 660.22 Prohibitions.

* * * * *

(kk) Possess lightsticks on a longline vessel within the Hawaii emergency longline closed Area C in violation of § 660.33 (d)(7).

(ll) Fail to carry onboard the vessel or to make available for inspection by an authorized officer an observer waiver form issued by the Administrator,

Pacific Islands Area Office, NMFS, or a designee of the Administrator as required under § 660.33(e)(2).

(mm) Direct longline fishing effort toward the harvest of swordfish in Hawaii emergency longline closed Area C.

3. In § 660.33, paragraphs (d)(4), (d)(5), and (e)(2) are suspended, and new paragraphs (d)(7), (d)(8), (d)(9), and (e)(7) are added to read as follows:

§ 660.33 Hawaii emergency closure.

* * * * *

(d)* * *

(7) A vessel registered for use under a Hawaii longline limited access permit may not possess lightsticks during a fishing trip where part (or all) of the trip involves fishing in Area C.

(8) Within 30 days of each landing of swordfish caught by longline gear in Area C, the permit holder or operator of a vessel registered for use under a Hawaii longline limited access permit must donate to charity at least 30 percent of the total gross revenues from the sale of such swordfish.

(9) Any longline gear deployed after November 3, 2000 by a vessel registered for use under a Hawaii longline limited access permit, fishing for Pacific pelagic management unit species in Area C, must be deployed such that the deepest point of the main longline between any two floats, i.e., the deepest point in each sag of the main line, is at a depth greater than 100 m (328.1 ft or 54.6 fm) below the sea surface.

(e) * * *

(7) A vessel registered for use with a Hawaii longline access permit may not use longline gear in Area C without a NMFS-approved observer aboard the vessel, unless it is issued a written waiver on a per trip basis by the Administrator, Pacific Islands Area Office, NMFS, or a designee. The waiver must be on board the vessel and made available for inspection by an authorized officer at any time during the trip for which the waiver is valid.

* * * * *

FR Doc. 00–28278 Filed 10–31–00; 4:31 pm]

BILLING CODE 3510–22–S

Proposed Rules

Federal Register
Vol. 65, No. 214
Friday, November 3, 2000

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

DEPARTMENT OF AGRICULTURE

Grain Inspection, Packers and Stockyards Administration

7 CFR Part 868

[Docket No. FGIS–2000–002a]

RIN 0580–AA74

Fees for Commodity and Rice Inspection Services

AGENCY: Grain Inspection, Packers and Stockyards Administration, USDA.

ACTION: Proposed rule.

SUMMARY: The Grain Inspection, Packers and Stockyards Administration (GIPSA) is proposing an approximate 3.7 percent increase in fees for all hourly rates and certain unit rates for inspection services performed under the Agricultural Marketing Act (AMA) of 1946 in the commodity and rice inspection programs. These increases are needed to cover increased operational costs resulting from the mandated January 2001 Federal pay increase.

DATES: Written comments must be submitted on or before January 2, 2001.

ADDRESSES: Interested persons are invited to submit written comments concerning this proposal. Written comments must be submitted to Sharon Vassiliades, GIPSA, USDA, 1400 Independence Avenue, SW, Room 1647-S, Washington, DC 20250–3604, or faxed to (202) 690–2755. Comments may also be sent by E-mail to: *comments@gipsadc.usda.gov*. Please state that your comments refer to Docket No. FGIS–2000–002a. Comments will be available for public inspection in the above office during regular business hours (7 CFR 1.27 (b)).

FOR FURTHER INFORMATION CONTACT: David Orr, Director, Field Management Division, at his E-mail address: *Dorr@gipsadc.usda.gov*, or telephone him at (202) 720–0228.

SUPPLEMENTARY INFORMATION:

A. Executive Order 12866 the Regulatory Flexibility Act, and the Paperwork Reduction Act

This rule has been determined to be nonsignificant for the purpose of Executive Order 12866 and, therefore, has not been reviewed by the Office of Management and Budget.

Also, pursuant to the requirements set forth in the Regulatory Flexibility Act, James R. Baker, Administrator, GIPSA, has determined that this rule will not have a significant economic impact on a substantial number of small entities as defined in the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*).

GIPSA regularly reviews its user-fee programs to determine if the fees are adequate and continues to seek cost saving opportunities and implement appropriate changes to reduce costs. Such actions can provide alternatives to fee increases. Employee salaries and benefits are major program costs that account for approximately 84 percent of GIPSA's total operating budget. A January 2001 general and locality salary increase that averages 3.7 percent for all GIPSA employees will increase program costs in both the commodity and the rice inspection programs.

1. Commodity Inspection Program

The commodity inspection program consists of two different programs, *i.e.*, graded commodities and processed commodities. Fees for these programs are in Tables 1 and 2 of 7 CFR 868.90. These programs serve two different markets: The graded commodity market is made up of producers and processors of edible beans, peas, and lentils. The processed commodity market consists of processors and shippers of products such as wheat flour, soybean meal, vegetable oil, and corn meal. USDA's Farm Service Agency (FSA) implemented program changes during FY 2000 that eliminated requirements for end-item and vessel loading observation inspections for processed commodities. Program changes, including personnel adjustments, have been implemented to begin offsetting operating costs due to the loss of the FSA program inspections. Additional cost-cutting measures will continue in FY 2001. Even with these cost-saving measures, the commodity inspection program will continue to lose funds. In FY 1999, operating costs in the commodity inspection program were $5,951,852 with revenue of $7,190,879 that resulted in a positive margin of $1,239,027 and a positive reserve balance of $1,764,140. As of August 31, 2000, FY 2000 operating costs were $4,835,881 with revenue of $5,065,643 that resulted in a positive margin of $229,762 and a positive reserve of $2,066,752. However, in the last two months, since all FSA program changes have been implemented, we have received $579,274 in revenue and $745,125 in costs that have resulted in a $165,851 negative margin. The salary adjustment will increase GIPSA's costs in the commodity inspection program by approximately $95,000. The current positive margin and reserve balance will not continue due to the loss of processed commodity inspection and the remaining programs in the commodity inspection program cannot absorb the 3.7 percent salary increase even with the planned cost-cutting measures.

The proposed fee increase for our graded commodities program applies primarily to GIPSA customers that produce, process, and market graded commodities for the domestic and international markets. There are approximately 156 such customers located primarily in the States of North Dakota, South Dakota, Oregon, Kansas, Colorado, Montana, Texas, Michigan, Nebraska, Minnesota, Washington, Idaho, and California. Many of these customers meet the criteria for small entities established by the Small Business Administration criteria for small businesses. Even though the fees are being increased, the increase will not be excessive (3.7 percent) and should not significantly affect those entities. Those entities are under no obligation to use our service and, therefore, any decision on their part to discontinue the use of our service should not prevent them from marketing their products.

2. Rice Inspection Program

The existing fee schedule for GIPSA's rice inspection program will not generate sufficient revenues to cover program costs while maintaining an adequate reserve balance. Fees for this program are in Tables 1 and 2 of 7 CFR 868.91. In FY 1999, GIPSA's operating costs in its Rice Inspection Program were $4,105,564 with revenue of $4,412,131 that resulted in a positive

margin of $306,567 and a negative reserve balance of $508,628. As of August 31, 2000, operating costs in the rice program were $3,694,050 with revenue of $4,421,869 that resulted in a positive margin of $727,819 and a positive reserve of $315,391. The current positive reserve balance is well below the desired 3-month reserve of approximately $1 million.

We have reviewed the financial position of our rice inspection program based on the increased salary and benefit costs, along with the projected FY 2001 workload. Even though the financial status of the rice inspection program has improved, we have concluded that we cannot absorb the increased costs caused by the 3.7 percent salary increase with the small positive reserve balance. This proposed fee increase will collect an estimated $155,500 in additional revenues in the rice program based on the projected FY 2001 work volume of 3.9 million metric tons.

This proposed fee increase applies primarily to GIPSA customers that produce, process, and market rice for the domestic and international markets. There are approximately 550 such customers located primarily in the States of Arkansas, Louisiana, and Texas. Many of these customers meet the criteria for small entities established by the Small Business Administration criteria for small businesses. Even though the fees are being increased, the increase will not be excessive (3.7 percent) and should not significantly affect those entities. Those entities are under no obligation to use our service and, therefore, any decision on their part to discontinue the use of our service should not prevent them from marketing their products.

There will be no additional reporting or record keeping requirements imposed by this action. In compliance with the Paperwork Reduction Act of 1995 (44 U.S.C. 35), the information collection and record keeping requirements in Part 868 have been previously approved by the Office of Management and Budget under control number 0580–0013. GIPSA has not identified any other Federal rules which may duplicate, overlap, or conflict with this rule.

B. Executive Order 12988

This proposed rule has been reviewed under Executive Order 12988, Civil Justice Reform. This action is not intended to have a retroactive effect. This action will not preempt any State or local laws, regulations, or policies unless they present irreconcilable conflict with this rule. There are no administrative procedures that must be exhausted prior to any judicial challenge to the provisions of this rule.

C. Proposed Action

Under the provisions of the Agricultural Marketing Act of 1946 (7 U.S.C. 1621, *et seq.*), commodity and rice inspection services are provided upon request and GIPSA must collect a fee from the customer to cover the cost of providing such services. Section 203 (h) of the AMA (7 U.S.C. 1622 (h)) provides for the establishment and collection of fees that are reasonable and, as nearly as practicable, cover the costs of the services rendered. These fees cover the GIPSA administrative and supervisory costs for the performance of official services, including personnel compensation and benefits, travel, rent, communications, utilities, contractual services, supplies, and equipment.

The commodity inspection fees were last amended on December 18, 1996, and became effective February 18, 1997 (61 FR 66533). The rice inspection fees were last amended on March 30, 2000, and became effective May 1, 2000 (65 FR 16787). These fees were to cover, as nearly as practicable, the level of operating costs as projected for FY 1997 and FY 2000, respectively. GIPSA continually monitors its cost, revenue, and operating reserve levels to ensure that there are sufficient resources for operations. During FY 1998, GIPSA implemented cost-saving measures in the rice program in an effort to provide more cost-effective services. The purpose of these measures was to reduce operating costs in order to reduce the negative retained earnings in this program. The cost containment measures included employee buyouts and better cross utilization of personnel between programs.

GIPSA regularly reviews its user-fee-financed programs to determine if the fees are adequate and continues to seek out cost-saving opportunities and implement appropriate changes to reduce costs. Such actions can provide alternatives to fee increases.

1. Commodity Inspection Program

The commodity inspection program consists of two different programs, graded and processed commodities. Fees for these programs can be found in 7 CFR 868.90 (a), Tables 1 and 2. These programs serve two different markets with different applicants. The graded commodity market is made up of producers and processors of edible beans, peas, and lentils. The processed commodity market consists of processors and shippers of products such as wheat flour, soybean meal, vegetable oil, and corn meal. USDA's Farm Service Agency (FSA) implemented program changes during FY 2000 that has resulted in a 96 percent reduction in processed commodity inspections. The processed commodity inspection program represents approximately 86 percent of all revenue and 62 percent of the cost. Initial program changes, including personnel adjustments, have been implemented to begin offsetting the lost revenue and reduce operating costs. Additional cost-cutting measures will continue in FY 2001. Even with these cost-saving measures, the commodity inspection program will continue to lose funds. In FY 1999, operating costs in the commodity inspection program were $5,951,852 with revenue of $7,190,879 that resulted in a positive margin of $1,239,027 and a positive reserve balance of $1,764,140. As of August 31, 2000, FY 2000 operating costs were $4,835,881 with revenue of $5,065,643 that resulted in a positive margin of $229,762 and a positive reserve of $2,066,752. However, $579,274 in revenue and $745,125 in costs for the preceding two months since all FSA program changes have been implemented, has resulted in a $165,851 negative margin. The salary adjustment will increase GIPSA's costs in the commodity inspection program by approximately $95,000. The current positive margin and reserve balance will not continue due to the loss of processed commodity inspection and the remaining programs in the commodity inspection program cannot absorb the 3.7 percent salary increase even with the planned cost-cutting measures.

The costs associated with salaries and benefits are recovered by the hourly rates for personnel performing direct service. Other associated costs, including non-salary related overhead, are collected through other fees contained in the fee schedule and are at levels that do not require any change. GIPSA is proposing a 3.7 percent increase to the hourly rates and certain unit rates in 7 CFR 868.90, (a) Table 1–Hourly Rates (Fees for Inspection of Commodities Other Than Rice). Currently, the regular workday hourly rate is $33.00, while Saturday, Sunday, and Holidays are $42.50. The other current unit rates are:

Miscellaneous Processed Commodities: (1) Additional Tests (cost per test, assessed in addition to the hourly rate):	
(i) Aflatoxin Test (Thin Layer Chromatography)	$51.40
(ii) Falling Number	12.00
(iii) Aflatoxin Test Kit	7.50
Graded Commodities (Beans, Peas, Lentils, Hops, and Pulses):	
(1) Additional Tests—Unit Rates (Beans, Peas, Lentils):	
(i) Field run (per lot or sample)	22.70
(ii) Other than field run (per lot or sample)	13.50
(iii) Factor analysis (per factor)	5.50
(2) Additional Tests—Unit Rates (Hops):	
(i) Lot or sample (per lot or sample)	29.00
(3) Additional Tests—Unit Rates (Nongraded Nonprocessed Commodities):	
(i) Factor analysis (per factor)	5.50
(4) Stowage Examination (service—on-request)	
(i) Ship (per stowage space) (minimum $250 per ship)	50.00
(ii) Subsequent ship examination (same as original) (minimum $150 per ship)	
(iii) Barge (per examination) (minimum $250 per ship)	40.00
(iv) All other carriers (per examination)	15.00

2. Rice Inspection Program

The existing fee schedule for GIPSA's rice inspection program will not generate sufficient revenues to cover program costs while maintaining an adequate reserve balance. Fees for this program are in 7 CFR 868.91, Tables 1 and 2. In FY 1999, GIPSA's operating costs in the rice program were $4,105,564 with revenue of $4,412,131 that resulted in a positive margin of $306,567 and a negative reserve balance of $508,628. As of August 31, 2000, operating costs in the rice program were $3,694,050 with revenue of $4,421,869 that resulted in a positive margin of $727,819 and a positive reserve of $315,391. The current positive reserve balance is well below the desired 3-month reserve of approximately $1 million.

We have reviewed the financial position of our rice inspection program based on the increased salary and benefit costs, along with the projected FY 2001 workload. Even though the financial status of our rice inspection program has improved, we have concluded that with the small positive reserve balance we cannot absorb the increased costs caused by the 3.7 percent salary increase. This proposed fee increase will collect an estimated $155,500 in additional revenues in the rice program based on the projected FY 2001 work volume of 3.9 million metric tons.

In 7 CFR 868.91, Table 1—Hourly Rates/Unit Rate Per CWT and Table 2—Unit Rates, currently the regular workday contract and noncontract fees are $42.80 and $52.40, respectively, while the nonregular workday contract and noncontract fees are $59.60 and $72.40, respectively. The unit rate per hundredweight for export port services is currently $0.052 per hundredweight. The rice current unit rates are:

Service	Rough rice	Brown rice for Processing	Milled rice
Inspection for quality (per lot, sublot, or sample inspection)	$34.50	$29.80	$21.20
Factor analysis for any single factor (per factor):			
(a) Milling yield (per sample)	26.75	26.75	.....
(b) All other factors (per factor)	12.70	12.70	12.70
Total oil and free fatty acid	.....	42.00	42.00
Interpretive line samples:			
(a) Milling degree (per set)	.....	.....	89.20
(b) Parboiled light (per sample)	.....	.....	22.35
Extra copies of certificates (per copy)	3.00	3.00	3.00

List of Subjects in 7 CFR Part 868

Administrative practice and procedure, Agricultural commodities.

For reasons set out in the preamble, 7 CFR part 868 is proposed to be amended as follows:

PART 868—GENERAL REGULATIONS AND STANDARDS FOR CERTAIN AGRICULTURAL COMMODITIES

1. The authority citation for part 868 continues to read as follows:

Authority: Secs. 202–208, 60 Stat. 1087 as amended (7 U.S.C. 1621, *et seq.*)

2. In § 868.90 paragraph (a) is revised to read as follows:

§ 868.90 Fees for certain Federal inspection services.

(a) The fees shown in Table 1 apply to Federal Commodity Inspection Services specified below.

TABLE 1.—HOURLY RATES [1] [3]

[Fees for inspection of commodities other than rice]

Hourly Rates (per service representative):	
Monday to Friday—$34.20	
Saturday, Sunday, and Holidays—$44.40	
Miscellaneous Processed Commodities: [2]	
(1) Additional Tests (cost per test, assessed in addition to the hourly rate):.	
(i) Aflatoxin Test (Thin Layer Chromatography)	$51.40
(ii) Falling Number	12.50

TABLE 1.—HOURLY RATES [1] [3]—Continued

[Fees for inspection of commodities other than rice]

(iii) Aflatoxin Test Kit	7.50
Graded Commodities (Beans, Peas, Lentils, Hops, and Pulses):	
(1) Additional Tests—Unit Rates (Beans, Peas, Lentils):	
(i) Field run (per lot or sample)	23.00
(ii) Other than field run (per lot or sample)	13.75
(iii) Factor analysis (per factor)	5.65
(2) Additional Tests—Unit Rates (Hops):	
(i) Lot or sample (per lot or sample)	29.30
(3) Additional Tests—Unit Rates (Nongraded Nonprocessed Commodities):	
(i) Factor analysis (per factor)	5.65
(3) Stowage Examination (service-on-request) [4].	
(i) Ship (per stowage space) (minimum $252.50 per ship)	50.50
(ii) Subsequent ship examinations (same as original)	([5])
(iii) Barge (per examination)	40.50
(iv) All other carriers (per examination)	15.50

[1] Fees for original commodity inspection and appeal inspection services include, but are not limited to, sampling, grading, weighing, stowage examinations, pre-inspection conferences, sanitation inspections, and other services requested by the applicant and that are performed within 25 miles of the field office. Travel and related expenses (commercial transportation costs, mileage, and per diem) will be assessed in addition to the hourly rate for service beyond the 25-mile limit. Refer to § 868.92. Explanation of service fees and additional fees, for all other service fees except travel and per diem.

[2] When performed at a location other than the Commodity Testing Laboratory.

[3] Faxed and extra copies of certificates will be charged at $1.50 per copy.

[4] If performed outside of normal business hours, 1½ times the applicable unit fee will be charged.

[5] Minimum $151.50 per ship.

* * * * *

3. Section 868.91 is revised to read as follows:

§ 868.91 Fees for certain Federal rice inspection services.

The fees shown in Tables 1 and 2 apply to Federal rice inspection services.

TABLE 1.—HOURLY RATES/UNIT RATE PER CWT

[Fees for Federal Rice Inspection Services]

Service [1]	Regular workday (Monday–Saturday)	Nonregular workday (Sunday–Holiday)
Contract (per hour per Service representative)	$44.80	$61.80
Noncontract (per hour per Service representative)	54.30	75.00
Export Port Services (per hundredweight) [2]	.054	.054

[1] Original and appeal inspection services include: Sampling, grading, weighing, and other services requested by the applicant when performed at the applicant's facility.

[2] Services performed at export port locations on lots at rest.

TABLE 2.—UNIT RATES

Service [1, 3]	Rough rice	Brown rice for processing	Milled rice
Inspection for quality (per lot, sublot, or sample inspection)	$34.80	$30.00	$21.50
Factor analysis for any single factor (per factor):			
(a) Milling yield (per sample)	27.00	27.00	.....
(b) All other factors (per factor)	12.90	12.90	12.90
Total oil and free fatty acid	.....	42.60	42.60
Interpretive line samples: [2]			
(a) Milling degree (per set)	.....	.....	91.00
(b) Parboiled light (per sample)	.....	.....	22.60
Extra copies of certificates (per copy)	3.00	3.00	3.00

[1] Fees apply to determinations (original or appeals) for kind, class, grade, factor analysis, equal to type, milling yield, or any other quality designation as defined in the U.S. Standards for Rice or applicable instructions, whether performed singly or in combination at other than at the applicant's facility.

[2] Interpretive line samples may be purchased from the U.S. Department of Agriculture, GIPSA, FGIS, Technical Services Division, 10383 North Executive Hills Boulevard, Kansas City, Missouri 64153–1394. Interpretive line samples also are available for examination at selected FGIS field offices. A list of field offices may be obtained from the Director, Field Management Division, USDA, GIPSA, FGIS, 1400 Independence Avenue, SW, STOP 3630, Washington, DC 20250–3630. The interpretive line samples illustrate the lower limit for milling degrees only and the color limit for the factor ''Parboiled Light'' rice.

[3] Fees for other services not referenced in table 2 will be based on the noncontract hourly rate listed in § 868.90, table 1.

Dated: October 30, 2000.

David Orr,

Acting Administrator, Grain Inspection, Packers and Stockyards Administration.

[FR Doc. 00–28145 Filed 11–2–00; 8:45 am]

BILLING CODE 3410–EN–P

DEPARTMENT OF THE TREASURY

Office of the Comptroller of the Currency

12 CFR Part 3

[Docket No. 00–24]

RIN 1557—AB14

FEDERAL RESERVE SYSTEM

12 CFR Parts 208 and 225

[Regulations H and Y; Docket No. R–1084]

FEDERAL DEPOSIT INSURANCE CORPORATION

12 CFR Part 325

RIN 3064–AC44

DEPARTMENT OF THE TREASURY

Office of Thrift Supervision

12 CFR Part 567

[Docket No. 2000–90]

RIN 1550–AB11

Simplified Capital Framework for Non-Complex Institutions

AGENCIES: Office of the Comptroller of the Currency, Treasury; Board of Governors of the Federal Reserve System; Federal Deposit Insurance Corporation; and Office of Thrift Supervision, Treasury.

ACTION: Advance notice of proposed rulemaking.

SUMMARY: The Office of the Comptroller of the Currency (OCC), the Board of Governors of the Federal Reserve System (Board), the Federal Deposit Insurance Corporation (FDIC), and the Office of Thrift Supervision (OTS) (collectively, the Agencies) are considering developing a simplified regulatory capital framework applicable to non-complex banks and thrifts (non-complex institutions). The Agencies believe that the size, structure, complexity, and risk profile of many banking and thrift institutions (banking organizations or institutions) may warrant the application of a simplified capital framework that could relieve regulatory burden associated with the existing capital rules.

The Agencies are considering the advantages and disadvantages associated with developing a regulatory capital framework specifically for non-complex institutions. The main objective of this advance notice of proposed rulemaking is to obtain preliminary views from the industry and the public regarding such a framework. The information gathered as a result of this advance notice of proposed rulemaking will assist the Agencies in determining whether to propose a simplified capital framework and, if so, how the framework should be structured and implemented.

In considering the development of a less burdensome regulatory framework, the Agencies would not lower capital standards or encourage a reduction in existing capital levels. Rather, a simplified, less burdensome framework may result in higher minimum regulatory capital requirements for certain institutions than required under current capital standards. Many non-complex institutions currently maintain levels of capital in excess of the regulatory minimum requirements, and the Agencies would therefore expect that most banking organizations subject to a simplified framework would not have to increase capital levels.

This advance notice of proposed rulemaking sets forth broad options for a simplified framework. The options advanced for comment include adopting a simplified risk-based framework (and maintaining the leverage ratio requirement) or adopting a leverage-based approach. The leverage-based approach may include either a traditional leverage framework or one that is modified to address off-balance sheet risks.

DATES: Comments must be received by no later than February 1, 2001.

ADDRESSES: Comments should be directed to:

OCC: Comments may be submitted to Docket No. 00–24, Communications Division, Third Floor, Office of the Comptroller of the Currency, 250 E Street, SW., Washington, DC 20219. Comments will be available for inspection and photocopying at that address. In addition, comments may be sent by facsimile transmission to (202) 874–5274, or by electronic mail to regs.comments@occ.treas.gov. You can make an appointment to inspect the comments by calling (202) 874–5043.

Board: Comments, which should refer to Docket No. R–1084, may be mailed to Ms. Jennifer J. Johnson, Secretary, the Board of Governors of the Federal Reserve System, 20th and C Streets, NW., Washington, DC 20551, or mailed electronically to regs.comments@federalreserve.gov. Comments addressed to Ms. Johnson may be delivered to the Board's mailroom between 8:45 a.m. and 5:15 p.m., and to the security control room outside of those hours. Both the mailroom and the security control room are accessible from the courtyard entrance on 20th Street between Constitution Avenue and C Street, NW.. Comments may be inspected in Room MP–500 between 9 a.m. and 5 p.m. weekdays pursuant to § 261.12, except as provided in § 261.14 of the Board's Rules Regarding Availability of Information, 12 CFR 261.12 and 261.14.

FDIC: Send written comments to Robert E. Feldman, Executive Secretary, Attention: Comments/OES, Federal Deposit Insurance Corporation, 550 17th Street, NW, Washington, DC 20429. Comments may be hand-delivered to the guard station at the rear of the 550 17th Street Building (located on F Street), on business days between 7 a.m. and 5 p.m. (facsimile number (202) 898–3838; Internet address: *comments@fdic.gov*). Comments may be inspected and photocopied in the FDIC Public Information Center, Room 100, 801 17th Street, NW, Washington, DC 20429, between 9 a.m. and 4:30 p.m. on business days.

OTS: Send comments to Manager, Dissemination Branch, Information Management & Services Division, Office of Thrift Supervision, 1700 G Street, NW, Washington, DC 20552, Attention Docket No. 2000–90. Hand deliver comments to Public Reference Room, 1700 G Street, NW, lower level, from 9 a.m. to 4 p.m. on business days. Send facsimile transmissions to FAX number (202) 906–7755 or (202) 906–6956 (if the comment is over 25 pages). Send e-mails to *public.info@ots.treas.gov* and include your name and telephone number. Interested persons may inspect comments at 1700 G Street, NW, from 10 a.m. until 4 p.m. on Tuesdays and Thursdays, or obtain comments or an index of comments by facsimile by telephoning the Public Reference Room at (202) 906–5900 from 9 a.m. until 5 p.m. on business days. Comments and the related index will also be posted on the OTS Internet Site at ''www.ots.treas.gov.''

FOR FURTHER INFORMATION CONTACT:

OCC: Amrit Sekhon, Risk Specialist, Capital Policy Division, (202) 874–5211; or Ron Shimabukuro, Senior Attorney, Legislative and Regulatory

Activities Division, (202) 874–5090, Office of the Comptroller of the Currency, 250 E Street SW, Washington, DC 20219.

Board: Norah Barger, Assistant Director (202/452–2402), Barbara Bouchard, Manager (202/452–3072), Division of Banking Supervision and Regulation, or David Adkins, Supervisory Financial Analyst (202/452–5259). For the hearing impaired *only*, Telecommunication Device for the Deaf (TDD), Janice Simms (202/872–4984), Board of Governors of the Federal Reserve System, 20th and C Streets, NW, Washington, DC 20551.

FDIC: Mark S. Schmidt, Associate Director, (202/898–6918), Division of Supervision, William A. Stark, Assistant Director, (202/898–6972), Division of Supervision, or Keith A. Ligon, Chief, Policy Unit, (202/898–3618), Division of Supervision.

OTS: Michael D. Solomon, Senior Program Manager for Capital Policy (202/906–5654), or Teresa A. Scott, Counsel (Banking and Finance) (202/906–6478), Office of Thrift Supervision, 1700 G Street, NW, Washington, DC 20552.

SUPPLEMENTARY INFORMATION:

I. Background

In 1989, the Agencies each adopted regulatory capital standards based on the Basel Capital Accord (1988 Accord).[1] The 1988 Accord sets forth a general framework for measuring the capital adequacy of internationally active banks under which assets and off-balance-sheet items are ''risk-weighted'' based on their perceived credit risk using four broad risk categories.[2] Institutions subject to the 1988 Accord are required to maintain a minimum ratio of regulatory capital [3] to total risk-weighted assets of 8 percent.[4]

In addition to risk-based capital requirements, United States banking organizations must comply with a minimum leverage ratio requirement. [5] Generally, strong banking organizations (*e.g.,* institutions assigned a composite rating of 1 under the Uniform Financial Institutions Ratings System) must maintain a minimum ratio of Tier 1 capital to average total consolidated on-balance sheet assets of 3 percent. For other banking organizations, the minimum leverage ratio is 4 percent. The Agencies view the risk-based and leverage capital requirements as minimums. Institutions should hold capital at a level that is commensurate with their individual risk profile.

United States banking organizations are also subject to Prompt Corrective Action (PCA) regulations. Generally, under these rules an institution's regulatory capital ratios are used to classify the institution into a PCA category. Institutions with the highest capital ratios (*i.e.,* at or above a 10 percent total risk-based capital ratio, at or above a 6 percent Tier 1 risk-based capital ratio, and at or above a 5 percent leverage capital ratio) are usually categorized as ''well capitalized.'' Institutions with lower capital ratios are assigned to lower capital categories. Institutions that are less than well capitalized have restrictions or conditions on certain activities and may also be subject to mandatory or discretionary supervisory action.

Although the 1988 Accord was developed for large and internationally active banking organizations, when the Agencies adopted the risk-based capital standards domestically, the standards were applied to all banking organizations regardless of size, structure, complexity, and risk profile. The four broad risk-weight categories, while imperfect, were viewed as a significant improvement over the previous domestic capital framework that did not take into account asset credit quality and discouraged banking organizations from holding low-risk assets. In addition, the capital adequacy framework incorporated off-balance sheet items into the risk-based capital formula. The consistent application of an international regulatory capital regime was also expected to minimize competitive equity concerns.

The 1988 Accord has had a stabilizing effect on the international banking system. Since its inception, capital levels have risen and competitive equity has been enhanced. Over the past decade, however, the world financial system has become more complex and challenging. The Basel Committee on Banking Supervision (Basel Committee) recognizes that the 1988 Accord needs to evolve along with recent financial innovations and changes in the financial marketplace. Accordingly, the Basel Committee is working to develop a new capital adequacy framework that would enhance the 1988 Accord.

As outlined in its June 1999 consultative paper, A New Capital Adequacy Framework, the Basel Committee is contemplating substantial revisions to the 1988 Accord. [6] Among other things, the Basel Committee is exploring the concept of using sophisticated internal risk measurement systems in the development of minimum capital standards. The Basel Committee is also developing a standardized approach that proposes revisions to the risk-weight framework of the 1988 Accord which might incorporate external ratings in the assessment of a minimum capital requirement.

While the approaches contemplated in the proposed revisions to the 1988 Accord may be appropriate for some large, complex, internationally active banks, many small domestic banking organizations may not have or need the infrastructure to implement a sophisticated internal ratings-based approach to regulatory capital.

[1] The 1998 Accord was developed by the supervisory authorities represented on the Basel Committee on Banking Supervision and endorsed by the G–10 Central Bank Governors. The framework is described in a document entitled ''International Convergence of Capital Measurement'' issued in July 1998 (with subsequent amendments). The Basel Committee on Banking Supervision is comprised of representatives of the central banks and supervisory authorities from the G–10 countries (Belgium, Canada, France, Germany, Italy, Japan, Netherlands, Sweden, Switzerland, the United Kingdom, and the United States) and Luxembourg. The Agencies' risk-based capital standards implementing the 1988 Accord are set forth in 12 CFR part 3 (OCC), 12 CFR parts 208 and 225, Appendices A and E (Board), 12 CFR part 325 (FDIC) and 12 CFR part 567 (OTS).

[2] The categories are 100 percent (the standard risk weight for most claims); 50 percent (primarily for residential mortgages); 20 percent for claims on, or guarantees provided by, certain entities (for example, qualifying depository institutions); and zero percent for very low risk assets (such as claims on, or guarantees provided by, qualifying governments).

[3] Regulatory capital may be comprised of three components. In general terms, Tier 1 capital includes common stockholder's equity, qualifying noncumulative perpetual preferred stock (and for bank holding companies limited amounts of cumulative perpetual preferred stock), and minority interests in the equity accounts of consolidated subsidiaries. Tier 2 capital includes limited amounts of the allowance for loan and lease losses, perpetual preferred stock, hybrid capital instruments and mandatory convertible debt, and term subordinated debt. Tier 3 capital (available only for certain institutions that apply specific rules for market risk) consists of short-term subordinated debt subject to certain restrictions on repayment. Items deducted from regulatory capital include goodwill and certain other intangible assets, investments in unconsolidated subsidiaries, reciprocal holdings of other banking institutions' capital instruments and some deferred tax assets. At least 50 percent of regulatory capital must be Tier 1. See each agency's capital rules referenced in footnote 1 for a more complete discussion.

[4] The 1988 Accord and the implementing United States standards addressed capital in relation to credit risk. In January 1996, the 1988 Accord was amended to include a measure for market risk. The amendment was incorporated into FRB, FDIC, and OCC standards in September 1996.

[5] Leverage guidlines for each agency are located at 12 CFR part 3 (OCC); 12 CFR part 208, Appendix B and 12 CFR part 225, Appendix D (Board); 12 CFR part 325 (FDIC); and 12 CFR part 567 (OTS).

[6] The Basel Committee consultative document was issued on June 3, 1999. Comment was requeted through March 2000. The document is available through the Bank for International Settlements website at www.bis.org.

Regardless of what revisions are made to the 1988 Accord, however, given the complexity of existing regulatory capital rules, a simplified capital framework could reduce regulatory burden for many institutions without compromising the principles of prudential supervision.

The Agencies wish to explore all options in the development of a regulatory framework for non-complex institutions. The following discussion outlines the Agencies' preliminary views on ways to simplify the regulatory capital framework for such institutions. The Agencies encourage comments from the industry and the public on all aspects of this advance notice of proposed rulemaking.

II. Discussion

A. Overview

This advance notice of proposed rulemaking discusses how non-complex institutions could be defined and presents three possible alternatives for measuring the regulatory capital of non-complex institutions. The Agencies believe that three key factors could serve to define a non-complex institution. These are the nature of the institution's activities, its asset size, and its risk profile. Broadly stated, a relatively small institution engaged in non-complex activities that presents a low-risk profile could be subject to a more simplified capital framework without compromising the safety and soundness of the institution or the banking system. The three broad alternatives for a simplified framework are a simple leverage ratio, a modified leverage ratio and a risk-based framework.

Question 1: Do institutions view maintenance of the current risk-based capital standards as posing undue burden for small institutions? If so, how? Would views change if the current standards were revised to make them more risk-sensitive, in line with the contemplated revisions to the 1988 Basel Accord as set forth in the June 1999 consultative paper?

Question 2: For non-complex institutions, should the Agencies maintain the current risk-based capital standards or develop a simplified capital adequacy framework? What are the advantages and disadvantages of adopting a separate framework?

B. Defining a Non-Complex Institution

The Agencies are considering the nature of a non-complex institution's activities, its asset size, and its risk profile as determinants of eligibility for the simplified capital framework. In general, the Agencies believe that a ''non-complex institution'' would possess the following characteristics:

—A relatively small asset size (e.g., consolidated assets of less than $5 billion).
—A relatively simple and low-risk balance sheet (e.g., primarily traditional, nonvolatile assets and liabilities).
—A moderate level of off-balance sheet activity that is compatible with core business activities (e.g., commitments, in the case of residential lenders).
—A minimal use of financial derivatives (i.e., institution uses financial derivatives solely for risk management purposes.)
—A relatively simple scope of operations and relatively little involvement in nontraditional activities as a source of income.

In this section, the Agencies describe possible criteria that could be used to determine whether an institution could be considered a non-complex institution.

Nature of Activities

Objective criteria could be used to measure the level of complexity associated with the activities conducted by domestic banking organizations. The Consolidated Reports of Condition and Income and Thrift Financial Reports (regulatory reports) provide the Agencies with information on the structure and operations of an institution. While subject to certain limitations, these data elements could provide objective support for defining a set of non-complex institutions.

The Agencies are considering using various data elements as an initial screen for determining whether a particular institution exhibits a ''complex'' profile. That is, where an institution reports a significant amount of certain data elements, the Agencies may consider the institution to be complex. Items collected within regulatory reports that could be used include: Trading assets and liabilities; interest only strips; credit derivatives—guarantor and beneficiary; foreign exchange spot contracts; other off-balance sheet assets and liabilities; foreign exchange, equity, commodity, and other derivatives; purchased mortgage servicing rights; purchased credit card relationships; structured notes; performance standby letters of credit; and interest rate derivatives. Data elements such as these could provide an initial screen for determining whether a particular institution exhibits a ''complex'' profile.

The Agencies envision using additional data elements that might become available due to revisions to regulatory reporting requirements. A concern about such screening criteria is setting an appropriate threshold level for reported activities. The number of institutions that may qualify as non-complex depends upon the threshold level set in establishing the screening criteria.

Question 3: What specific data elements should be considered in determining whether an institution is non-complex? At what level should the thresholds be set for such elements to qualify for the non-complex framework?

Question 4: What information sources other than regulatory reports are available for measuring the level of complexity of domestic banking organizations (e.g., examination reports or other supervisory information or ratings)?

Asset Size

The Agencies believe that a strong relationship exists between the asset size of an institution and its relative complexity. In general, banking organizations of larger asset size exhibit greater levels of complexity. The strength of this correlation changes with the size of the institution. For example, banking organizations with assets of less than $5 billion generally engage in less complex activities than larger banking organizations. This effect is generally more pronounced for institutions with less than $1 billion in assets. However, some smaller banking organizations are engaged in activities reflecting a high level of complexity. The Agencies are considering the extent to which asset size alone might be sufficient to determine which banking organizations may be eligible for the non-complex capital framework.

Question 5: What are the advantages and disadvantages of using asset size to determine ''complexity''? What would be a reasonable and appropriate asset size limit for banking organizations to qualify for the non-complex framework?

Question 6: Should banking organizations within a holding company be subject to an asset size limit based on an aggregate or individual institution basis?

Question 7: Should the Agencies apply a simplified framework to all non-complex institutions regardless of size?

Question 8 :Should off-balance sheet assets (e.g., securitized assets) be considered within the asset size limit? If not, why not?

Risk Profile

The Agencies are considering whether banking organizations of any size that present a higher risk profile should be

required to comply with a more sophisticated risk measurement and capital adequacy framework. A small asset size and lack of complexity do not necessarily equate to lower risk. There can be instances where a small and otherwise non-complex banking organization may be exposed to risks that warrant excluding the institution from the simplified framework.

Factors considered when assessing an institution's overall risk profile should include the level of involvement in activities that present greater degrees of credit, liquidity, market, or other risks, such as sub-prime lending activities, significant asset securitization activities, or trading activities. The issues encountered in trying to define ''high-risk'' are similar to those encountered in trying to define ''non-complex.'' Approaches could include objective measures derived from regulatory reporting data (as discussed previously) or more subjective alternatives that incorporate assessments made by supervisors in reports of examination, or some combination of objective measures and subjective assessments.

Question 9: What methods for determining a ''low-risk'' institution are reasonable and appropriate?

C. Setting a Minimum Capital Threshold for Non-Complex Institutions

While a simplified capital framework for non-complex institutions might be less burdensome, such a framework might also be less risk sensitive and flexible. For this reason, the Agencies believe that the minimum capital standard should be set at a level that more than adequately addresses the risks that may not precisely or specifically be measured and identified by the simplified framework. The minimum capital level in such a framework should be a relatively high threshold above which supervisory concerns regarding capital adequacy are minimized. Therefore, a higher minimum capital requirement may ensure that banking organizations that are exempted from the risk-sensitive measures continue to hold sufficient capital.

Setting a higher minimum capital threshold for non-complex institutions raises issues and concerns. To the greatest extent possible, the simplified framework should avoid creating regulatory arbitrage incentives vis-a-vis the risk-based capital standards. However, the minimum capital level for non-complex institutions must continue to promote safety and soundness. A higher minimum threshold in exchange for simpler standards, therefore, may be an appropriate trade-off.

One method to address these concerns is to establish a system that allows a degree of flexibility in designating an institution non-complex and subject to the simplified capital framework. For example, a non-complex institution could be allowed, but not required, to calculate its capital under the simplified framework. A non-complex institution could instead elect to use the more sophisticated, risk-based framework applicable to international or ''complex'' banking organizations. The trade-off between burden and benefit could be a determination reached by the individual institution, with appropriate supervisory oversight.

Question 10: What factors should be considered in the determination of a minimum threshold capital level for non-complex institutions? Should additional or different elements be included in the definition of capital under a non-complex framework?

Question 11: Should the institution have the option to decide whether to use the simplified framework?

D. Options for Measuring the Capital Adequacy of Non-Complex Institutions

Each option should promote safety and soundness while minimizing regulatory burden. In addition, any alternative to the existing framework would have to be compatible with PCA mandates. The Agencies have some flexibility in establishing a relevant capital measure for non-complex institutions for PCA purposes.[7] The Agencies do not foresee eliminating the leverage requirements established under the Prompt Corrective Action standards.

The alternatives set out in the following paragraphs are: (1) A risk-based ratio (that maintains a leverage requirement); (2) a leverage ratio; and (3) a modified leverage ratio that incorporates certain off-balance sheet exposures. The Agencies also recognize that the risk-based capital framework remains a viable option for non-complex institutions. The Agencies are seeking input on these and any other alternatives to measure regulatory capital commensurate with the size, structure, complexity, and risk profile of non-complex institutions. Comment is requested on the benefits and drawbacks and potential impact on banking organizations of each approach.

A Risk-Based Ratio

One alternative for a non-complex framework is a risk-based capital standard. Such a risk-based capital standard would be consistent with the principles underlying the evolving risk-based standards under discussion by the Basel Committee, but could be tailored to the size, structure, and risk profile of less complex banking organizations. For example, the risk-based approach could be based upon a modified risk-weight system that is consistent with the structure of non-complex institutions.

Potentially, such a risk-based standard for non-complex institutions could both reduce burden and set capital requirements in relation to risk. Implementation of such a system could also prove advantageous because it would not require a structural overhaul to the way banking organizations currently compute capital requirements.

A potential weakness of such an approach could be that, while striving for the dual purposes of greater simplicity and a better match between capital requirements and risk, the approach might fall short of attaining either goal. In effect, it may turn out that greater simplicity in risk-based capital measures means requirements that are less closely aligned to risk (and closer to a leverage measure).

Alternatively, finer and more accurate measurements of risk that require greater computational complexity in the determination of regulatory capital means greater regulatory burden. A key consideration in the development of a simplified framework is to strike an appropriate balance between these potentially conflicting goals.

A Leverage Ratio

Another option for a capital adequacy measure for non-complex institutions is to use only a leverage ratio. Under this alternative, non-complex institutions would no longer be required to comply with the risk-based capital framework. The leverage ratio provides a simple, straightforward measure of capital relative to total assets.

A concern is that the leverage ratio does not adequately account for off-balance sheet exposures and that a minimum capital requirement should accommodate this expanding area of banking risk. Even non-complex institutions can generate significant off-balance sheet exposures (*e.g.,* by issuing standby letters of credit, selling loans with recourse, or extending short-term loan commitments). Another weakness

[7] Section 38 of the Federal Deposit Insurance Act (12 U.S.C. 1831o) establishes PCA guidelines as they relate to capital standards. In general, the capital standards prescribed by each appropriate Federal banking agency shall include a leverage limit and a risk-based capital requirement. However, the section also states that an appropriate Federal banking agency may, by regulation, establish any additional relevant capital measures to carry out the purpose of this section, or rescind any relevant capital measure upon determining that the measure is no longer an appropriate means for carrying out the purpose of this section.

of the leverage ratio is that it does not account for the wide spectrum of credit risk and creates an incentive for the institution to avoid investing in low-risk assets.

A Modified Leverage Ratio

To address some of the concerns with the leverage ratio discussed above, it might be appropriate to consider modifying the measure to account for off-balance sheet exposures. A modified leverage ratio could incorporate the simplicity of the leverage ratio while seeking to remedy its main weaknesses. A modified leverage ratio would be a relatively simple measure—a major objective of the non-complex framework. A disadvantage of the modified leverage ratio is that, unlike the risk-based approach, it would provide no capital benefit to banking organizations that maintain a low-risk profile and might encourage institutions to invest in higher-risk assets.

The appropriate capital framework for a non-complex institution depends partly on the screening criteria chosen to assess complexity or risk. If complex or high-risk banking organizations can be effectively screened out of the non-complex category, then the benefits of a leverage-based approach will likely be enhanced. Similarly, if banking organizations with significant off-balance sheet items are screened out of the non-complex framework, then use of a modified leverage ratio (that incorporates off-balance sheet items) might be unnecessary to assure sufficient levels of regulatory capital.

Question 12: What elements of the current risk-based framework should be retained within a simplified risk-based framework? What elements should not be included?

Question 13: Should classes of assets be re-assigned to other and potentially new risk weights, based on relative comparisons of historical charge-off data or other empirical sources, including but not limited to credit ratings?

Question 14: Is a leverage ratio a sufficient method for determining capital adequacy of non-complex institutions in a range of economic conditions?

Question 15: If off-balance sheet items are incorporated into a modified leverage ratio, what items should be incorporated, and how?

Question 16: What degree of burden reduction is foreseeable regarding any of the alternatives? Do the foreseeable benefits of burden reduction outweigh any concerns about establishing a non-complex domestic framework?

E. Implementation Issues

The establishment of a simplified capital framework presents a host of implementation issues. How would banking organizations be placed within the simplified framework? Once subjected to the simplified framework, how would the institution transition to a more complex framework, if needed? Would there be a transition or adjustment period? These implementation issues can be foreseen, but not fully addressed, until a framework is determined.

Moreover, the Agencies must determine the least burdensome and most efficient manner to collect data necessary to identify the universe of non-complex institutions and to provide this information to banking organizations in a timely manner. Options include requiring the Agencies to determine which banking organizations are subject to the non-complex framework using current regulatory reports, or requiring a banking organization to seek entry into the non-complex framework by filing an application.

On an ongoing basis, a change in size, structure, complexity, or risk profile of a non-complex institution could impact its continued eligibility for the simplified framework. Institutions that were no longer deemed ''non-complex'' could be required to comply with the standards applicable to complex banking organizations or to take other remedial steps. For an institution transitioning from the non-complex framework to the complex regime, an adjustment period might be necessary to meet reporting and capital requirements.

Establishment of a process for monitoring on-going eligibility for the simplified framework should also be considered. The process used to collect and report data should not undermine burden reduction, one of the primary objectives of a non-complex framework.

Question 17: How could the non-complex capital adequacy framework be initially implemented and thereafter applied on an ongoing basis?

Question 18: Should banking organizations no longer deemed ''non-complex'' be required to comply with the otherwise applicable capital standards? What other alternatives could be made available for these banking organizations? What types of transition would be most appropriate?

III. OCC and OTS Executive Order 12866 Determination

The Comptroller of the Currency and the Director of the Office of Thrift Supervision have determined that this advance notice of proposed rulemaking does not constitute a significant regulatory action under Executive Order 12866.

Dated: October 26, 2000.

John D. Hawke, Jr.,

Comptroller of the Currency.

By order of the Board of Governors of the Federal Reserve System, October 23, 2000.

Jennifer J. Johnson,

Secretary of the Board.

By order of the Board of Directors.

Dated at Washington, DC, this 17th day of October, 2000.

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

Dated: October 19, 2000.

By the Office of Thrift Supervision.

Ellen Seidman,

Director.

[FR Doc. 00–28270 Filed 11–2–00; 8:45 am]

BILLING CODE 4810–33–P; 6210–01–P; 6714–01–P; 6720–01–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

14 CFR Part 39

[Docket No. 2000–NM–70–AD]

RIN 2120–AA64

Airworthiness Directives; Airbus Model A319, A320, and A321 Series 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 all Airbus Model A319, A320, and A321 series airplanes. This proposal would require revising the Airworthiness Limitations Section of the Instructions for Continued Airworthiness to incorporate service life limits for certain items and inspections to detect fatigue cracking, accidental damage, or corrosion in certain structures. This proposal is prompted by issuance of a revision to Airbus Industrie A319/A320/A321 Maintenance Planning Document and Airworthiness Limitation Items document, which specify new or more restrictive compliance times for structural inspection and replacement action. The actions specified by the proposed AD are intended to ensure the structural integrity of these airplanes.

DATES: Comments must be received by December 4, 2000.

ADDRESSES: Submit comments in triplicate to the Federal Aviation Administration (FAA), Transport Airplane Directorate, ANM–114, Attention: Rules Docket No. 2000–NM–70–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056. Comments may be inspected at this location between 9 a.m. and 3 p.m., Monday through Friday, except Federal holidays. Comments may be submitted via fax to (425) 227–1232. Comments may also be sent via the Internet using the following address: 9-anm-nprmcomment@faa.gov. Comments sent via fax or the Internet must contain ''Docket No. ''2000–NM–70–AD'' in the subject line and need not be submitted in triplicate. Comments sent via the Internet as attached electronic files must be formatted in Microsoft Word 97 for Windows or ASCII text.

The service information referenced in the proposed rule may be obtained from Airbus Industrie, 1 Rond Point Maurice Bellonte, 31707 Blagnac Cedex, France. This information may be examined at the FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington.

FOR FURTHER INFORMATION CONTACT: Norman B. Martenson, Manager, International Branch, ANM–116, FAA, Transport Airplane Directorate, 1601 Lind Avenue, SW., Renton, Washington 98055–4056; telephone (425) 227–2110; fax (425) 227–1149.

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.

Submit comments using the following format:

- Organize comments issue-by-issue. For example, discuss a request to change the compliance time and a request to change the service bulletin reference as two separate issues.
- For each issue, state what specific change to the proposed AD is being requested.
- Include justification (*e.g.,* reasons or data) for each request.

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 2000–NM–70–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. 2000–NM–70–AD, 1601 Lind Avenue, SW., Renton, Washington 98055–4056.

Discussion

The Direction Generale de l'Aviation Civile (DGAC), which is the airworthiness authority for France, has notified the FAA that a revision to Section 9–1 of the Airbus Industrie A319/A320/A321 Maintenance Planning Document (MRB) has been issued. That revised section provides the service life limits for certain items. In addition, a revision to Issue 3 of Airbus Industrie A319/A320/A321 Airworthiness Limitation Items (ALI) has been issued, which provides an inspection program to detect fatigue corrosion, accidental damage, and corrosion in certain structures. [The FAA refers to the information included in Section 9–1 of the MRB and Issue 3 of the ALI as the Airworthiness Limitations Sections (ALS) of the Instructions for Continued Airworthiness.] These revisions affect all Airbus Model A319, A320, and A321 series airplanes. The revisions to the MRB and ALI documents provide mandatory replacement times and structural inspection intervals approved under section 25.571 of the Joint Aviation Requirements and the Federal Aviation Regulations (14 CFR 25.571). As airplanes gain service experience, or as results of post-certification testing and evaluation are obtained, it may become necessary to add new or more restrictive life limits or structural inspections in order to ensure the continued structural integrity of the airplane.

The DGAC advises that analysis of fatigue test data has revealed that certain inspections must be performed at specific intervals to preclude fatigue cracking in certain areas of the airplane. In addition, the DGAC advises that certain service life limits must be imposed for various components on these airplanes to preclude the onset of fatigue cracking in those components. Such fatigue cracking, if not corrected, could adversely affect the structural integrity of these airplanes.

Explanation of Relevant Service Information

Airbus Industrie has issued Section 9–1, ''Life Limits/Monitored Parts,'' Revision 1, dated August 13, 1999, of Airbus Industrie A319/A320/A321 Maintenance Planning Document (MPD), Volume 1. (The service life limits of revision 20 and on of Chapter 05–11–00 of the Aircraft Maintenance Manual were moved to Section 9–1 of the MPD to provide data to enable traceability and monitoring of selected parts for the airplanes.) Airbus Industrie also issued A319/A320/A321 Airworthiness Limitation Items (ALI), AI/SE–M4/95A.0252/96, Issue 3, dated May 27, 1999, which specifies inspection procedures, thresholds, and intervals for structural significant items (SSI's). The ALI document specifies new or more restrictive inspection and replacement actions. Accomplishment of the actions specified in these documents is intended to adequately address the identified unsafe condition.

The DGAC has approved the revisions to the MPD and ALI documents in order to assure the continued airworthiness of these airplanes in France. The DGAC has not issued a corresponding airworthiness directive, although accomplishment of the new or more restrictive life limits and structural inspections contained in Section 9–1 of the MPD and in Issue 3 of the ALI documents may be considered mandatory for operators of these airplanes in France.

FAA's Conclusions

The FAA has reviewed the revisions to Section 9–1 of the MPD and Issue 3 of the ALI documents and 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. Pursuant to the bilateral airworthiness agreement, the DGAC has kept the FAA informed of the situation described above. 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. The FAA has determined that the revisions to Section 9–1 of the MPD and to Issue 3 of the ALI documents must be incorporated into the Airworthiness Limitations Section (ALS) of the Instructions for Continued Airworthiness.

Explanation of Requirements of Proposed Rule

Since an unsafe condition has been identified that is likely to exist or develop on other airplanes of the same type design registered in the United States, the proposed AD would require a revision to the ALS of the Instructions for Continued Airworthiness to incorporate inspections to detect fatigue cracking of certain Significant Structural Items (SSI's) and to revise life limits for certain equipment and various components that are specified in the previously referenced maintenance document.

Explanation of Action Taken by the FAA

In accordance with airworthiness standards requiring ''damage tolerance assessments'' for transport category airplanes (section 25.1529 of the Federal Aviation Regulations (14 CFR 25.1529), and the Appendices referenced in that section), all products certificated to comply with that section must have Instructions for Continued Airworthiness (or, for some products, maintenance manuals) that include an ALS. That section must set forth:

- Mandatory replacement times for structural components,
- Structural inspection intervals, and
- Related approved structural inspection procedures necessary to show compliance with the damage-tolerance requirements.

Compliance with the terms specified in the ALS is required by sections 43.16 (for persons maintaining products) and 91.403 (for operators) of the Federal Aviation Regulations (14 CFR 43.16 and 91.403).

In order to require compliance with these inspection intervals and life limits, the FAA must engage in rulemaking, namely the issuance of an AD. For products certificated to comply with the referenced part 25 requirements, it is within the authority of the FAA to issue an AD requiring a revision to the ALS that includes reduced life limits, or new or different structural inspection requirements. These revisions then are mandatory for operators under section 91.403(c) of the Federal Aviation Regulations (14 CFR 91.403), which prohibits operation of an airplane for which airworthiness limitations have been issued unless the inspection intervals specified in those limitations have been complied with.

After that document is revised, as required, and the AD has been fully complied with, the life limit or structural inspection change remains enforceable as a part of the airworthiness limitations. (This is analogous to AD's that require changes to the Limitations Section of the Airplane Flight Manual.)

Requiring a revision of the airworthiness limitations, rather than requiring individual inspections, is advantageous for operators because it allows them to record AD compliance status only once—at the time they make the revision—rather than after every inspection. It also has the advantage of keeping all airworthiness limitations, whether imposed by original certification or by AD, in one place within the operator's maintenance program, thereby reducing the risk of non–compliance because of oversight or confusion.

Cost Impact

The FAA estimates that 36 airplanes of U.S. registry would be affected by this proposed AD, that it would take approximately 1 work hour per airplane to accomplish the proposed actions, and that the average labor rate is $60 per work hour. Based on these figures, the cost impact of the proposed AD on U.S. operators is estimated to be $2,160, or $60 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 a substantial direct effect on the States, on the relationship between the national Government and the States, or on the distribution of power and responsibilities among the various levels of government. Therefore, it is determined that this proposal would not have federalism implications under Executive Order 13132.

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:

Airbus Industrie: Docket 2000–NM–70–AD.

Applicability: All Model A319, A320, and A321 series airplanes, 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 ensure continued structural integrity of these airplanes, accomplish the following:

Airworthiness Limitations Revision

(a) Within 30 days after the effective date of this AD, revise the Airworthiness Limitations Section (ALS) of the Instructions for Continued Airworthiness by incorporating Section 9–1, ''Life Limits/Monitored Parts,'' Revision 1, dated August 13, 1999, of the Airbus A319/A320/A321 Maintenance Planning Document, Volume 1, and Airbus Industrie A319/A320/A321 Airworthiness Limitation Items AI/SE–M4/95A.0252/96, Issue 3, dated May 27, 1999, into the ALS.

(b) Except as provided by paragraph (c) of this AD: After the actions specified in paragraph (a) of this AD have been accomplished, no alternative inspections or

inspection intervals may be approved for the structural elements specified in the document listed in paragraph (a) of this AD.

Alternative Methods of Compliance

(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, International Branch, ANM–116, FAA, Transport Airplane Directorate. Operators shall submit their requests through an appropriate FAA Principal Maintenance Inspector, who may add comments and then send it to the Manager, International Branch, ANM–116.

Note 2: Information concerning the existence of approved alternative methods of compliance with this AD, if any, may be obtained from the International Branch, ANM–114.

Special Flight Permits

(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 October 27, 2000.

Donald L. Riggin,

Acting Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 00–28092 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–P

DEPARTMENT OF EDUCATION

34 CFR Parts 75 and 350

Direct Grant Programs and Disability and Rehabilitation Research Projects and Centers Program

AGENCY: Department of Education.

ACTION: Notice of proposed rulemaking.

SUMMARY: The Secretary proposes to amend the Education Department General Administrative Regulations (EDGAR) and the regulations for the National Institute on Disability and Rehabilitation Research (NIDRR). The proposed amendments to EDGAR would revise the general selection criteria concerning project design, services, and personnel available for use in direct grant programs. Consistent with the requirements of section 427 of the General Education Provisions Act (GEPA), these amendments would focus on ensuring that discretionary grant applicants demonstrate in their applications the steps they will take to ensure equitable access to, and participation in, their federally assisted programs by members of traditionally underrepresented groups. The proposed amendment to the criterion on quality of project personnel also would add a mandatory factor measuring the extent to which the application includes effective strategies for employing and advancing in employment qualified individuals with disabilities in the proposed project, including the accessibility of the project's worksite and equipment to these individuals. The Secretary also proposes to include the latter amendment concerning project personnel in the regulations providing selection criteria for certain programs administered by the NIDRR.

DATES: We must receive your comments on or before January 2, 2001.

ADDRESSES: Address all comments about these proposed regulations to Julius C. Cotton, U.S. Department of Education, 400 Maryland Avenue, SW., room 3652, ROB–3, Washington, DC 20202–4248. If you prefer to send your comments through the Internet, use the following address: comments@ed.gov.

You must include the term ''proposed selection criteria'' in the subject line of your electronic message.

FOR FURTHER INFORMATION CONTACT: Julius C. Cotton. Telephone: (202) 708–8562. If you use a telecommunications device for the deaf (TDD), you may call the Federal Information Relay Service (FIRS) at 1–800–877–8339.

Individuals with disabilities may obtain this document in an alternative format (*e.g.*, Braille, large print, audiotape, or computer diskette) on request to the contact person listed under **FOR FURTHER INFORMATION CONTACT**.

SUPPLEMENTARY INFORMATION:

Invitation To Comment

We invite you to submit comments regarding these proposed regulations and the potential effect of the use of the proposed selection criteria in direct grant programs supported by the Department.

We invite you to assist us in complying with the specific requirements of Executive Order 12866 and its overall requirement of reducing regulatory burden that might result from these proposed regulations. Please let us know of any further opportunities we should take to reduce potential costs or increase potential benefits while preserving the effective and efficient administration of the Department's direct grant programs.

During and after the comment period, you may inspect all public comments about these proposed regulations in room 3652, ROB–3, Seventh & D Streets, SW., Washington, DC, between the hours of 8:30 a.m. and 4:00 p.m., Eastern time, Monday through Friday of each week except Federal holidays.

Assistance to Individuals With Disabilities in Reviewing the Rulemaking Record

On request, we will supply an appropriate aid, such as a reader or print magnifier, to an individual with a disability that needs assistance to review the comments or other documents in the public rulemaking record for these proposed regulations. If you want to schedule an appointment for this type of aid, you may call (202) 205–8113 or (202) 260–9895. If you use a TDD, you may call the Federal Information Relay Service at 1–800–877–8339.

Background

The Department of Education's mission is to ensure equal access to education and promote educational excellence throughout the nation. To ensure that these goals are being met in Department-funded discretionary grant programs, we are proposing several changes to the list of general selection criteria and factors in EDGAR. These EDGAR criteria and factors are used by most programs of the Department. Many programs do not have separate criteria and rely entirely on EDGAR criteria. Other programs have separate regulatory criteria. EDGAR authorizes the programs with separate criteria to use program criteria (and statutory criteria) in conjunction with the EDGAR criteria to evaluate applications. As a result, these amendments would affect most programs of the Department. We propose to amend the NIDRR regulations which do not incorporate the EDGAR provision that permits the use of both EDGAR and program criteria.

The proposed changes stem from two related departmental efforts that have the common goal of ensuring equity and excellence in Department-funded grant projects. The first effort relates to current requirements found in section 427 of the General Education Provisions Act (GEPA) (20 U.S.C. 1228a), which was enacted by Congress in 1994. Section 427 of GEPA requires that each applicant for a Department grant include in its application a description of the steps the applicant proposes to take to ensure equitable access to, and participation in, its federally assisted programs for students, teachers, and other program beneficiaries with special needs by addressing barriers to that access and participation, including barriers based on gender, race, national origin, color, disability, or age. The Secretary is prepared to provide technical assistance to applicants in connection with meeting the

requirements of section 427 of GEPA and with the selection criteria in this notice of proposed rulemaking.

Although grant applicants currently provide statements in their applications indicating how they will ensure equitable access and participation, we believe that greater emphasis should be placed on how well the applicants address the GEPA 427 requirements. Under the proposed changes, discretionary grant applicants for programs using the EDGAR list of selection criteria would be rated based on the extent to which their grant applications include an effective project design and project services for ensuring equitable access and participation. These factors also would be amended to more closely track the language in section 427 of GEPA. They would be mandatory factors under their respective criteria.

The second effort involves a similar concern relating to the diversity of project staff who carry out funded projects. Current provisions in EDGAR include—under the criterion for project personnel—a mandatory factor for considering the extent to which the applicant encourages applications for employment from persons who are members of groups that have been traditionally underrepresented. The Secretary is concerned that inadequate attention has been given by many grantees to the employment and advancement of individuals with disabilities. Therefore, this proposal would strengthen these current provisions as they relate to employment and advancement of these individuals and to the provision of accessible worksites and equipment for persons with disabilities. Section 606 of the Individuals with Disabilities Education Act (IDEA) requires the Secretary to ensure that each recipient of assistance under IDEA makes positive efforts to employ and advance in employment qualified individuals with disabilities. We believe that—in promoting excellence and equity in Department-funded projects—this is an appropriate factor to be evaluated in making competitive selections not only under IDEA, but also in other Department programs. Therefore—under the Secretary's general rulemaking authority—we are proposing that the existing criterion on quality of project personnel be amended to add a factor that focuses specifically on individuals with disabilities, consistent with the provisions in section 606 of the IDEA.

For Department programs using the revised EDGAR criterion on quality of project personnel, applicants would be rated on how well their application demonstrates effective strategies for employing and advancing in employment qualified individuals with disabilities in the proposed project. These strategies also include those for the provision of accessible worksites and equipment. In applying this criterion, the Secretary, as appropriate, would also consider the applicant's past success in employing and advancing in employment individuals with disabilities. The latter consideration would be inappropriate, for example, for a newly formed private, nonprofit organization.

Within the Office of Special Education and Rehabilitative Services, NIDRR supports specialized disability-related activities and uses selection criteria found in 34 CFR part 350 rather than the general EDGAR selection criteria. A similar factor is proposed for addition to part 350 to be used in administering NIDRR programs.

Executive Order 12866

Clarity of the Regulations

Executive Order 12866 and the President's Memorandum of June 1, 1998, on ''Plain Language in Government Writing'' require each agency to write regulations that are easy to understand.

The Secretary invites comments on how to make these proposed regulations easier to understand, including answers to questions such as the following:

- Are the requirements in the proposed regulations clearly stated?
- Do the proposed regulations contain technical terms or other wording that interferes with their clarity?
- Does the format of the proposed regulations (grouping and order of sections, use of headings, paragraphing, etc.) aid or reduce their clarity?
- Would the proposed regulations be easier to understand if we divided them into more (but shorter) sections? (A ''section'' is preceded by the symbol ''§ '' and a numbered heading; for example, *§ 75.210 General selection criteria.*)
- Could the description of the proposed regulations in the **SUPPLEMENTARY INFORMATION** section of this preamble be more helpful in making the proposed regulations easier to understand? If so, how?
- What else could we do to make the proposed regulations easier to understand?

Send any comments that concern how the Department could make these proposed regulations easier to understand to the person listed in the **ADDRESSES** section of the preamble.

Regulatory Flexibility Act Certification

The Secretary certifies that these proposed regulations would not have a significant economic impact on a substantial number of small entities. The small entities affected would be applicants for the Department's direct grant programs. The proposed regulations would not have a significant economic impact on any small entities but are expected to benefit all applicants by reducing delays in the grant award process that otherwise would be caused by rulemaking necessary to establish special selection criteria for individual competitions.

Paperwork Reduction Act of 1995

These proposed regulations do not contain any information collection requirements.

Intergovernmental Review

Some of the programs that are affected by these regulations are subject to the requirements of Executive Order 12372 and the regulations in 34 CFR part 79. One of the objectives of the Executive order is to foster an intergovernmental partnership and a strengthened federalism. The Executive order relies on processes developed by State and local governments for coordination and review of proposed Federal financial assistance.

This document provides early notification of our specific plans and actions for these programs.

Assessment of Educational Impact

The Secretary particularly requests comments on whether these proposed regulations would require transmission of information that any other agency or authority of the United States gathers or makes available.

Electronic Access to This Document

You may view this document, as well as all other Department of Education documents published in the **Federal Register**, in text or Adobe Portable Document Format (PDF) on the Internet at either of the following sites:

http://ocfo.ed.gov/fedreg.htm
http://www.ed.gov/news.html

To use PDF you must have Adobe Acrobat Reader, which is available free at either of the previous sites. If you have questions about using PDF, call the U.S. Government Printing Office (GPO); toll free, at 1–888–293–6498; or in the Washington, DC, area at (202) 512–1530.

Note: The official version of this document is the document published in the **Federal Register**. Free Internet access to the official edition of the **Federal Register** and the Code of Federal Regulations is available on GPO

Access at: http://www.access.gpo.gov/nara/index.html.

(Catalog of Federal Domestic Assistance Number 84.133 for Disability and Rehabilitation Research: General Provisions)

List of Subjects

34 CFR Part 75

Accounting, Administrative practice and procedure, Grant programs—education, Reporting and recordkeeping requirements.

34 CFR Part 350

Administrative practice and procedure, Eligibility, Grant administration.

Dated: October 26, 2000.

Richard W. Riley,

Secretary of Education.

For the reasons discussed in the preamble, the Secretary proposes to amend parts 75 and 350 of title 34 of the Code of Federal Regulations as follows:

PART 75—DIRECT GRANT PROGRAMS

1. The authority citation for part 75 continues to read as follows:

Authority: 20 U.S.C. 1221e–3 and 3474, unless otherwise noted.

2. Section 75.210 is amended as follows:

a. By revising the undesignated introductory text;

b. Redesignating paragraph (c)(2) as (c)(3);

c. Adding a new paragraph (c)(2);

d. Revising newly redesignated paragraph (c)(3) introductory text; and

e. Revising paragraphs (d)(2) and (e)(2).

The revisions and addition read as follows:

§ 75.210 General selection criteria.

In determining the selection criteria to be used in each grant competition, the Secretary may select one or more of the following criteria and may select from among the list of optional factors under each criterion. However, paragraphs (c)(2), (d)(2), and (e)(2) of this section are mandatory factors under their respective criteria:

* * * * *

(c) * * *

(2) In determining the quality of the design of the proposed project, the Secretary considers the extent to which the application proposes effective steps to eliminate barriers that may impede equitable access or participation by groups that have been traditionally underrepresented based on race, color, national origin, gender, age, or disability.

(3) In addition to paragraph (c)(2) of this section, the Secretary also considers one or more of the following factors:

* * * * *

(d) * * *

(2) In determining the quality of the services to be provided by the proposed project, the Secretary considers the quality and effectiveness of the applicant's strategies for ensuring equal access and treatment for eligible project participants who are members of groups that have been traditionally underrepresented based on race, color, national origin, gender, age, or disability, including its steps to overcome barriers to equitable participation by those eligible participants.

* * * * *

(e) * * *

(2)(i) In determining the quality of project personnel—

(A) The Secretary considers the extent to which the applicant encourages applications for employment from persons who are members of groups that have been traditionally underrepresented based on race, color, national origin, gender, or age; and

(B) The Secretary considers the extent to which an application includes effective strategies for employing and advancing in employment qualified individuals with disabilities in the proposed project, including the accessibility of the project's worksite and equipment to these individuals.

(ii) In determining the effectiveness of the strategies under paragraph (e)(2)(i)(B) of this section, the Secretary, as appropriate, considers the applicant's success, as described in the application, in employing and advancing in employment qualified individuals with disabilities.

* * * * *

PART 350—DISABILITY AND REHABILITATION RESEARCH PROJECTS AND CENTERS PROGRAM

3. The authority citation for part 350 continues to read as follows:

Authority: Sec. 204; 29 U.S.C. 761–762, unless otherwise noted.

4. Section 350.54 is amended by revising paragraph (n)(2) to read as follows:

§ 350.54 What selection criteria does the Secretary use in evaluating an application?

* * * * *

(n) * * *

(2)(i) In determining the quality of project staff—

(A) The Secretary considers the extent to which an applicant encourages applications for employment from persons who are members of groups that have been traditionally underrepresented based on race, color, national origin, gender, or age; and

(B) The Secretary considers the extent to which an application includes effective strategies for employing and advancing in employment qualified individuals with disabilities in the proposed project, including the accessibility of the project's worksite and equipment to these individuals.

(ii) In determining the effectiveness of the strategies under paragraph (n)(2)(i)(B) of this section, the Secretary, as appropriate, considers the applicant's success, as described in the application, in employing and advancing in employment qualified individuals with disabilities.

* * * * *

[FR Doc. 00–27991 Filed 11–2–00; 8:45 am]

BILLING CODE 4000–01–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 52

[CA 241–0244b; FRL–6893–2]

Approval and Promulgation of State Implementation Plans; California State Implementation Plan Revision, Antelope Valley Air Pollution Control District

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule.

SUMMARY: EPA is proposing to approve revisions to the California State Implementation Plan (SIP) for the Antelope Valley Air Pollution Control District (AVAPCD). The revisions concern the recission and associated negative declarations for one volatile organic compound source category and one oxides of nitrogen source category for the Antelope Valley Air Pollution Control District (AVAPCD).

The intended effect of this action is to bring the AVAPCD SIP up to date in accordance with the requirements of the Clean Air Act, as amended in 1990 (CAA or the Act). EPA is finalizing the approval of these recissions and associated negative declarations from the California SIP under provisions of the CAA regarding EPA action on SIP submittals, SIPs for national primary and secondary ambient air quality standards and plan requirements for nonattainment areas. EPA is approving these revisions in accordance with the requirements of the CAA.

DATES: Comments must arrive by December 4, 2000.

ADDRESSES: Mail comments to: Andrew Steckel, Chief, Rulemaking Office (AIR–4), Air Division, U.S. Environmental Protection Agency, Region IX, 75 Hawthorne Street, San Francisco, CA 94105–3901.

You can inspect copies of the submitted SIP revisions and EPA's technical support documents (TSDs) at our Region IX office during normal business hours. You may also see copies of the submitted SIP revisions at the following locations:

California Air Resources Board, Stationary Source Division, Rule Evaluation Section, 2020 ''L'' Street, Sacramento, CA 95812.

Antelope Valley Air Pollution Control District, 43301 Division Street, Suite 206, Lancaster, CA 93539–4409.

FOR FURTHER INFORMATION CONTACT: Julie A. Rose, Rulemaking Office, AIR–4, Air Division, U.S. Environmental Protection Agency, Region 9, 75 Hawthorne Street, San Francisco, CA 94105–3901, telephone: (415) 744–1184.

SUPPLEMENTARY INFORMATION: The rules being approved for recission and the negative declarations being approved for the Antelope Valley Air Pollution Control District (AVAPCD) portion of the California SIP are listed in the following Table:

SUBMITTED RECISSIONS AND NEGATIVE DECLARATIONS

Rule No. and title	Adoption date	Submittal date	Type of revision
1103, Pharmaceuticals and Cosmetic Manufacturing Operations	01–18–00	03–28–00	Recission and Negative Declaration.
1159, Nitric Acid Units—Oxides of Nitrogen	01–18–00	03–28–00	Recission and Negative Declaration.

In the Final Rules section of this **Federal Register**, the EPA is approving the state's SIP submittal as a direct final rule without prior proposal because the Agency views this as a noncontroversial revision and anticipates no adverse comments.

A detailed rationale for this approval is set forth in the direct final rule. If no adverse comments are received, no further activity is contemplated. If 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. Any parties interested in commenting should do so at this time.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: October 4, 2000.

Felicia Marcus,

Regional Administrator, Region IX.

[FR Doc. 00–27660 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–U

FEDERAL EMERGENCY MANAGEMENT AGENCY

44 CFR Part 67

[Docket No. FEMA–B–7401]

Proposed Flood Elevation Determinations

AGENCY: Federal Emergency Management Agency (FEMA).

ACTION: Proposed rule.

SUMMARY: Technical information or comments are requested on the proposed base (1-percent-annual-chance) flood elevations and proposed base flood elevation modifications for the communities listed below. The base flood elevations and modified base flood elevations are the basis for the floodplain management measures that the community is required either to adopt or to show evidence of being already in effect in order to qualify or remain qualified for participation in the National Flood Insurance Program (NFIP).

DATES: The comment period is ninety (90) days following the second publication of this proposed rule in a newspaper of local circulation in each community.

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

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

SUPPLEMENTARY INFORMATION: The Federal Emergency Management Agency proposes to make determinations of base flood elevations and modified base flood elevations for each community listed below, in accordance with Section 110 of the Flood Disaster Protection Act of 1973, 42 U.S.C. 4104, and 44 CFR 67.4(a).

These proposed base flood and modified base flood elevations, together with the floodplain management criteria required by 44 CFR 60.3, are the minimum that are required. They should not be construed to mean that the community must change any existing ordinances that are more stringent in their floodplain management requirements. The community may at any time enact stricter requirements of its own, or pursuant to policies established by other Federal, State, or regional entities. These proposed elevations are used to meet the floodplain management requirements of the NFIP and are also used to calculate the appropriate flood insurance premium rates for new buildings built after these elevations are made final, and for the contents in these buildings.

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

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

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

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

Executive Order 12778, Civil Justice Reform. This proposed rule meets the applicable standards of Section 2(b)(2) of Executive Order 12778.

List of Subjects in 44 CFR Part 67

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

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

PART 67—[AMENDED]

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

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

§ 67.4 [Amended]

2. The tables published under the authority of § 67.4 are proposed to be amended as follows:

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
California	Solano County (Unincorporated Areas).	Gibson Canyon Creek	Approximately 2,250 feet downstream of Byrnes Road.	None	*69
			Approximately 100 feet upstream of Browns Valley Road.	None	*143
		South Branch Gibson Canyon Creek.	Just downstream of Crocker Drive	*103	*102
			Just upstream of Browns Valley Road	*137	*142
		Horse Creek	Approximately 500 feet downstream of Willow Avenue.	None	*77
			Approximately 1,500 feet upstream of Willow Avenue.	None	*79
Maps are available for inspection at the Solano County Department of Environmental Management, 601 W. Texas Street, Fairfield, California. Send comments to The Honorable Michael Johnson, County Manger, 580 W. Texas Street, Fairfield California, 94533.					
California	Vacaville (City) Solano County.	Gibson Canyon Creek	Approximately 2,100 feet downstream of Interstate Highway 80 (Eastbound).	*76	*78
			Approximately 1,200 feet upstream of Eubanks Road.	None	*113
		South Branch Gibson Canyon Creek.	At confluence with Gibson Canyon Creek	*98	*98
			At intersection with Interstate Highway 505.	*104	*103
			Approximately 500 feet upstream of Eubanks Road.	*117	*121
		Horse Creek	Approximately 800 feet downstream of Leisure Town Road.	*80	*82
			Approximately 2,000 feet upstream of Sewer Maintenance Road.	*134	*137
		Middle Branch Horse Creek.	Just upstream of Interstate Highway 80	*90	*91
			Approximately 2,200 feet upstream of Interstate Highway 505.	None	*112
		Pine Tree Creek	At confluence with Horse Creek	*98	*97
			At upstream side of Putah South Canal	*114	*122
			Just downstream of Browns Valley Road	*136	*136
			At Browns Valley Road Crossing of Southern Pacific Railroad.	#3	#2
		South Branch Horse Creek.	At confluence with Horse Creek	*119	*114
			Just downstream of Southern Pacific Railroad.	132	*134
			Just downstream of Sundance Drive	*134	#2
		Middle Swale to South Branch.	At confluence with South Branch Horse Creek.	*120	*122
		Horse Creek	Just downstream of Southern Pacific Railroad.	*133	*131
			Just upstream of Southern Pacific Railroad.	None	#1
		North Branch Horse Creek	At confluence with Horse Creek	None	*83
			At downstream side of Interstate Highway 80.	None	*88
		Pine Tree Creek Split	At convergence with Pine Tree Creek	None	*122
			Approximately 1,100 feet upstream of convergence with Pine Tree Creek.	None	*125
Maps are available for inspection at the Vacaville City Hall, 650 Merchant Street, Vacaville, California. Send comments to The Honorable David Fleming, Mayor, City of Vacaville, 650 Merchant Street, Vacaville, California 95688.					
Colorado	Durango (City) La Plata County.	Animas River	Approximately 0.67 mile downstream of U.S. Highway 155/160.	None	*6,375

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
			Approximately 3.56 miles upstream of 32nd Street.	None	*6,551
		Dry Gulch	Approximately 1,500 Feet upstream of confluence with Junction Creek.	*6,626	*6,628
			Approximately 5,670 feet upstream of Borrego Drive.	None	*6,873
		Lightner Creek	At confluence with Animas River	None	*6,485
			Approximately 1,800 feet upstream of confluence with Animas River.	None	*6,513
Maps are available for inspection at the Planning Department, 1235 Camino Del Rio, Durango, Colorado.					
Send comments to The Honorable Joe Golgan, Mayor, City of Durango, 949 E. 2nd Avenue, Durango, Colorado 81301.					
Colorado	La Plata County (Unincorporated Areas).	Animas River	Approximately 2.09 miles downstream of U.S. Highway 155/160.	None	*6,337
			Approximately 2.8 miles upstream of 32nd Street.	*6,550	*6,548
			Approximately 3.56 miles upstream of 32nd Street.	*6,551	*6,551
		Lightner Creek	At confluence with Animas River	*6,485	*6,484
			Approximately 3,525 feet upstream of U.S. Highway 160.	*6,703	*6,699
Maps are available for inspection at the Building Department, 1060 E. 2nd Avenue, Durango, Colorado.					
Send comments to The Honorable Frank Joswick, Chairman, La Plata County Board of Commissioners, 1060 E. 2nd Avenue, Durango, Colorado 81301.					
Iowa	Monona County and Incorporated Areas.	Missouri River	Approximately 5.3 miles Downstream of the McCandless Cleghorn outlet.	None	*1,032
			Approximately 17.9 miles upstream of Iowa Highway 175.	None	*1,065
		McCandless Cleghorn Drainage Ditch.	At its confluence with the Missouri River	None	*1.039
			At County Highway 45	None	*1.063
Maps are available for inspection at the Monona County Zoning Office, 610 Iowa Avenue, Onawa, Iowa.					
Send comments to The Honorable Neil Gorham, Chairman, Monona County Board of Supervisors, 610 Iowa Avenue, Onawa, Iowa 51040.					
Maps are available for inspection at Whiting City Hall, 605 Whittier Street, Whiting, Iowa.					
Send comments to The Honorable Jerry Rowe, Mayor, City of Whiting, City Hall, 605 Whittier Street, Whiting, Iowa 51063.					
Kansas	Andover (City) (Butler County).	Four Mile Creek	Approximately 12.9 miles upstream of confluence with Walnut River.	*1,275	*1,266
			Approximately 17.5 miles upstream of confluence with Walnut River.	*1,289	*1,288
		Four Mile Creek Tributary	Just upstream of 110th Street	None	*1,287
			Approximately 9,850 feet upstream of confluence with Four Mile Creek.	None	*1,312
		Republican Creek	At approximately 1.3 miles upstream of confluence with Four Mile Creek.	*1,267	*1,266
			At downstream side of Andover Road	None	*1,338
		Republican Creek Tributary.	Approximately 1,900 feet downstream of U.S. Highway 54.	None	*1,290
			Just upstream of U.S. Highway 54	None	*1,300
		North Tributary of Republican Creek.	Approximately 500 feet downstream of Andover Road.	None	*1,341
			Just upstream of Andover Road	None	*1,343
		Terradyne Fork	Approximately 2,500 feet upstream of confluence with Four Mile Creek.	None	*1,320
			Approximately 7,300 feet upstream of confluence with Four Mile Creek.	None	*1,348
Maps are available at City Hall, 909 North Alexander Road, Andover, Kansas.					
Send comments to The Honorable Dennis L. Bush, Mayor, City of Andover, P.O. Box 295, Andover, Kansas 67002.					
Kansas	Augusta (City) (Butler County).	Elm Creek (above Augusta Lake.	At mouth at Augusta Lake	None	*1,263
			Approximately 1,900 feet upstream of Augusta Lake Road.	None	*1,269

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
Maps are available at City Hall, 116 East Sixth Street, Augusta, Kansas.					
Send comments to The Honorable Ross Rountree, Mayor, City of Augusta, P.O. Box 489, Augusta, Kansas 67010.					
Kansas	Butler County (Unincorporated Areas).	Constant Creek	At confluence with Walnut River	*1,270	*1,270
			Just upstream of Atchison, Topeka, and Sante Fe Raiway.	*1,274	*1,278
			At downstream side of Interstate Highway 35/Kansas Turnpike.	None	*1,335
		Dry Creek	At mouth of Sante Fe Lake north Limits	None	*1,275
			Approximately 250 feet downstream of Interstate Highway 35/Kansas Turnpike.	None	*1,294
		Dry Creek Tributary	At confluence with Dry Creek	None	*1,280
			At downstream limit of Interstate Highway 35/Kansas Turnpike.	None	*1,302
		East Tributary to Eight Mile Creek.	At confluence with Eight Mile Creek	None	*1,267
			Approximately 3,600 feet upstream of confluence to East Tributary to Eight Mile Creek.	None	*1,313
		Tributary to East Tributary to Eight Mile Creek.	At confluence with East Tributary to Eight Mile Creek.	None	*1,296
			Approximately 3,000 feet upsteam of confluence with East Tributary to Eight Mile Creek.	None	*1,307
		West Tributary to Eight Mile Creek.	At confluence with Eight Mile Creek	None	*1,288
			Approximately 6,250 feet upstream of 160th Street.	None	*1,311
		Tributary to West Tributary to Eight Mile Creek.	At confluence with West Tributary to Eight Mile Creek.	None	*1,294
			Approximately 1,500 feet upstream of 160th Street.	None	*1,311
		Elm Creek (above Augusta Lake).	Approximately 1,700 feet downstream of 70th Street (County Road 614).	None	*1,269
			Approximately 200 feet downstream of 40th Street (County Road 608).	None	*1,326
		Elm Creek—Tributary A	At confluence with Elm Creek	None	*1,316
			Approximately 2,400 feet upstream of confluence with Elm Creek.	None	*1,320
		Elm Creek—Tributary B	At confluence with Elm Creek	None	*1,309
			Approximately 150 feet upstream of Shumway Road.	None	*1,329
		Elm Creek Tributary C	At confluence with Elm Creek Tributary B	None	*1,312
			Approximately 4,800 feet upstream of Shumway Road.	None	*1,340
		Four Mile Creek	Approximately 12 miles upstream of confluence with Walnut River.	*1,263	*1,263
			Approximately 13.5 miles upstream of confluence with Walnut River.	*1,271	*1,270
			Approximately 900 feet upstream of 110th Street.	*1,290	*1,289
		Four Mile Creek Tributary	At confluence with Four Mile Creek	None	*1,283
			Approximately 3,000 feet upstream of confluence with Four Mile Creek.	None	*1,285
		Republican Creek	At confluence with Four Mile Creek	*1,261	*1,262
			Approximately 1,000 feet downstream of Andover Road.	None	*1,336
		Republican Creek Tributary.	At confluence with Republican Creek	None	*1,273
			Approximately 200 feet upstream of 90th Street.	None	*1,314
		North Tributary to Republican Creek.	Just upstream of Andover Road	None	*1,343
		Repubilcan Creek	Approximately 3,000 feet upstream of Andover Road.	None	*1,354
		Tributary to Santa Fe Lake	At Santa Fe Lake	None	*1,276

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
			Approximately 100 feet upstream of County Road 612.	None	*1,314
Maps are available at 205 West Central, Third Floor, El Dorado, Kansas.					
Send comments to the Honorable Randall Doll, Chairman, Butler County Board of Commissioners, 205 West Central, Fourth Floor, El Dorado, Kansas 67042.					
Kansas	Chanute (City) Neosho County.	Second Street Channel	Approximately 440 feet downstream of Katy Road.	*917	*917
			At Highland Avenue	*926	*924
			Approximately 60 feet upstream of Wilson Avenue.	None	*964
Maps are available for inspection at the Engineering Department, Memorial Building, 101 S. Lincoln, Chanute, Kansas.					
Send comments to the Honorable Ed Cox, Mayor, P.O. Box 907, Chanute, Kansas 66720.					
	Douglas County (Incorporated Areas).	Atchison, Topeka, and Santa Fe Tributary (Douglas County).	Approximately 300 feet upstream of County Road 1550 North.	*817	+821
			Approximately 1,300 feet upstream of Atchison, Topeka, and Santa Fe Railway.	*826	+827
		Atchison, Topeka, and Santa Fe Tributary (City of Lawrence).	Approximately 1,300 feet upstream of Atchison, Topeka, and Santa Fe Railway.	*826	+827
			Just upstream of 13th Street	*830	+831
			Approximately 600 feet upstream of Leanard Street.	*861	+855
		Baldwin Creek (Douglas County).	Approximately 2,500 feet upstream of County Road 900 East.	*921	+922
			Just downstream of County Road 1800 North.	*839	+840
			Just upstream of County Road 100 East	*869	+870
		Baldwin Creek Tributary (Douglas County).	Approximately 300 feet downstream of County Road 975 East.	*884	+885
			Approximately 400 feet upstream of County Road 975 East.	*930	+931
		Belle Haven Tributary (Douglas County).	Approximately 300 feet downstream of West 29th Terrace.	N/A	+826
		Belle Haven Tributary (City of Lawrence).	Approximately 300 feet downstream of West 29th Terrace.	N/A	+826
			Approximately 500 feet upstream of West 29th Terrace.	*830	+829
			Approximately 350 feet upstream of West 27th Terrace.	*838	+836
		Broken Arrow Tributary (City of Lawrence).	Approximately 1,850 feet downstream of Private Drive.	*826	+825
			Approximately 1,300 feet upstream of Private Drive.	*846	+847
		Brook Street Tributary (City of Lawrence).	Just downstream of 13th Street	*829	+827
			Approximately 1,100 feet upstream of 15th Street.	*844	+843
		Coal Creek (Douglas County).	Approximately 400 feet downstream of County Road 1100 North.	*820	+817
			Just downstream of County Road 700 North.	*859	+860
			Approximately 1,900 feet upstream of County Road 600 North.	*883	+884
		Coon Creek (Douglas County).	Approximately 200 feet downstream of West Woodson Avenue.	N/A	+855
		Coon Creek (City of Lecompton).	Approximately 200 feet downstream of West Woodson Avenue.	N/A	+855
		County Club—Hope Plaza Tributary (Douglas County).	Just downstream of Michigan Street	N/A	+830
		County Club—Hope Plaza Tributary (City of Lawrence).	Approximately 850 feet upstream of Complex Road.	*833	+834
		Deerfield Tributary (Douglas County).	Just upstream of Kasold Drive	*859	+856

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
			Approximately 1,100 feet upstream of Kansas Turnpike.	*859	+857
		Deerfield Tributary (City of Lawrence).	Approximately 1,100 feet upstream of Kansas Turnpike.	+859	*857
			Just downstream of Princeton Boulevard	*881	+883
		Eudora East Tributary (Douglas County).	Approximately 80 feet upstream of 10th Street.	*837	+840
			Approximately 1,300 feet upstream of Private Access Road.	*841	+841
			Approximately 2,800 feet upstream of the Corporate Limit line with the City of Eudora.	*864	+864
		Eudora East Tributary (City of Eudora).	Approximately 650 feet upstream of Atchison, Topeka, and Santa Fe Railway.	*N/A	+810
			Approximately 80 feet upstream of 10th Street.	*837	+840
			Approximately 1,100 feet upstream of Private Access Road.	*N/A	+840
		Eudora Middle Tributary (Douglas County).	Just downstream of Atchison, Topeka, and Santa Fe Railway.	*806	+807
		Eudora Middle Tributary (City of Eudora).	Approximately 100 feet upstream of Atchison, Topeka, and Santa Fe Railway.	*807	+814
			Just downstream of 10th Street	*819	+824
			Approximately 800 feet upstream of 12th Street.	*837	+837
		Haskell Tributary (City of Lawrence).	Approximately 150 feet upstream of downstream limit of detailed study.	*826	+823
			Approximately 100 downstream of the upstream limit of detailed study.	*837	+834
		Hidden Valley Tributary (Douglas County).	Just downstream of County Road 1350 North.	*834	+837
			Just downstream of 23rd Street	*849	+850
			Approximately 3,000 feet upstream of 23rd Street.	*877	N/A
		Hidden Valley Tributary (City of Lawrence).	Just downstream of County Road 1350 North.	*834	+837
			Just upstream of 23rd Street	*N/A	+851
			Approximately 3,000 feet upstream of 23rd Street.	*N/A	+871
		Kansas River (City of Lawrence).	Approximately 5,500 feet upstream of confluence of Atchison, Topeka, and Santa Fe Railway Tributary.	*820	+820
			Approximately 200 feet downstream of North 2nd Street.	*826	+827
			Approximately 6,500 feet upstream of the confluence of Balwin Creek.	*836	+837
		Kansas River (Douglas County).	Just downstream of County Road 2172 East.	*805	+807
			Approximately 5,500 feet upstream of confluence of Atchison, Topeka, and Santa Fe Railway Tributary.	*820	+820
			Approximately 6,500 feet upstream of the confluence of Baldwin Creek.	*836	+837
			Approximately 3,500 feet upstream of Eisenhower Memorial Drive.	*849	+848
			Approximately 300 feet downstream of Douglas County/Shawnee County Line.	*862	+861
		Kansas River (City of Lecompton).	Approximately 3,500 feet upstream of Eisenhower Memorial Drive.	*849	+848
		Kanwaka Tributary (Douglas County).	Just downstream of Private Drive	*923	+930
			Approximately 4,500 feet upstream of Private Drive.	*996	+1,000
		KLWN Tributary (City of Lawrence).	Approximately 2,400 feet downstream of West 31st Street.	*832	+833
			Just downstream of 31st Street	*842	+843
			Approximately 2,250 feet upstream of West 31st Street.	*863	+862

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
		Little Wakarusa Creek (Douglas County).	Approximately 200 feet downstream of County Road 2000 East.	*810	+812
			Approximately 10,500 feet upstream of County Road 2000 East.	*815	+814
		Maple Grove Drainage (Douglas County).	Approximately 2,350 feet downstream of Union Pacific Railroad.	*814	+811
		Maple Grove Drainage (City of Lawrence).	Approximately 450 upstream of North 9th Street.	*819	+820
		Maple Grove Drainage West Fork (Douglas County).	Approximately 1,700 feet upstream of Union Pacific Railroad.	*824	+823
			Just upstream of County Road 1400 East	*826	+824
		Naismith Creek (Douglas County).	Approximately 2,600 feet upstream of 31st Street.	*828	+826
		Naismith Creek (City of Lawrence).	Approximately 1,500 feet downstream of West 27th Street.	*829	+830
			Approximately 500 feet downstream of West 23rd Street.	*847	+848
			Just upstream of 21st Street	*864	+865
		North Spring Creek (Douglas County).	Approximately 2,500 feet upstream of County Road 1275 North.	*810	+813
		Pleasant Grove East Tributary (Douglas County).	Approximately 2,000 feet downstream of County Road 1100 North.	*829	+830
			Just downstream of County Road 1400 East.	*847	+850
			Approximately 500 feet downstream of County Road 1000 North.	*879	+878
		Pleasant Grove West Tributary (Douglas County).	Approximately 2,400 feet downstream of County Road 1100 North.	*829	+830
			Just downstream of County Road 1300 East.	*874	+876
			Approximately 1,650 feet upstream of County Road 1300 East.	*930	+931
		Pleasant Valley Tributary (Douglas County).	Approximately 850 feet downstream of County Road 1300 East.	*829	+830
			Just upstream of County Road 1100 North.	*844	+845
			Just downstream of County Road 1200 East.	*884	+894
		Quail Creek (Douglas County).	Approximately 2,200 feet upstream of confluence with Yankee Tank Creek.	*834	N/A
		Quail Creek (City of Lawrence).	Just downstream of Brush Creek Drive ...	*839	+840
			Approximately 350 downstream of Quail Creek Drive.	*866	+871
			Approximately 1,000 feet upstream of Quail Creek Drive.	*881	+880
		Tauy Creek East Fork (Douglas County).	Approximately 4,450 downstream of County Road 150 North.	*978	+978
			Just downstream of County Road 200 North.	**996	+996
			Approximately 1,900 feet downstream of High Street.	N/A	+1,003
			Just Upstream of Highway 56	**1,025	+1,030
			Approximately 450 feet upstream of County Road 1700 East.	**1,055	+1,055
		Tauy Creek East Fork (City of Baldwin).	Just upstream of County Road 200 North	N/A	+997
			Just downstream of Highway 56	**1,021	+1,022
			Approximately 450 feet upstream of County Road 1700 East.	N/A	+1,069
			Approximately 1,900 feet upstream of County Road 1700 East.	N/A	+1,055
		Tauy Creek East Fork Tributary (Douglas County).	At the confluence with Tauy Creek East Fork.	**987	+988
			Approximately 750 feet downstream of 6th Street.	**994	+995

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
		Tauy Creek East Fork Trituary (City of Baldwin).	Approximately 750 feet downstream of 6th Street.	**994	+995
			Approximately 250 feet upstream of Chapel Street.	**1,042	+1,043
		Tauy Creek East Fork Tributary A (City of Baldwin).	Approximately 150 feet downstream of 3rd Street.	**1,022	+1,019
			Approximately 200 feet upstream of 1st Street.	**1,042	+1,042
		Tauy Creek East Fork Tribuary B (City of Baldwin).	Approximately 1,000 feet downstream of 3rd Street.	**1,004	+1,004
			Just downstream of 3rd Street	**1,019	+1,020
		Tauy Creek East Fork Tributary C (City of Baldwin).	Approximately 1,250 feet downstream of 3rd Street.	**1,007	+1,007
			Approximately 400 feet upstream of High Street.	**1,035	+1,037
		Vinland Creek (Douglas County).	Approximately 3,500 feet downstream of County Road 790 North.	*839	+838
			Just upstream of County Road 700 North	*862	+864
		Vinland Creek West Fork (Douglas County).	Just downstream of County Road 1650 East.	*858	+862
			Just upstream of County Road 1600 East	*885	+888
		Wakarusa River (Douglas County).	Just downstream of County Road 2172 East.	*805	+807
			Just upstream of Atchison, Topeka, and Santa Fe Railway.	*807	+808
			Just upstream of County Road 1900 East	*812	+813
			Approximately 1,300 feet upstream of County Road 1750 East.	*818	+815
			Approximately 3,000 feet upstream of U.S. Highway 59.	*830	+829
			Approximately 3,000 feet upstream of County Road 1150 East.	*834	+833
		Wakarusa River (City of Eudora).	Just downstream of County Road 2172 East.	*805	+807
			Just upstream of Atchison, Topeka, and Santa Fe Railway.	*807	+808
		Wakarusa River (left overbank flow) (Douglas County).	Approximately 200 feet downstream of Haskell Avenue.	*824	+818
			Approximately 1,300 feet upstream of County Road 1750 East.	*818	+814
			Approximately 200 feet upstream of County Road 1400 East.	*828	+823
		Wakarusa River (left overbank flow) (City of Lawrence).	Approximately 200 feet downstream of Haskell Avenue.	*824	+818
	Douglas County (Incorporated Areas).	Washington Creek (Douglas County).	Just upstream of County Road 1200 East	*833	+836
			Approximately 3800 feet upstream of County Road 1075 North.	*845	+846
			Just upstream of County Road 650 East	*905	+908
		Washington Creek Tributary (Douglas County).	Approximately 850 feet downstream of County Road 1075 North.	*837	+842
			Approximately 200 feet downstream of Private Road.	*860	+858
			Approximately 2,600 feet upstream of County Road 900 North.	*879	+878
		Yankee Tank Creek (Douglas County).	Approximately 500 feet downstream of Kasold Drive.	*832	+831
		Yankee Tank Creek East Branch (City of Lawrence).	Approximately 1,650 feet upstream of Kasold Drive.	*838	+837
			Just downstream of Highway 10	*851	+850
			Approximately 400 feet downstream of West 15th Street.	*883	+881

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
		Yankee Tank Creek West Branch (Douglas County).	Approximately 4,700 feet downstream of South Lawrence Trafficway.	N/A	+834
			Approximately 600 feet upstream of South Lawrence Trafficway.	*842	+843
		Yankee Tank Creek West Branch (City of Lawrence).	Approximately 4,700 feet downstream of South Lawrence Trafficway.	N/A	+834
Maps are available for inspection at the Douglas County Department of Public Works, 1242 Massachusetts Street, Lawrence, Kansas.					
Send comments to the Honorable Craig Weinaug, Douglas County Administrator, County Courthouse, 1100 Massachusetts Street, Lawrence, Kansas 66044.					
Maps are available for inspection at the City of Lawrence Planning Department, 6 East Sixth Street, Lawrence, Kansas.					
Send comments to the Honorable James R. Henry, Mayor, City of Lawrence, P.O. Box 708, Lawrence, Kansas 66044.					
Maps are available for inspection at the City of Lecompton City Hall, 333 Elmore Street, Lecompton, Kansas.					
Send comments to the Honorable Jeff Goodrick, Mayor, City of Lecompton, P.O. Box 100, Lecompton, Kansas 66050.					
Maps are available for inspection at the City of Eudora City Hall, 4 East Seventh Street, Eudora, Kansas.					
Send comments to the Honorable Fred Stewart, Mayor, City of Eudora, P.O. Box 650, Eudora, Kansas 66025.					
Maps are available for inspection at City of Baldwin City Hall, 803 Eighth Street, Baldwin, Kansas.					
Send comments to the Honorable Stan Krysztof, Mayor, City of Baldwin, P.O. Box 86, Baldwin, Kansas 66006.					
	El Dorado (City) (Butler County).	Constant Creek	Approximately 350 feet downstream of Sunset Road.	*1,276	$1,280
			Just downstream of Central Avenue	*1,313	*1,311
			Approximately 700 feet upstream of 6th Street.	*1,328	*1,328
Maps are available at 220 East First Street, El Dorado, Kansas.					
Send comments to the Honorable Susan Seeber, Mayor, City of El Dorado, 220 East First Street, El Dorado, Kansas 67042.					
Kansas	Manhattan (City) Riley County.	Kansas River	Approximately 3,600 feet downstream of State Highway 177.	*1,012	*1,013
			Approximately 2,000 feet downstream of State Highway 177 (at County Boundary).	*1,014	*1,015
			Approximately 1,600 feet upstream of State Highway 177.	*1,018	*1,018
		Wildcat Creek	Just downstream of the Union Pacific Railroad.	*1,020	*1,020
			Just upstream of K–18 Highway	*1,020	*1,025
			Approximately 9,200 feet upstream of confluence with Little Kitten Creek.	None	*1,060
		Little Kitten Creek	Approximately 1,750 feet above confluence with Wildcat Creek.	None	*1,055
			Approximately 3,700 feet upstream of Kimball Avenue.	None	*1,144
		Virginia-Nevada Tributary	At confluence with Wildcat Creek	*1,036	*1,038
			At upstream side of Dickens Avenue	*1,066	*1,068
		CI–CO Tributary	At Anderson Avenue	None	*1,051
			Approximately 1,560 feet upstream of Clafin Road.	*1,077	*1,076
Maps are available for inspection at the Community Development Office, 1101 Poyntz Avenue, Manhattan, Kansas.					
Send comments to The Honorable Roger Reitz, Mayor, City of Manhattan, 1101 Poyntz Avenue, Manhattan, Kansas, 66502–5497.					
Kansas	Riley County (Unincorporated Areas).	Kansas River	At downstream county boundary	*990	*990
			Approximately 5,700 feet upstream of confluence with Big Blue River.	*1,012	*1,013
			Approximately 11,800 feet downstream of the confluence Dry Branch.	*1,040	*1,041
			Approximately 1,000 feet downstream of State Highway 18.	*1,048	*1,048
		Wildcat Creek	At confluence with Kansas River	*1,020	*1,019
			Approximately 4,600 feet upstream of confluence with Little Kitten Creek.	*1,056	*1,055
			Approximately 1,000 feet downstream of North Scenic Drive.	*1,062	*1,062
		Little Kitten Creek	At confluence with Wildcat Creek	*1,050	*1,051

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
			Just downstream of Anderson Avenue	*1,060	*1,061
		Eureka Valley Tributary	At confluence with Sevenmile Creek	*1,034	*1,034
			Approximately 300 feet upstream of State Highway 18.	1,038	*1,037
			Just downstream of Wildcat Creek Road	*1,074	*1,073
		CI–CO Tributary	At confluence with Wildcat Creek	None	*1,045
			Just upstream of Missouri, Kansas, and Texas Railroad.	None	*1,051
Maps are available for inspection at the Riley County Planning and Zoning Office, 110 Courthouse Plaza, Manhattan, Kansas.					
Send comments to The Honorable Jim Williams, Chairman, Riley County Board of Commissioners, 110 Courthouse Plaza, Manhattan, Kansas 66502.					
New Mexico	Dona Ana County (Unicorporated Areas).	Sanhill Arroyo	At Dona Ana Drain	None	*3,909
			Approximately 1,360 feet upstream of Thurmand Road.	None	*4,336
			At Intersection of McGuffey Street and Northgate Road.	None	#2
			At Intersection of McGuffey Road and Benavidez Road.	None	*4,340
			At intersection of Mesa Grande Drive and Answer Drive.	None	#3
Maps are available for inspection at the Dona Ana Flood Commission, 430 South Main, Dona Ana Annex, Las Cruces, New Mexico.					
Send comments to The Honorable Carlos Garza, Chairman, Dona Ana County Board of Commissioners, 180 West Amador Avenue, Las Cruces, New Mexico 88001.					
Nex Mexico	Las Cruces (City) Dona Ana County.	Sandhill Arroyo	Approximately 1,650 feet downstream of Elks Road.	*3,974	*3,977
			Approximately 1,060 feet downstream of Thurmand Road.	None	*4,316
			At intersection of Village Drive and Central Avenue.	None	#2
Maps are available for inspection at City Engineering Department, 575 South Alameda Boulevard, Las Cruces, New Mexico.					
Send comments to The Honorable Rubin A. Smith, Mayor, City of Las Cruces, P.O. Box 2000, Las Cruces, New Mexico 88004.					
New Mexico	Lovington (City) Lea County.	Main Street Ditch	Just upstream of County Road	None	*3,890
			Just downstream of Jefferson Avenue	None	*3,917
		Railroad Ditch	Approximately 5,450 feet downstream of confluence with Railroad Ditch Tributary.	.....	*3,800
			Just downstream of Ninth Street	None	*3,911
		Railroad Ditch Tributary	Approximately 360 feet downstream of State Route 18.	None	*3,894
			Just downstream of Avenue R	None	*3,899
Maps are available for inspection at City Hall, 214 S. Love, Lovington, New Mexico.					
Send comments to The Honorable Troy J. Harris, Mayor, City of Lovington, P.O. Box 1268, Lovington, New Mexico 88260.					
New Mexico	Raton (City) Colfax County.	Raton Creek	Approximately 3,360 feet downstream of Frontage Road.	None	*6,541
			Approximately 1,560 feet Upstream of North Second Street.	None	*6,705
		Middle Creek	Approximately 600 feet downstream of Interstate Highway 25.	None	*6,527
			At Atchison, Topeka and Santa Fe Railway Crossing.	None	*6,633
		South Creek	Approximately 900 feet upstream of confluence with Middle Creek.	None	*6,520
			Approximately 120 feet upstream of South Second Street (U.S. Highway 85).	None	*6,552
Maps are available for inspection at the Office of City Engineer, City Hall, 224 Savage Avenue, Raton, New Mexico.					
Send comments to The Honorable Eric Honeyfield, City Manager, P.O. Box 910, Raton, New Mexico 87740.					
South Dakota	Deadwood (City) Lawrence County.	Whitewood Creek	Approximately 800 feet downstream of U.S. Highway 14–A.	None	*4,394

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
			Approixmately 550 feet downstream of U.S.Highway 85.	*4,640	*4,642
		Deadwood Creek	Approximately 1,225 feet upstream of Shine Street.	*4,574	None
			Just upstream of U.S.Highway 14–A	*4,630	*4,640
			Approximately 1,550 feet Upstream of U.S. Highway 14–A.	None	*4,658
		Spring Creek	At upstream end of culvert, approximately 400 feet upstream of North Williams Street.	None	*4,580
			At western corporate limit, approximately 2,600 feet upstream of North Williams Street.	None	*4,753
Maps are available for inspection at 102 Sherman Street, Deadwood, South Dakota.					
Send comments to The Honorable Barb Allen, Mayor, City of Deadwood, 102 Sherman Street, Deadwood, South Dakota 57732.					
Texas	Huntsville (City) Walker County.	Alligator Branch	Approximately 4,200 feet upstream of confluence with Prairie Branch.	None	*307
			Approximately 7,400 feet upstream of confluence with Prairie Branch.	None	*323
		Baldwin Creek	Approximately 36,500 feet above confluence with Nelson Creek.	None	*244
			Approximately 43,500 feet above confluence with Nelson Creek.	None	*261
		Caney Creek	Approximately 1,900 feet upstream of confluence with Winters Bayou.	None	*354
			Approximately 24,000 feet of confluence with Winters Bayou.	None	*374
		Crabb Creek	Approximately 17,400 feet upstream of confluence Nelson Creek.	None	*257
			Approximately 27,100 feet upstream of confluence Nelson Creek.	None	*287
		East Fork	At confluence with Tanyard Branch	None	*271
			Approximately 5,500 feet upstream of confluence with Tanyard Branch.	None	*298
		Ford Branch	At confluence with Wayne Creek	None	*272
			Approximately 2,700 feet upstream of confluence with Wayne Creek.	None	*286
		Hadley Creek	At Rosenwall Road	None	*250
			Approximately 200 feet north of Huntsville Airport Runway.	None	*292
		Horse Branch	At its confluence with Town Branch	None	*274
			Approximately 450 feet downstream of FM 2821.	*288	*285
			Approximately 3,500 feet upstream of Holly Bend Road.	*335	*329
		Mays Creek	Approximately 2,600 feet upstream of confluence of Shepard Creek.	None	*320
			Approximately 13,400 feet upstream of confluence of Shepherd Creek.	None	*355
		McDonald Creek	Approximately 2,300 feet downstream of Sunset Lake Dam.	None	*293
			Approximately 1,900 feet upstream of Spring Lake Dam.	None	*376
		McGary Creek	Approximately 8,050 feet downstream of concluence with Tributary 6.	None	*279
			Approximately 9,700 feet upstream of confluence with Tributary 5.	None	*351
		Parker Creek	Approximately 10,500 feet upstream of confluence with Harmon Creek.	None	*212
			Approximately 1,000 feet upstream of FM 247.	None	*279
		Prairie Branch	Approximately 14,800 feet upstream of confluence with East Sandy Creek.	None	*287
			Approximately 800 feet upstream of Broadmoor Drive.	None	*368
		Robinson Creek	Approximately 4,700 feet downstream of confluence with Tributary 4.	None	*283
			Approximately 16,350 feet upstream of confluence with Tributary 4.	None	*362

State	City/town/country	Source of flooding	Location	# Depth in feet above ground. * Elevation in feet. (NGVD)	
				Existing	Modified
		Shepherd Creek	Approximately 3,700 feet upstream of confluence with Mays Creek.	None	*317
			Approximately 7,150 feet upstream of confluence with Tributary 3.	None	*381
		Sixmile Branch	Approximately 400 feet downstream of confluence with Thompson Branch.	None	*253
			Approximately 1,400 feet upstream of confluence with Thompson Branch.	None	*261
		Tanyard Branch	Approximately 500 feet upstream of confluence with Harmony Creek.	None	*224
			Approximately 2,600 feet upstream of State Highway 190.	None	*363
		Thompson Branch	At confluence with Sixmile Branch	None	*254
			Approximately 1,000 feet upstream of confluence with Sixmile Branch.	None	*260
		Town Branch	At confluence with Parker Creek	None	*260
			Approximately 700 feet upstream of Avenue J and 14th Street.	*359	*361
		Tributary A	At confluence with Town Branch	*324	*322
			Approximately 280 feet upstream of its confluence with Town Branch.	*325	*324
			Approximately 300 feet upstream of State Highway 30/190.	None	*338
		Tributary B	At confluence with Horse Branch	*308	*307
			Approximately 800 feet upstream of Private Dam.	*328	*327
		Tributary 2	At confluence with Tanyard Branch	None	*225
			Approximately 1,250 feet upstream of Robinson Road.	None	*253
		Tributary 3	At confluence with Shepherd Creek	None	*358
			Approximately 1,700 feet upstream of confluence with Shepherd Creek.	None	*364
		Tributary 4	At confluence with Robinson Creek	None	*293
			Approximately 7,800 feet upstream of confluence with Robinson Creek.	None	*330
		Tributary 5	At confluence with McGary Creek	None	*319
			Approximately 7,600 feet upstream of confluence with McGary Creek.	None	*347
		Tributary 6	At confluence with McGary Creek	None	*292
			Approximately 10,500 feet upstream of confluence with McGary Creek.	None	*319
		Tributary 7	Approximately 14,800 feet upstream of confluence with Hadley Creek.	None	*256
			Approximately 20,400 feet upstream of confluence with Hadley Creek.	None	*275
		Tributary 8	Approximately 3,700 feet upstream of confluence with Parker Creek.	None	*217
			Approximately 8,000 feet upstream of confluence with Parker Creek.	None	*231
		Tributary 9	At confluence with Shepherd Creek	None	*332
			Approximately 6,700 feet upstream of confluence with Shepherd Creek.	None	*347
		Wayne Creek	Approximately 2,100 feet upstream of confluence with Harmony Creek.	None	*259
			Approximately 12,600 feet upstream of confluence with Harmony Creek.	None	*298

Maps are available for inspection at City Service Center, 448 Highway 75 North, Huntsville, Texas.

Send comments to The Honorable Gene Pipes, City Manager, City of Huntsville, 1212 Avenue M, Huntsville, Texas 77340.

Utah	Utah County (Unincorporated Areas).	Jordan River	At downstream County boundary	*4,490	*4,491
			At Cedar Fort Road	*4,494	*4,493
			Approximately 1,400 feet upstream of Saratoga Road.	*4,495	*4,492

Maps are available for inspection at the Community Development Department, 100 E. Center Street, Room 3800, Provo, Utah.

Send comments to The Honorable Jerry D. Grover, Utah County Commission Chairman, 100 East Center Street, Room 2300, Provo, Utah 84606.

* Elevation is in NGVD. Add 0.3 foot (approximately) to the elevation in NGVD to obtain the elevation in NAVD.
** Elevation is in NGVD. Add 0.4 foot (approximately) to the elevation in NGVD to obtain the elevation in NAVD.
+ Elevation in feet (NAVD 1988).

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

Dated: October 30, 2000.

Margaret E. Lawless,

Deputy Associate Director for Mitigation.

[FR Doc. 00–28258 Filed 11–2–00; 8:45 am]

BILLING CODE 6718–04–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Parts 20, 42, 61, 63, and 64

[IB Docket No. 00–202, FCC 00–367]

Policy and Rules Concerning the International Interexchange Marketplace and 2000 Biennial Regulatory Review

AGENCY: Federal Communications Commission.

ACTION: Notice of proposed rule making.

SUMMARY: This document solicits comments on whether the Commission should continue to require U.S. non-dominant interexchange carriers to file tariffs for international services pursuant to the requirements of the Communications Act. The Commission initiated this proceeding to determine whether to extend the complete detariffing regime that it adopted for domestic, interexchange services to the international services of non-dominant interexchange carriers, including U.S. carriers classified as dominant due to foreign affiliations. The Commission believes that these proposals will foster competition in the U.S. international services market and bring lower rates to U.S. consumers.

DATES: Comments are due on or before November 17, 2000, and reply comments are due on or before December 4, 2000.

ADDRESSES: Federal Communications Commission, Secretary, 445 12th Street, SW., Room TW–B204F, Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: Lisa Choi, Policy and Facilities Branch, Telecommunications Division, International Bureau, (202) 418–1460.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Notice of Proposed Rule Making, FCC 00–367, adopted on October 12, 2000, and released on October 18, 2000. The full text of this document is available for inspection and copying during normal business hours in the Office of Media Relations, Reference Operations Division, (Room CY–A257) of the Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554. The document is also available for download over the Internet at http://www.fcc.gov/Bureaus/International/Notices/2000//fcc00367.doc. The complete text of this document also may be purchased from the Commission's copy contractor, International Transcription Service, Inc., 1231 20th Street, NW., Washington, DC 20036, (202) 857–3800.

This NPRM contains proposed information collections subject to the Paperwork Reduction Act of 1995 (PRA). It will be submitted to the Office of Management and Budget (OMB) for review under the PRA. OMB, the general public, and other Federal agencies will be invited to comment on the proposed information collections contained in this proceeding.

Summary of Notice of Proposed Rulemaking

1. In 1996, the Commission adopted policies and rules regarding the detariffing of domestic interexchange services (Domestic Detariffing Order) (61 FR 59340, November 22, 1996). In the Domestic Detariffing Order, the Commission concluded that complete detariffing with limited exceptions for permissive detariffing, satisfies the criteria set forth in section 10(a) of the Communications Act. The Commission made no determination as to whether detariffing international, interexchange services satisfied the requirements of section 10, as competitive conditions in the international marketplace may vary from those in the domestic interexchange marketplace.

2. On October 12, 2000, the Commission adopted a Notice of Proposed Rulemaking (NPRM) to determine whether competitive conditions in the international interexchange marketplace support detariffing non-dominant carriers' provision of international services in accordance with the criteria in section 10 of the Communications Act of 1996. The Commission initiated this proceeding in response to the Communications Act of 1996, which requires the Commission to review all regulations that apply to operations or activities of any provider of telecommunications service and to repeal or modify any regulation it determines to be no longer necessary in the public interest. Since adopting the Domestic Detariffing Order, there have been dramatic changes in the market for international interexchange services resulting in increased competition. Thus, the Commission commenced this proceeding to examine whether to continue to require U.S. non-dominant interexchange carriers to file tariffs for international services pursuant to the requirements of section 203 of the Act. The Commission solicits comments on all of the proposals and tentative conclusions contained in the NPRM.

3. The NPRM seeks comment on the Commission's tentative conclusion that the Communications Act requires it to forbear from applying section 203 of the Act and to adopt a policy of complete detariffing for international interexchange services with limited exceptions for permissive detariffing. The NPRM seeks comment on the Commission's determination that its proposals meet the statutory forbearance criteria of section 10 of the Communications Act.

4. The NPRM solicits comment on the Commission's tentative conclusion that tariff filing requirements are not necessary to ensure that the charges, practices, classifications or regulations for the international interexchange services of non-dominant interexchange carriers are just and reasonable, and are not unjustly or unreasonably discriminatory. The NPRM also solicits comment on whether there remains a justification to retain tariffs on certain routes on which sufficient competition may not exist. The Commission tentatively concludes that its policies and enforcement authority, in conjunction with market forces will generally ensure that the rates, practices, and classifications of non-dominant interexchange carriers for international interexchange services will be just and reasonable and not unjustly or unreasonably discriminatory.

5. Comments are requested on the Commission's tentative conclusion that tariffs are not necessary for the protection of consumers of interexchange services. The Commission tentatively concludes that tariffs are not necessary for the protection of consumers. Rather, the Commission believes that tariff filing requirements may harm consumers by undermining the development of competition and possibly leading to higher rates by stifling price reductions

and marketing innovations. The Commission tentatively concludes that detariffing will benefit consumers by permitting carriers to respond to price and service changes in an unregulated manner. The NPRM also discusses the ''filed-rate'' doctrine and seeks comment on the Commission's tentative conclusion that only with complete detariffing can the Commission be certain to avoid the uncertainty, confusion, and potential harm to consumers associated with the ''file-rate'' doctrine. The NPRM seeks comment on whether detariffing will protect consumer harm.

6. The NPRM also seeks comment on the Commission's tentative conclusion that complete detariffing for international interexchange services will enhance competition among providers of such services, promote competitive market conditions, and achieve other objectives that are in the public interest. The NPRM sets forth the Commission's analysis on the benefits of complete detariffing and how it meets the statutory forbearance criteria, and comments are requested on these issues whether complete detariffing is in the public interest. In the Domestic Detariffing Order, the Commission found that permissive detariffing, as opposed to complete detariffing, satisfied the public interest and is warranted in two instances: (1) international interexchange direct-dial services to which end-users obtain access by dialing a carrier access code; and (2) international interexchange services provided during the initial forty-five days of service or until there is a written contract between the carrier and the customer. The NPRM addresses these exceptions, and comments are solicited on the Commission's conclusions and whether there are limited exceptions for permissive detariffing.

7. The Commission believes that consumers must have adequate information concerning carriers' rates, terms and conditions to ensure carrier compliance with requirements and for consumers to determine the most appropriate rate plans available. The Commission proposes to require non-dominant interexchange providers of international services to disclose information about their rates, terms and conditions to the public, maintain price and service information regarding the international offerings that can be submitted to the agency upon request, and post information about their offerings on their Internet websites. The Commission proposes that carriers provide the same information that is currently provided in tariffs, and the information must be available to the public in at least one location during regular business hours. The Commission also proposes that carriers with Internet websites post this information on-line in a timely and easily accessible manner with regular updates. The NPRM solicits comments on the proposals regarding maintenance of price and service information and the public disclosure requirements.

8. The NPRM also addresses the issue of price squeeze behavior, and it seeks comment on whether complete detariffing will affect the Commission's ability to monitor potential price squeeze behavior on international routes where U.S. carriers are affiliated with foreign carriers that possess market power.

9. The NPRM also seeks comments on the proposal that the Commission revisit its previous conclusion that permissive detariffing of CMRS providers of international services on unaffiliated routes is in the public notice.

10. The NPRM discusses the carrier-to-carrier contract filing requirement in § 43.51 of the Commission's rules and solicits comments on the Commission's tentative conclusions and proposals to limit the requirement to contracts between an authorized carrier and: (1) An authorized carrier classified as dominant for reasons other than a foreign affiliation; and (2) a foreign carrier possessing market power.

Procedural Matters

11. *Ex Parte Presentations.* This proceeding shall be treated as a ''permit-but-disclose'' proceeding in accordance with the Commission's *Ex Parte* rules. Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentations must contain summaries of the substance of the presentations and not merely a listing of the subjects discussed. More than a one or two sentence description of the views and arguments presented is generally required. Other rules pertaining to oral and written presentations are set for section 1.120(b) of the Commission's rules as well.

12. *Initial Regulatory Flexibility Analysis.* As required by the Regulatory Flexibility Act, 5 U.S.C. 603, the Commission has prepared this present Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on small entities by the policies and rules proposed in this NPRM. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the NPRM provided herein, including this IRFA, to the Chief Counsel for the Advocacy of the Small Business Administration. In addition, the NPRM and IRFA comments will be published in the **Federal Register**.

13. *Need for, and Objectives, of, the Proposed Rules:* The Commission is issuing this NPRM to review our regulatory regime for international interexchange telecommunications services, and to implement certain provisions of the 1996 Act. In light of the dramatic changes in the market for international interexchange services resulting from increased privatization and liberalization of foreign markets, the World Trade Organization (WTO) Basic Telecom Agreement, decreasing settlement rates and increased competition in the U.S. international services market, we believe it is timely for us to review our requirement that U.S. carriers file tariffs for international interexchange services under section 203 of the Act. Because tariffs can limit the flexibility necessary for all U.S. carriers, including smaller carriers, to offer new services in a competitive market and may harm consumers through the effect of the ''filed rate doctrine,'' we propose requiring complete or mandatory detariffing, with limited exceptions, in this NPRM for the international interexchange services provided by non-dominant carriers. Complete detariffing will reduce carriers' filing costs, and, on balance, the public disclosure and maintenance of information requirements proposed in this item are minimal and do not outweigh the benefits to all U.S. carriers and U.S. consumers to be gained from detariffing. The objective of the NPRM is to provide an opportunity for public comment and to provide a record for a Commission decision on the issues stated above.

14. *Legal Basis:* We tentatively conclude that section 10 of the Communications Act requires the Commission to forbear completely from the tariff requirements contained in section 203 of the Communications Act. In addition, section 11 of the Communications Act directs the Commission to undertake a biennial review of its regulations concerning the operations or activities of any provider of telecommunications services. Thus, the NPRM is adopted pursuant to sections 1, 2, 4, 10, 11, 201–205, 218, 220, 226, 303(g), 303(r) and 332 of the Communications Act of 1934, as amended. 47 U.S.C. 151, 152, 154, 160, 161, 201–205, 215, 218, 220, 226, 303(g), 303(r) and 332.

15. *Description and Estimate of the Number of Small Entities To Which the Proposed Rules Will Apply:* The RFA

directs agencies to provide a description of, and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted. The Regulatory Flexibility Act defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small business concern'' under section 3 of the Small Business Act. A small business concern is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA. Any rule changes that might occur as a result of this proceeding could impact entities which are small business entities, as defined in section 601(3) of the Regulatory Flexibility Act. The proposed rules in this NPRM will reduce regulatory burdens on all non-dominant providers of international interexchange services, including small business entities.

16. The SBA has developed a definition of small entities for telephone communications companies other than radiotelephone (wireless) companies. The Census Bureau reports that there were 2,321 such companies that had been operating for at least one year at the end of 1992. According to the SBA's definition, a wireline telephone company is a small business if it employs no more than 1,500 persons. All but 26 of the 2,321 wireline companies listed by the Census Bureau were reported to have fewer than 1,000 employees. Thus, even if all 26 of those companies had more than 1,500 employees, there would still be 2,295 wireline companies that might qualify as small entities or small incumbent LECs. Although it seems certain that some of these carriers are not independently owned and operated, we are unable at this time to estimate with greater precision the number of wireline carriers and service providers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that fewer than 2,295 of these wireline companies are small entities that might be affected by these proposals.

17. Specifically, the proposals contained in the NPRM apply to entities seeking authorization to provide international service. The proposals, however, may affect other entities as well. The Commission, therefore, encourages interested parties to comment on the proposals in the NPRM. The proposals contained in the NPRM are intended to improve market efficiency by permitting carriers to respond to the dynamics of the marketplace and further the goals of the Communications Act. At this time, we are not certain as to the number of small entities that will be affected by the proposals. Agency data indicates there has been a steady increase in the number of section 214 applications filed with the Commission. The total number of licensees is difficult to determine, because many licenses are jointly held by several licensees. Based on agency data, we would estimate that there could be 800 applicants that might be a small entity.

18. *Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements:* We believe that the proposed rules will reduce significantly the reporting burdens placed on small entities. The proposed rules would eliminate the requirement of filing tariffs for non-dominant interexchange carriers. These carriers would be required to retain business records containing price and service information regarding their international interexchange offerings. This information, however, is maintained by carriers in the normal course of business. The proposed rules only impose a requirement that providers of international interexchange services maintain this information for a period of at least two years and six months. It is likely that carriers maintain this information for this specific time period, as a normal business practice.

19. We propose that carriers adopt a public disclosure requirement to make information available to the public concerning current rates, terms, and conditions for all of their international interexchange services, in at least one location during regular business hours. For those carriers with Internet websites, we propose that the carriers make the information available on their websites. In lieu of tariffs, the public disclosure requirement will ensure that the information is readily available to the public in an accessible format.

20. The rules also propose to modify the requirement for filing carrier-to-carrier contracts, thereby reducing the filing burden on most carriers. We propose to simplify and modify our rules and set forth specific criteria that would trigger the carrier contract filing requirement.

21. The proposals should enhance competition among providers of services, promote competitive market conditions and achieve benefits for the consumers while reducing the regulatory burdens on all non-dominant providers of international interexchange services, including small business entities.

22. *Steps Taken to Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered:* The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives: (1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.

23. We believe that the proposals will facilitate the development of increased competition in the international telecommunications marketplace and provide more flexibility for carriers to respond to the dynamics of the marketplace. Accounting rate reform policies, market forces, and increased competitive entry into the U.S. market have led to substantial reductions in consumer rates for international interexchange services. We believe that tariffs are no longer necessary to ensure that charges, practices, classification or regulations are just and reasonable and are not unjustly or unreasonably discriminatory. In addition, we believe that our proposals will contribute to market efficiency by permitting carriers to respond to the dynamics of the marketplace.

24. In considering alternatives for small entities, we believe that the proposals contained in the NPRM are the least burdensome on small entities. We do not propose to standardize the requirements because the information is unique to the carrier and may be maintained in a manner that is consistent with the carrier's business practices. We propose to reduce the administrative costs to small entities by eliminating the tariff filing requirement. In addition, the public disclosure requirement should not impose burdens on small entities because the information is maintained in the normal course of business.

25. In this NPRM, we are proposing to extend the policies and rules regarding the detariffing of domestic interexchange services to the international interexchange services of non-dominant carriers. We request comment on whether small entities would be adversely affected by the proposals herein and whether the proposals will enable small entities to respond to the demands of the market

with minimum regulatory oversight, delays, and expenses. We believe that our proposals would have either no impact, or would reduce, any economic burdens on small entities. After evaluating the comments in this proceeding, the Commission will further examine the impact of any rule changes on small entities and set forth findings in the Final Regulatory Flexibility Analysis.

26. *Federal Rules Which Overlap, Duplicate or Conflict with the Commission's Proposal:* None.

27. *Paperwork Reduction Act.* The NPRM contains either new or modified information collections subject to the Paperwork Reduction Act of 1995 (PRA). The Commission will submit the proposed information collections to the Office of Management and Budget (OMB) for review under the PRA. Upon submission to OMB, comments from OMB, the general public, and other federal agencies will be invited on the proposed information collections contained in the proceeding.

Ordering Clauses

28. Pursuant to sections 1, 4, 10, 11, 201–205, 211, 218, 220, 226, 303(g), 303(r) and 332 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154, 160, 161, 201–205, 211, 218, 220, 226, 303(g), 303(r) and 332 the Notice of Proposed Rulemaking is hereby adopted.

29. The Commission's Consumer Information Bureau, Reference Information Center, shall send a copy of this Notice of Proposed Rulemaking, including the regulatory flexibility certification, to the Chief Counsel for Advocacy of the Small Business Administration, in accordance with paragraph 603(a) of the Regulatory Flexibility Act, Public Law 96–354, 94 Stat. 1164, 5 U.S.C. 601, *et seq.* (1981).

List of Subjects

47 CFR Part 20

Communications common carriers.

47 CFR Parts 42, 61, 63, and 64

Communications common carriers, Reporting and recordkeeping requirements.

Federal Communications Commission.

Magalie Roman Salas,

Secretary.

Proposed Rule Changes

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 CFR parts 20, 42, 61, 63 and 64 as follows:

PART 20—COMMERCIAL MOBILE RADIO SERVICES

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

Authority: 47 U.S.C. 154, 160, 251–254, 303, and 332 unless otherwise noted.

2. Section 20.15 is amended by revising paragraphs (c) and (d) to read as follows:

§ 20.15 Requirements under Title II of the Communications Act.

* * * * *

(c) Commercial mobile radio service providers shall not file tariffs for international and interstate service to their customers, international and interstate access service, or international and interstate operator service. Sections 1.771–1.773 and part 61 of this chapter are not applicable to international and interstate services provided by commercial mobile radio service providers. Commercial mobile radio service providers shall cancel tariffs for international and interstate service to their customers, international and interstate access service, and international and interstate operator service.

(d) Nothing in this section shall be construed to modify the Commission's rules and policies on the provision of international service under Part 63 of this chapter. A commercial mobile radio service provider is required to comply with the requirement in § 42.11 if it provides international service to markets where it has an affiliation with a foreign carrier that possesses market power and that collects settlement payments from U.S. carriers. For purposes of this paragraph, affiliation is defined in § 63.18(h)(1)(i) of this chapter.

* * * * *

PART 42—PRESERVATION OF RECORDS OF COMMUNICATIONS COMMON CARRIERS

3. The authority citation for part 42 continues to read as follows:

Authority: Section 4(i), 48 Stat. 1066, as amended, 47 U.S.C. 154(I). Interprets or applies sections 219 and 220, 48 Stat. 1077–78, 47 U.S.C. 219, 220.

4. Section 42.10 is amended by revising paragraph (a) to read as follows:

§ 42.10 Public availability of information concerning interexchange services.

(a) A nondominant interexchange carrier (IXC) shall make available to any member of the public, in at least one location, during regular business hours, information concerning its current rates, terms and conditions for all of its international and interstate, domestic, interexchange services. Such information shall be made available in an easy to understand format and in a timely manner. Following an inquiry or complaint from the public concerning rates, terms and conditions for such services, a carrier shall specify that such information is available and the manner in which the public may obtain the information.

* * * * *

5. Section 42.11 is amended by revising paragraph (a) to read as follows:

§ 42.11 Retention of information concerning detariffed interexchange services.

(a) A nondominant IXC shall maintain, for submission to the Commission and to state regulatory commissions upon request, price and service information regarding all of the carrier's international and interstate, domestic, interexchange service offerings. A commercial mobile radio service provider of international service shall only maintain such price and service information about its international service offerings and only for those routes on which the commercial mobile radio service provider is affiliated with a foreign carrier that possesses market power. The price and service information maintained for purposes of this paragraph shall include documents supporting the rates, terms, and conditions of the carrier's international and interstate, domestic, interexchange offerings. The information maintained pursuant to this section shall be maintained in a manner that allows the carrier to produce such records within ten business days.

* * * * *

PART 43—REPORTS OF COMMUNICATION COMMON CARRIERS AND CERTAIN AFFILIATES

6. The authority citation for part 43 continues to read as follows:

Authority: 47 U.S.C. 154; Telecommunications Act of 1996, Public Law 104–104, sec. 402(b)(2)(B), (c), 110 Stat. 56 (1996) as amended unless otherwise noted. 47 U.S.C. 211, 219, 220 as amended.

7. Section 43.51 is revised to read as follows:

§ 43.51 Contracts and concessions.

(a) (1) Any carrier set forth in paragraph (b) of this section must file with the Commission within 30 days of execution a copy of each contract, agreement, concession, license, authorization, operating agreement or other arrangement to which it is a party

and amendments thereto with respect to the following:

(i) The exchange of services; and,

(ii) The interchange or routing of traffic and matters concerning rates, accounting rates, division of tolls, or the basis of settlement of traffic balances, except as provided in paragraph (c) of this section.

(2) If the contract, agreement, concession, license, authorization, operating agreement or other arrangement and amendments thereto is made other than in writing, a certified statement covering all details thereof must be filed by at least one of the parties to the agreement. Each other party to the agreement which is also subject to these provisions may, in lieu of also filing a copy of the agreement, file a certified statement referencing the filed document. The Commission may, at any time and upon reasonable request, require any communication common carrier not subject to the provisions of this section to submit the documents referenced in this section.

(b) The following carriers must comply with the requirements of paragraph (a) of this section:

(1) A communications common carrier that is engaged in domestic communications and has not been classified as non-dominant pursuant to § 61.3 of this chapter,

(2) A U.S. common carrier, other than a provider of commercial mobile radio services, that enters into a contract, agreement, concession, license, authorization, operating agreement or other arrangement and amendments thereto with a foreign carrier that has market power in a foreign market, or

(3) A U.S. carrier that has been classified as dominant on any of the international routes included in the contract, except for carriers classified as dominant on a particular route due only to a foreign carrier affiliation under § 63.10 of this chapter.

(c) With respect to contracts coming within the scope of paragraph (a)(1)(ii) of this section between subject telephone carriers and connecting carriers, except those contracts related to communications with foreign or overseas points, such documents shall not be filed with the Commission; but each subject telephone carrier shall maintain a copy of such contracts to which it is a party in appropriate files at a central location upon its premises, copies of which shall be readily accessible to Commission staff and members of the public upon reasonable request therefor; and upon request by the Commission, a subject telephone carrier shall promptly forward individual contracts to the Commission.

(d) Any U.S. carrier that interconnects an international private line to the U.S. public switched network, at its switch, including any switch in which the carrier obtains capacity either through lease or otherwise, shall file annually with the Chief of the International Bureau a certified statement containing the number and type (*e.g.,* a 64-kbps circuit) of private lines interconnected in such a manner. The certified statement shall specify the number and type of interconnected private lines on a country specific basis. The identity of the customer need not be reported, and the Commission will treat the country of origin information as confidential. Carriers need not file their contracts for such interconnections, unless they are specifically requested to do so. These reports shall be filed on a consolidated basis on February 1 (covering international private lines interconnected during the preceding January 1 to December 31 period) of each year. International private lines to countries for which the Commission has authorized the provision of switched basic services over private lines at any time during a particular reporting period are exempt from this requirement.

(e) *International settlements policy.* (1) If a U.S. carrier files an operating agreement (whether in the form of a contract, concession, license, etc.) with a foreign carrier with market power in that foreign market to begin providing switched voice, telex, telegraph, or packet-switched service between the United States and a foreign point and the terms and conditions of such agreement relating to the exchange of services, interchange or routing of traffic and matters concerning rates, accounting rates, division of tolls, the allocation of return traffic, or the basis of settlement of traffic balances, are not identical to the equivalent terms and conditions in the operating agreement of another carrier providing the same or similar service between the United States and the same foreign point, the carrier must also file with the International Bureau a modification request § 64.1001 of this chapter. Unless a carrier is providing switched voice, telex, telegraph, or packet-switched service between the United States and a foreign point pursuant to an operating agreement that is exempt from the international settlements policy, the carrier shall not bargain for or agree to accept more than its proportionate share of return traffic.

(2) If a carrier files an amendment to an existing operating agreement with a foreign carrier with market power in that foreign market to provide switched voice, telex, telegraph, or packet-switched service between the United States and a foreign point, and other carriers provide the same or similar service to the same foreign point, and the amendment relates to the exchange of services, interchange or routing of traffic and matters concerning rates, accounting rates, division of tolls, the allocation of return traffic, or the basis of settlement of traffic balances, the carrier must also file with the International Bureau a modification request § 64.1001 of this chapter.

(3) A carrier that enters into a contract, including an operating agreement, with a carrier in a foreign point for the provision of a common carrier service between the United States and that point is not subject to the requirements of this subsection if the foreign point appears on the Commission's list of international routes that the Commission has exempted from the international settlements policy.

Note to § 43.51(e)(3): The Commission's list of international routes exempted from the international settlements policy is available from the International Bureau's World Wide Web site at *http://www.fcc.gov/ib.* A party that seeks to add a foreign market to the list of markets that are exempt from the international settlements policy must show that U.S. carriers are able to terminate at least 50 percent of U.S.-billed traffic in the foreign market at rates that are at least 25 percent below the benchmark settlement rate adopted for that country in IB Docket No. 96–261, Report and Order, 12 FCC Rcd 19,806, 62 FR 45758 (Aug. 29, 1997). A party that seeks to remove a foreign market from the list of markets that are exempt from the international settlements policy must show that U.S. carriers are unable to terminate at least 50 percent of U.S.-billed traffic in the foreign market at rates that are at least 25 percent below the benchmark settlement rate adopted for that country in IB Docket No. 96–261.

(f) *Confidential treatment.* (1) A carrier providing service on an international route that is exempt from the international settlements policy under paragraph (e)(3) of this section, but that is otherwise required by paragraphs (a) and (b) of this section to file a contract covering that route with the Commission, may request confidential treatment under § 0.457 of this chapter for the rates, terms and conditions that govern the settlement of U.S. international traffic.

(2) Carriers requesting confidential treatment under this paragraph must include the information specified in § 64.1001(c) of this chapter. Such filings shall be made with the Commission, with a copy to the Chief, International Bureau. The transmittal letter accompanying the confidential filing

shall clearly identify the filing as responsive to § 43.51(f).

Note 1 to § 43.51: To the extent that a foreign government provides telecommunications services directly through a governmental organization, body or agency, it shall be treated as a carrier for the purposes of this section.

Note 2 to § 43.51: Carriers may rely on the Commission's list of foreign carriers that do not qualify for the presumption that they lack market power in particular foreign points for purposes of determining which foreign carriers are subject to the contract filing requirements set forth in this section. The Commission's list of foreign carriers that do not qualify for the presumption that they lack market power in particular foreign points is available from the International Bureau's World Wide Web site at *http://www.fcc.gov/ib.* The Commission will include on the list of foreign carriers that do not qualify for the presumption that they lack market power in particular foreign points any foreign carrier that has 50 percent or more market share in the international transport or local access markets of a foreign point. A party that seeks to remove such a carrier from the Commission's list bears the burden of submitting information to the Commission sufficient to demonstrate that the foreign carrier lacks 50 percent market share in the international transport and local access markets on the foreign end of the route or that it nevertheless lacks sufficient market power on the foreign end of the route to affect competition adversely in the U.S. market. A party that seeks to add a carrier to the Commission's list bears the burden of submitting information to the Commission sufficient to demonstrate that the foreign carrier has 50 percent or more market share in the international transport or local access markets on the foreign end of the route or that it nevertheless has sufficient market power to affect competition adversely in the U.S. market.

PART 61—TARIFFS

8. The authority citation for part 61 continues to read as follows:

Authority: sections 1, 4(I), 4(j), 201–205, and 403 of the Communications Act of 1934, as amended 47 U.S.C. 151, 154(I), 154(j), 201–205, and 403 unless otherwise noted.

9. Section 61.3 is amended by revising paragraph (u) to read as follows:

§ 61.3 Definitions.

* * * * *

(u) *Non-dominant carrier.* A carrier not found to be dominant. The nondominant status of providers of international interexchange services for purposes of this subpart is not affected by a carrier's classification as dominant as defined in § 63.10 of this chapter.

* * * * *

10. Section 61.19 is revised to read as follows:

§ 61.19 Detariffing of international and interstate, domestic interexchange services.

(a) Except as otherwise provided in paragraphs (b) and (c) of this section, or by Commission order, carriers that are nondominant in the provision of international and interstate, domestic interexchange services shall not file tariffs for such services.

(b) Carriers that are nondominant in the provision of international and domestic, interstate, interexchange services are permitted to file tariffs for dial-around 1+ services. For the purposes of this paragraph, dial-around 1+ calls are those calls made by accessing the interexchange carrier through the use of that carrier's carrier access code.

(c) Carriers that are nondominant in the provision of international and domestic, interstate, interexchange services are permitted to file a tariff for such services applicable to those customers who contact the local exchange carrier to designate an interexchange carrier or to initiate a change with respect to their primary interexchange carrier. Such tariff will enable the interexchange carrier to provide service to the customer until the interexchange carrier and the customer consummate a written agreement, but in no event shall the interexchange carrier provide service to its customer pursuant to such tariff for more than 45 days.

11. Section 61.28 is revised to read as follows:

§ 61.28 International dominant carrier tariff filing requirements.

(a) Any carrier classified as dominant for the provision of particular international communications services on a particular route for any reason other than a foreign carrier affiliation pursuant to § 63.10 of this chapter shall file tariffs for those services pursuant to the notice and cost support requirements for tariff filings of dominant domestic carriers, as set forth in subpart E of this part.

(b) Other than the notice and cost support requirements set forth in paragraphs (a) of this section, all tariff filing requirements applicable to all carriers classified as dominant for the provision of particular international communications services on a particular route for any reason other than a foreign carrier affiliation pursuant to § 63.10 of this chapter are set forth in subpart C of this part.

12. Section 61.74 is amended by removing paragraph (d) and redesignating paragraphs (e) and (f) as paragraphs (d) and (e).

PART 63—EXTENSION OF LINES, NEW LINES AND DISCONTINUANCE, REDUCTION, OUTAGE AND IMPAIRMENT OF SERVICE BY COMMON CARRIERS; AND GRANTS OF RECOGNIZED PRIVATE OPERATING AGENCY STATUS

13. The authority citation for part 63 continues to read as follows:

Authority: Section 1, 4(I), 4(j), 10, 11, 201–205, 214, 218, 403 and 651 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 154(i), 154(j), 160, 201–205, 214, 218, 403, and 571, unless otherwise noted.

14. Section 63.10 is amended by revising paragraph (c)(1) to read as follows:

§ 63.10 Regulatory classification of U.S. international carriers.

* * * * *

(c) * * *

(1) Authorized carriers regulated as dominant for the provision of international communications services on a particular route for any reason other than a foreign carrier affiliation pursuant to this section shall file tariffs for those services as set forth in § 61.28 of this chapter.

* * * * *

15. Section 63.17 is amended by revising paragraph (b)(3) to read as follows:

§ 63.17 Special provisions for U.S. international common carriers.

* * * * *

(b) * * *

(3) Authorized carriers filing tariffs pursuant to §§ 61.19 or 61.28 of this chapter that route U.S.-billed traffic via switched hubbing shall tariff their service on a ''through'' basis between the United States and the ultimate point of origination or termination;

* * * * *

16. Section 63.21 is amended by revising paragraphs (b) and (c) to read as follows:

§ 63.21 Conditions applicable to all international Section 214 authorizations.

* * * * *

(b) Carriers must file copies of operating agreements entered into with their foreign correspondents that possess market power within 30 days of their execution, and shall otherwise comply with the filing requirements contained in § 43.51 of this chapter.

(c) Carriers regulated as dominant for the provision of international communications services on a particular route for any reason other than a foreign carrier affiliation under § 63.10 shall file tariffs pursuant to section 203 of the

Communications Act, 47 U.S.C. 203, and part 61 of this chapter. Carriers regulated as non-dominant, as defined in § 61.3 of this chapter, and providing detariffed interexchange services pursuant to § 61.19 of this chapter must comply with all applicable public disclosure, and maintenance of information requirements in §§ 42.10, and 42.11 of this chapter.

* * * * *

[FR Doc. 00–28060 Filed 11–2–00; 8:45 am]

BILLING CODE 6712–10–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Parts 224 and 226

[Docket No. 001025297-0297-01; I.D. 101000E]

RIN 0648-XA58

Listing Endangered and Threatened Species and Designating Critical Habitat: Petition To List Lower Columbia River Coho Salmon

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of finding and request for information.

SUMMARY: NMFS has received a petition to list the lower Columbia River populations of coho salmon (*Oncorhynchus kisutch*) on an emergency basis and to designate critical habitat under the Endangered Species Act (ESA). NMFS determines that the petition presents substantial scientific information indicating that a listing may be warranted, but that there is insufficient evidence to support an emergency listing. NMFS solicits information and comments pertaining to these coho salmon populations and their habitats, and seeks suggestions from the public for peer reviewers for any proposed listing determination that may result from the agency's status review of the species.

DATES: Information and comments must be received by January 2, 2001.

ADDRESSES: Information and comments on this action should be submitted to Chief, Protected Resources Division, NMFS, 525 NE Oregon Street - Suite 500, Portland, OR 97232. Comments will not be accepted if submitted via e-mail or the Internet. However, comments may be sent via fax to (503) 230-5435.

FOR FURTHER INFORMATION CONTACT: Garth Griffin, NMFS, Northwest Region, (503) 231-2005 or Chris Mobley, NMFS, Office of Protected Resources, (301) 713-1401.

SUPPLEMENTARY INFORMATION:

Electronic Access

Reference materials regarding this rule can also be obtained from the internet at www.nwr.noaa.gov.

Background

On July 24, 2000, NMFS received a petition from Oregon Trout, Native Fish Society, and Oregon Council of Trout Unlimited to list wild populations of lower Columbia River coho salmon as endangered under the ESA. The petitioners further requested that NMFS list these populations on an emergency basis and concurrently designate critical habitat for them in accordance with the ESA. Copies of this petition are available from NMFS (See **ADDRESSES**).

Lower Columbia River coho salmon populations have been the subject of two previous ESA status reviews. The first review resulted from a June 7, 1990, petition from Oregon Trout and several co-petitioners requesting ESA protection for lower Columbia River coho salmon. NMFS accepted the petition but later determined that listing was not warranted because available information was inconclusive and did not allow the agency to identify a distinct population segment (hence a ''species'') under the ESA (56 FR 29553, June 27, 1991). In 1993, NMFS received additional petitions which prompted a more comprehensive status review of coho salmon in California, Oregon, Idaho, Washington, and southern British Columbia (60 FR 38011, July 25, 1995). This status review identified six distinct population segments (referred to as Evolutionarily Significant Units or ''ESUs'') of coho salmon, three of which were subsequently listed as threatened species–the central California coast ESU (61 FR 56138, October 31, 1996); southern Oregon/northern California coasts ESU (62 FR 24588, May 6, 1997), and Oregon coast ESU (63 FR 42587, August 10, 1998). NMFS determined that listing was not warranted for three other ESUs - the Olympic Peninsula ESU, Puget Sound/Strait of Georgia ESU, and southwest Washington/lower Columbia River ESU - but that the latter two ESUs should be classified as candidate species due to specific risk factors and concerns about the overall health of the ESUs. The agency committed to re-assessing these candidate ESUs to determine if listing proposals were warranted (60 FR 38011, 38022, July 25, 1995).

In 1996, NMFS' West Coast Coho Salmon Biological Review Team (BRT) updated the 1995 status review and produced a draft document that was distributed to co-managers for review and comment in December 1996 (NMFS, 1996). In this draft update, the BRT reached preliminary conclusions regarding the stock structure of coho populations in the candidate ESUs. With respect to Columbia River coho salmon populations, the BRT concluded that the southwest Washington/lower Columbia River ESU may warrant splitting into separate southwest Washington and lower Columbia River ESUs, but the level of risk faced by these separate ESUs was still in question. Since the time of these preliminary conclusions, NMFS has continued to update and compile data via meetings with comanagers and coho salmon experts in the Pacific Northwest but has not proposed any changes to the ESA status of the candidate ESUs.

Analysis of Petition

Section 4(b)(3) of the ESA contains provisions concerning petitions from interested persons requesting the Secretary of Commerce (Secretary) to list species under the ESA (16 U.S.C. 1533(b)(3)(A)). Section 4(b)(3)(A) requires that, to the maximum extent practicable, within 90 days after receiving such a petition, the Secretary must make a finding whether the petition presents substantial scientific information indicating that the petitioned action may be warranted. This includes determining whether there is evidence that the subject populations may qualify as a ''species'' under the ESA, in accordance with NMFS' Policy on Applying the Definition of Species under the Endangered Species Act to Pacific Salmon (56 FR 58612, November 20, 1991).

NMFS' ESA implementing regulations define ''substantial information'' as the amount of information that would lead a reasonable person to believe that the measure proposed in the petition may be warranted. In evaluating a petitioned action, the Secretary considers several factors, including whether the petition contains detailed narrative justification for the recommended measure, describing, based on available information, past and present numbers and distribution of the species involved and any threats faced by the species (50 CFR 424.14(b)(2)(ii)). In addition, the Secretary considers whether the petition provides information regarding the status of the species over all or a significant portion of its range (50 CFR 424.14(b)(2)(iii)).

NMFS evaluated whether the petition met the ESA's standard for ''substantial information'' and applied this standard in determining whether to accept the petition as well as whether to invoke an emergency listing under the ESA. NMFS believes it is appropriate to accept the petition to list the species but to reject the petitioner's request for an emergency listing as ''endangered.'' On this latter issue the petition failed to present new and substantial information to resolve longstanding uncertainties about ESU configuration and level of risk to these populations. However, the petition does highlight key issues warranting consideration by NMFS, including: (1) recent genetic evidence bearing on the issue of whether to split the southwest Washington/lower Columbia River ESU; (2) viability analyses indicating that Clackamas and Sandy River coho salmon populations are at high risk of extinction; and (3) evidence that populations may persist in other lower Columbia River tributaries. NMFS believes that an emergency listing should occur only after the ESU structure has been determined. NMFS will not presuppose the outcome of a more rigorous status review and BRT assessment.

Petition Finding

After reviewing the information contained in the petition, as well as information readily available to NMFS scientists, the Secretary determines that the petition presents substantial scientific information indicating the petitioned action may be warranted. However, NMFS does not believe that available information supports the petitioner's request for an emergency listing. In accordance with section 4(b)(3)(B) of the ESA, the Secretary will make his determination whether the petitioned action is warranted for this species within 12 months from the date the petition was received (i.e., by July 24, 2001).

Listing Factors and Basis for Determination

Under section 4(a)(1) of the ESA, a species can be determined to be threatened or endangered based on any of the following factors: (1) The present or threatened destruction, modification, or curtailment of a species' habitat or range; (2) overutilization for commercial, recreational, scientific, or educational purposes; (3) disease or predation; (4) inadequacy of existing regulatory mechanisms; or (5) other natural or manmade factors affecting the species continuing existence. Listing determinations are based solely on the best available scientific and commercial data after taking into account any efforts being made by any state or foreign nation to protect the species.

Information Solicited

To ensure that the status review is complete and based on the best available scientific and commercial data, NMFS solicits information and comments concerning the status of Columbia River basin coho salmon populations (see **DATES** and **ADDRESSES**). Specifically, the agency is seeking updated information since 1994 on: (1) abundance estimates and measures of population productivity, including spawner-recruit or spawner-spawner survival data, smolt production estimates, size and fecundity data, and ocean survival rates; (2) impacts associated with hatchery production including estimates of hatchery fish releases, straying rates, and proportions of hatchery fish in spawner escapements to lower Columbia River tributaries; (3) estimates of hatchery fish survival and their reproductive success in the wild; (4) genetic, life history, habitat, and other evidence distinguishing Columbia River coho salmon populations from coastal populations; (5) current or planned activities and their possible impact on this species (e.g., harvest measures and habitat actions); and (6) efforts being made to protect coho salmon in Washington and Oregon.

NMFS also requests information describing the quality and extent of freshwater, estuarine and marine habitats for Columbia River coho salmon, as well as information on areas that may qualify as critical habitat. Areas that include the physical and biological features essential to the recovery of the species should be identified. Essential features include, but are not limited to, the following: (1) Habitat for individual and population growth, and for normal behavior; (2) food, water, air, light, minerals, or other nutritional or physiological requirements; (3) cover or shelter; (4) sites for reproduction and rearing of offspring; and (5) habitats that are protected from disturbance or are representative of the historic geographical and ecological distributions of the species. NMFS is also seeking information and maps describing natural and manmade barriers within the species' current and historical range in the Columbia River basin.

For areas potentially qualifying as critical habitat, NMFS also requests information describing (1) the activities that affect the area or could be affected by the designation, and (2) the economic costs and benefits of additional requirements of management measures likely to result from the designation. The economic cost to be considered in a critical habitat designation under the ESA is the probable economic impact ''of the (critical habitat) designation upon proposed or ongoing activities'' (50 CFR 424.19). NMFS must consider the incremental costs specifically resulting from a critical habitat designation that are above the economic effects attributable to listing the species. Economic effects attributable to listing include actions resulting from section 7 consultations under the ESA to avoid jeopardy to the species and from the taking prohibitions under section 9 or 4(d) of the ESA. Comments concerning economic impacts should distinguish the costs of listing from the incremental costs that can be directly attributed to the designation of specific areas as critical habitat.

On July 1, 1994, NMFS, jointly with the U.S. Fish and Wildlife Service, published a series of policies regarding listings under the ESA, including a policy for peer review of scientific data (59 FR 34270). The intent of the peer review policy is to ensure that listings are based on the best scientific and commercial data available. NMFS now solicits the names of recognized experts in the field who could take part in the peer review process for the agency's status review of Columbia River coho salmon. Peer reviewers may be selected from academic and scientific community, tribal and other Native American groups, Federal and state agencies, the private sector, and public interest groups.

Authority: 16 U.S.C. 1531 *et seq.*

Dated: October 30, 2000.

William T. Hogarth,

Deputy Administrator for Fisheries, National Marine Fisheries Service.

[FR Doc. 00–28306 Filed 11– 2–00; 8:45 am]

BILLING CODE 3510–22–S

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[I.D. 091800K]

Mid-Atlantic Fishery Management Council; Public Hearings

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Cancellation of public hearings.

SUMMARY: NMFS announces the cancellation of two public hearings that had dates and locations yet to be determined by the Atlantic States Marine Fisheries Commission (ASMFC) and held in the states of Massachusetts and Rhode Island on the public hearing draft of Amendment 13 to the Summer Flounder, Scup, and Black Sea Bass Fishery Management Plan. The intent to schedule these meetings was announced in the **Federal Register** on September 27, 2000.

FOR FURTHER INFORMATION CONTACT: Daniel T. Furlong, Executive Director of the Mid-Atlantic Fishery Management Council (Council), 302–674–2331, ext. 19, or John Dunnigan, Executive Director, ASMFC, 202–289–6400, ext. 304.

SUPPLEMENTARY INFORMATION: NMFS, the Council, and ASMFC jointly manage the summer flounder fishery off the Atlantic coast. An earlier notice, published in the **Federal Register** (65 FR 58035, September 27, 2000) announced four public hearings with specific locations and dates to gather public comments on draft Amendment 13. The same notice also advised the public that two additional hearings (one in Massachusetts and one in Rhode Island) would be held at locations and times to be determined by the ASMFC and announced later through another notice in the **Federal Register**. The ASMFC has decided not to hold these hearings.

Dated: October 30, 2000.

Bruce C. Morehead,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 00–28305 Filed 11–2–00; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic Atmospheric Administration

50 CFR Part 679

[Docket No. 001023289–0289–01; I.D. 083000C]

RIN 0648–AO25

Fisheries of the Exclusive Economic Zone Off Alaska; Extension of the Interim Groundfish Observer Program through December 31, 2002

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic Atmospheric Administration (NOAA), Commerce.

ACTION: Proposed rule; request for comments.

SUMMARY: NMFS proposes a rule to extend through 2002 the existing regulations for the Interim North Pacific Groundfish Observer Program (Observer Program), which otherwise would expire December 31, 2000. This action is necessary to ensure uninterrupted observer coverage through December 31, 2002. The intention is to advance the management objectives of the Fishery Management Plan for the Groundfish Fishery of the Bering Sea and Aleutian Islands Area and the Fishery Management Plan for Groundfish of the Gulf of Alaska (FMPs). The proposed rule would not amend the existing regulations, except to extend the certifications of observer contractors who are currently certified by NMFS.

DATES: Comments on this proposed rule must be received by November 20, 2000.

ADDRESSES: Comments should be sent to Sue Salveson, Assistant Regional Administrator for Sustainable Fisheries, Alaska Region, NMFS, P.O. Box 21668, Juneau, AK 99802, Attn: Lori Gravel, or delivered to the Federal Building, 709 West 9th Street, Juneau, AK. Copies of the Environmental Assessment/Regulatory Impact Review/Final Regulatory Flexibility Analysis (EA/RIR/FRFA) prepared for the 1997 Interim Groundfish Observer Program, the RIR/FRFA prepared for the 1998 Interim Groundfish Observer Program, the RIR/FRFA prepared for the 1999–2000 Interim Groundfish Observer Program, and the RIR/Initial Regulatory Flexibility Analysis (IRFA) prepared for this proposed regulatory action may also be obtained from the same address. Send comments on any ambiguity or unnecessary complexity arising from the language used in this proposed rule to the Regional Administrator, Alaska Region, P.O. Box 21668, Juneau AK 99802.

FOR FURTHER INFORMATION CONTACT: Bridget Mansfield, 907–586–7228.

SUPPLEMENTARY INFORMATION:

Background

NMFS manages the U.S. groundfish fisheries of the Gulf of Alaska and the Bering Sea and Aleutian Islands Area in the Exclusive Economic Zone under the FMPs. The North Pacific Fishery Management Council (Council) prepared the Fishery Management Plans (FMPs) pursuant to the Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act). Regulations implementing the FMPs appear at 50 CFR part 679. General regulations that pertain to U.S. fisheries appear at subpart H of 50 CFR part 600.

The Council adopted and NMFS implemented the Interim Groundfish Observer Program (Interim Program) in 1996, which superseded the North Pacific Fisheries Research Plan (Research Plan). The requirements of the 1996 Interim Program were extended through 1997 (61 FR 56425, November 1, 1996), again through 1998 (62 FR 67755, December 30, 1997), and again through 2000 (63 FR 69024, December 15, 1998). The Interim Program provides the framework for the collection of data by observers to obtain information necessary for the conservation and management of the groundfish fisheries managed under the FMPs. Further, it authorizes mandatory observer coverage requirements for vessels and shoreside processors and establishes vessel, processor and contractor responsibilities relating to the observer program. NMFS' intent is that the Interim Program be effective until a long-term program is developed and implemented that addresses several current concerns. These include data integrity, observer compensation, working conditions for observers, and equitable distribution of observer costs.

NMFS is working with the Council and the Council's Observer Advisory Committee (OAC) to address the concerns above and to develop new options for an alternative infrastructure for the Observer Program. A new infrastructure would be expected to ensure the continued collection of quality observer data and address observer coverage cost distribution issues through a fee system or alternate funding mechanism.

The development of a new infrastructure will require extensive time and coordination among NMFS staff, the OAC, and representatives of the industry sectors and observer interests. The intent of NMFS and the Council is to implement a replacement structure for the program prior to the proposed expiration of the current Interim Observer Program on December 31, 2002.

A description of the regulatory provisions of the Interim Groundfish Observer Program was provided in the proposed and final rules implementing this program (61 FR 40380, August 2, 1996; 61 FR 56425, November 1, 1996, respectively) as well as the proposed and final rules extending this program through 1998 and again through 2000 (62 FR 49198, September 19, 1997; 62 FR 67755, December 30, 1997; 63 FR 47462, September 8, 1998; 63 FR 69024, December 15, 1998, respectively). No changes to the existing regulations are proposed in this rulemaking, except to extend certification of observer

contractors who are currently certified by NMFS under the terms and conditions set forth in the regulations at § 679.50(i).

NMFS will continue efforts to enhance the existing Interim Program under separate rulemaking. At its June 2000 meeting, the Council recommended several changes to the regulations implementing the Observer Program to address concerns about observer coverage requirements and the adequacy of regulatory provisions supporting the working environment of observers. NMFS anticipates that a proposed rule to implement the Council's recommendation will be published in the **Federal Register** next year for public review and comment. These changes include the following: Revised coverage requirements for shoreside processors, shoreside observer housing, transportation and communication standards, revised coverage requirements for the groundfish pot fishery, and restrictions on distribution of personal information on individual observers.

Classification

This proposed rule has been determined to be not significant for purposes of Executive Order 12866.

This rule would extend without change existing collection-of-information requirements subject to the Paperwork Reduction Act (PRA). The collection of this information has been approved by the Office of Management and Budget (OMB) under OMB control numbers 0648–0307 and 0648–0318.

Notwithstanding any other provision of the law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the PRA, unless that collection of information displays a currently valid OMB control number.

The extension of the existing regulations implementing the Interim Observer Program through December 31, 2002, is consistent with the intent and purpose of the Interim Observer Program. The extension will provide the same benefits as listed in the EA/RIR/FRFA for the Interim Observer Program dated August 27, 1996, the RIR/FRFA for the extension of the Interim Observer Program through 1998 dated October 28, 1997, and the RIR/FRFA for the extension of the Interim Observer Program through 2000, dated June 4, 1998. Copies of these analyses are available from NMFS (see **ADDRESSES**).

NMFS prepared an IRFA, which describes the impact this proposed rule would have on small entities, if adopted. A copy of this analysis is also available from NMFS (see **ADDRESSES**).

Observer costs borne by vessels and processors are based on whether an observer is deployed aboard a vessel or at a shoreside processor, and on overall coverage needs. Higher costs are borne by those vessels and shoreside processors that require higher levels of coverage. Most of the catcher vessels participating in the groundfish fisheries off Alaska and that are required to carry an observer (i.e., vessels 60 ft (18.3 m) length overall (LOA) and longer) meet the definition of a small entity under the Regulatory Flexibility Act (RFA). Since 1995, about 270 catcher vessels annually carry observers. The FRFAs prepared for the 1998 and 2000 Interim Observer Program describe the degree to which these vessels would be economically impacted by observer coverage levels or other regulatory provisions of the Observer Program. The proposed action is not expected to result in any economic impacts beyond those already analyzed in these previous FRFAs because (1) this rule would not implement any changes in required coverage levels or other regulations implementing the Interim Observer Program, except for the extension of the effective date; and (2) the underlying socieconomic conditions of the fishery and participating small entities has remained constant.

Although exact quantification of relative costs is not possible due to the unavailability of data, we can conclude that smaller vessels generally pay a proportionally larger share toward observer coverage than do larger vessels and shoreside processors when seen as a percentage of ex-vessel or product prices. Additionally, impacts of this action cannot be isolated from other factors, including price fluctuation. A fluctuation in ex-vessel or product value would likewise result in a fluctuation of cost of observer coverage as a percentage of the resulting revenues.

Costs borne by industry to meet observer coverage requirements under the Interim Observer Program are considerable ($8–$10 million) and would continue under the proposed action to extend the program. However, impacts of extending the current interim program would be expected to be minimal relative to the No Action alternative. These impacts include: (1) elimination of all observer jobs provided through the program; (2) elimination of earnings realized by observer providers, including the real potential for some companies to go out of business; and (3) potential lost revenue to industry in terms of inaccurate catch accounting and potential mis-allocation of Total Allowable Catch (TAC) resulting in premature or delayed fishery closures. Premature closures cause forfeiture of valuable catch and could adversely impact product supply and prices paid by consumers. Delayed closures of the fishery cause resources to be less effectively managed, with adverse long-term implications for productivity and future catch levels. While these costs cannot be readily estimated, they do represent a real potential loss and would be relatively larger for smaller vessels that pay a higher proportional cost for observer coverage.

The RFA requires that the IRFA describe significant alternatives to the proposed rule that accomplish the stated objectives of the applicable statutes and minimize any impact on small entities. The IRFA must discuss significant alternatives to the proposed rule such as (1) establishing different reporting requirements for small entities that take into account the resources available to small entities, (2) consolidating or simplifying of reporting requirements, (3) using performance rather than design standards, and (4) allowing exemptions from coverage for small entities.

NMFS did not consider alternatives that address modifying reporting requirements for small entities or the use of performance standards. Such alternatives are not relevant to this proposed action and would not mitigate the impacts on small entities. Allowing for additional exemptions for small entities from this proposed action would undermine the collection of information needed to effectively manage the Alaska groundfish fisheries.

However, this proposed action does include measures that will minimize the significant economic impacts of observer coverage requirements on at least some small entities. Vessels less than 60 ft(18.3 m) LOA are not required to carry an observer while fishing for groundfish. Similarly, vessels 60 ft and greater, but less than 125 ft (38.1 m) LOA, have lower levels of observer coverage than those 125 ft and above. These requirements, which have been incorporated into the requirements of the North Pacific Groundfish Observer Program since its inception in 1989, effectively mitigate the economic impacts on some small entities without significantly adversely affecting the implementation of the conservation and management responsibilities imposed by the FMPs and the Magnuson-Stevens Act.

Regulations implementing the existing observer program will expire at the end of 2000 unless extended. Implementation of an alternative

program structure including an alternative funding mechanism is not feasible by the end of this year, which would be necessary to provide observer coverage for the 2001–2002 groundfish fisheries. The preferred alternative for an extension of the current interim observer program is the only option that could be implemented by January 1, 2001, and ensure the groundfish fisheries could commence without interruption.

The President has directed Federal agencies to use plain language in their communications with the public, including regulations. To comply with this directive, we seek public comment on any ambiguity or unnecessary complexity arising from the language used in this proposed rule. Such comments should be sent to the Regional Administrator, Alaska Region (see **ADDRESSES**).

List of Subjects in 50 CFR Part 679

Alaska, Fisheries, Reporting and recordkeeping requirements.

Dated: October 27, 2000

William T. Hogarth,

Acting Assistant Administrator for Fisheries, National Marine Fisheries Service.

For the reasons set out in the preamble, 50 CFR part 679 is proposed to be amended as follows:

PART 679—FISHERIES OF THE EXCLUSIVE ECONOMIC ZONE OFF ALASKA

1. The authority citation for 50 CFR part 679 continues to read as follows:

Authority: 16 U.S.C. 773 *et seq.,* 1801*et seq.*, and 3631 *et seq.*

2. In § 679.50, the section heading, and paragraphs (i)(1)(i) and (i)(1)(iii) are revised to read as follows:

§ 679.50 Groundfish Observer Program applicable through December 31, 2002.

* * * * *

(i) * * *

(1) * * *

(i) *Application.* An applicant seeking to become an observer contractor must submit an application to the Regional Administrator describing the applicant's ability to carry out the responsibilities and duties of an observer contractor as set out in paragraph (i)(2) of this section and the arrangements to be used. Observer contractors certified for the year 2000 to provide observers through the North Pacific Groundfish Observer Program, are exempt from this requirement to submit an application and are certified for the term specified in paragraph (i)(1)(iii) of this section.

* * * * *

(iii) *Term.* Observer contractors will be certified through December 31, 2002. NMFS can decertify or suspend observer contractors pursuant to paragraph (j) of this section.

* * * * *

[FR Doc. 00–28304 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–22–S

Notices

Federal Register
Vol. 65, No. 214
Friday, November 3, 2000

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

Animal and Plant Health Inspection Service

[Docket No. 00–099–1]

Notice of Request for Approval of an Information Collection

AGENCY: Animal and Plant Health Inspection Service, USDA.

ACTION: New information collection; comment request.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Animal and Plant Health Inspection Service's intention to initiate the Bluetongue Surveillance Pilot Project sentinel trial, which will be an information collection activity. The purpose of the sentinel trial, which will be voluntary, is to support international export trade through the identification and development of an economically feasible and highly representative surveillance system to substantiate the regionalization of the United States for bluetongue. The sentinel trial will take place on farms in Montana, Nebraska, North Dakota, and South Dakota.

DATES: We invite you to comment on this docket. We will consider all comments that we receive by January 2, 2001.

ADDRESSES: Please send four copies (an original and three copies) of your comment to: Docket No. 00–099–1, Regulatory Analysis and Development, PPD, APHIS, Suite 3C03, 4700 River Road, Unit 118, Riverdale, MD 20737–1238. Please state that your comment refers to Docket No. 00–099–1.

You may read any comments that we receive on this docket in our reading room. The reading room is located in room 1141 of the USDA South Building, 14th Street and Independence Avenue, SW., Washington, DC. Normal reading room hours are 8 a.m. to 4:30 p.m., Monday through Friday, except holidays. To be sure someone is there to help you, please call (202) 690–2817 before coming.

APHIS documents published in the **Federal Register**, and related information, including the names of organizations and individuals who have commented on APHIS dockets, are available on the Internet at http://www.aphis.usda.gov/ppd/rad/webrepor.html.

FOR FURTHER INFORMATION CONTACT: For information on the Bluetongue Surveillance Pilot Program sentinel trial, contact Ms. Marj Swanson, Management Analyst, Centers for Epidemiology and Animal Health, VS, APHIS, 555 S. Howes, Fort Collins, CO 80521; (970) 490–7978. For copies of more detailed information on the information collection, contact Mrs. Celeste Sickles, APHIS' Information Collection Coordinator, at (301) 734–7477.

SUPPLEMENTARY INFORMATION:

Title: Bluetongue Surveillance Pilot Program.

OMB Number: 0579–XXXX.

Type of Request: Approval of a new information collection.

Abstract: The United States Department of Agriculture is responsible for protecting the health of our Nation's animals and poultry by preventing the spread of contagious, infectious, or communicable animal diseases from one State to another and by eradicating such diseases from the United States when feasible. In connection with this mission, the Animal and Plant Health Inspection Service (APHIS), Veterinary Services, Center for Animal Health Monitoring, is requesting approval to initiate the Bluetongue Surveillance Pilot Program (BSPP) sentinel trial information collection activity.

Bluetongue viruses are transmitted by blood-feeding midges (*Culicoides* spp.), which breed in cattle manure and transmit the viruses between hosts, which include antelope, cattle, deer, elk, goats, and sheep. Cattle are infected naturally by these viruses but rarely show clinical signs. However, sheep and other ruminants show signs of the disease, including abortion, birth defects, emaciation, ulcers in the digestive system and mouth, lameness, pneumonia, and death. Twenty-four serotypes of bluetongue virus are distributed throughout the tropical and temperate regions of the world; except for Greece and Italy on occasion, Europe is bluetongue virus-free. The viruses and vectors (insects) have evolved to establish well-defined regional complexes of selected serotypes adapted to specific midge populations. In the United States, four serotypes of bluetongue virus are known to occur; however, their range is restricted to Western and Southern States. This is the result of climatic and ecologic conditions that determine the distribution of the North American vector, *Culicoides sonorensis*.

Bluetongue is an Office International des Epizooties (OIE) List A disease. The criteria for inclusion on this list are transmissibility, potential for serious and rapid spread, and major economic importance in the international trade of animals and animal products. For these reasons, countries, especially those entirely free of bluetongue, take action to minimize the risk of introducing exotic serotypes of the virus, thus restricting trade. These restrictions are estimated to cost the United States $125 million annually (USDA Agricultural Research Service, 1999).

The current method of bluetongue surveillance tests blood samples taken from animals at the time of slaughter through the APHIS Market Cattle Identification (MCI) system. Every 2 years, slaughter samples are tested from 18 Northeastern and North Central States, Alaska, Hawaii, and western Washington, which are considered to be free of bluetongue. In the MCI slaughter survey in 1996, 9,053 slaughter samples were tested. Four of the 14 geographic areas sampled had 2 percent or greater positive samples, which exceeds the OIE standard and leads to restrictions on the export of animals from those areas. Slaughter surveillance as the method for bluetongue surveillance has limited specificity and geographic representativeness with regard to the demands of international trade. Detection of low levels of bluetongue antibody may reflect animal movement rather than disease occurrence at the sampling locations, as the life history of the animals sampled is unknown.

The purpose of the BSPP sentinel trial is to support international export trade through the identification and development of an economically feasible and more representative surveillance system to substantiate the

regionalization of bluetongue. The BSPP sentinel trial is a surveillance methodology development activity. In the surveillance trial, specific sentinel animals and farms will be tested serologically over time in contrast to the randomized on-farm and slaughter market surveillance currently practiced. Neither one-time, on-farm nor slaughter market surveillance allows animals to be tracked over time, and the geographic history of the origin of the animals is difficult to establish with consistent reliability.

The Center for Animal Health Monitoring is proposing the BSPP sentinel trial, which will use active serosurveillance, adult insect trapping, and soil sampling for insect larvae from suspect vector breeding sites. The objectives of this study include: (1) Develop a pilot sentinel system as a tool to substantiate disease freedom and compare it to other surveillance options; (2) test for bluetongue status in two demarcated populations (free and infected); and (3) develop data on the epidemiology of bluetongue in a seasonally infected area.

The ideal choice of States is a contiguous north-south group, (*e.g.*, Montana, North Dakota, South Dakota, and Nebraska) that transects the border between the disease-free (North Dakota) and the seasonally affected zone (Montana and Nebraska) with a transitional State (South Dakota) having both free and infected zones. This provides a continuous gradient of environmental determinants of vector distribution that can be measured when moving from north to south.

The Sanitary and Phytosanitary Agreement of the World Trade Organization provides that countries can create disease-free and low-prevalence zones. Determination of such areas must be based on factors such as geography, ecosystems, epidemiological surveillance, and the effectiveness of sanitary and phytosanitary controls. Further, it is up to the exporting country to develop a regionalization proposal with sufficient information to substantiate zoning for a disease. The importing country is charged with reviewing the proposal and providing a transparent and science-based decision. In the case of bluetongue, a vector-borne disease, it is largely the ecology of the vector that determines the distribution of the disease.

The potential benefits to trade from better bluetongue surveillance include access to new export markets and preservation of existing markets through increased confidence in disease freedom.

Information from this study will be disseminated and used by livestock producers, animal health officials, private veterinary practitioners, animal industry groups, policymakers, public health officials, the media, educational institutions, and others to improve agricultural productivity and competitiveness.

Participation in the BPSS sentinel trial is voluntary, and all data are confidential.

We are asking the Office of Management and Budget (OMB) to approve the use of this information collection activity.

The purpose of this notice is to solicit comments from the public (as well as affected agencies) concerning this information collection. These comments will help us:

(1) Evaluate 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) Evaluate the accuracy of our estimate of the burden of the information collection, including the validity of the methodology and assumptions used;

(3) Enhance the quality, utility, and clarity of the information to be collected; and

(4) Minimize the burden of the information collection on those who are to respond, through use, as appropriate, of automated, electronic, mechanical, and other collection technologies, *e.g.,* permitting electronic submission of responses.

Estimate of burden: The public reporting burden for this collection of information is estimated to average .93814 hours per response.

Respondents: Industry personnel, private veterinary practitioners, company and independent producers, academicians, State veterinary medical officers, and State public health officials.

Estimated annual number of respondents: 1,365.

Estimated annual number of responses per respondent: 1.06593.

Estimated annual number of responses: 1,455.

Estimated total annual burden on respondents: 1,373 hours. (Due to rounding, the total annual burden hours may not equal the product of the annual number of responses multiplied by the average reporting burden per response.)

All responses to this notice will be summarized and included in the request for OMB approval. All comments will also become a matter of public record.

Done in Washington, DC, this 30th day of October 2000.

Bobby R. Acord,

Acting Administrator, Animal and Plant Health Inspection Service.

[FR Doc. 00–28247 Filed 11–2–00; 8:45 am]

BILLING CODE 3410–34–P

DEPARTMENT OF AGRICULTURE

Commodity Credit Corporation

Request for Reinstatement and Revision of a Previously Approved Information Collection

AGENCY: Commodity Credit Corporation, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the intention of the Commodity Credit Corporation (CCC) and the Farm Service Agency (FSA) to request the reinstatement and revision of a previously approved information collection. This information collection is used by CCC and FSA to document or determine whether representatives or survivors of a producer are entitled to received payments earned by a producer who dies, disappears, or is declared incompetent before receiving payments or other disbursements.

DATES: Comments on this notice must be received on or before January 2, 2001 to be assured consideration.

ADDITIONAL INFORMATION OR COMMENTS: Contact David Tidwell, Agricultural Program Specialist, Production, Emergencies, and Compliance Division, USDA, FSA, STOP 0517, 1400 Independence Avenue, SW, Washington, DC 20250–0517, telephone (202)720–4542.

SUPPLEMENTARY INFORMATION:

Title: Application for Payment of Amounts Due Persons Who Have Died, Disappeared, or Have Been Declared Incompetent.

OMB Control Number: 0560–0026.

Type of Request: Extension and revision of a currently approved information collection.

Abstract: Persons desiring to claim payment due a person who has died, disappeared, or has been declared incompetent must do so on Form FSA–325, ''Application for Payment of Amounts Due Persons Who Have Died, Disappeared, or Have Been Declared Incompetent''. This information is used by FSA county office employees to document the relationship of heirs or beneficiaries and determine the order of precedence for disbursing payments to

survivors of the person who has died, disappeared, or been declared incompetent.

Information is obtained only when a producer eligible to receive a payment or disbursement dies, disappears, or is declared incompetent, and documentation is needed to determine if any survivors are entitled to receive such payments or disbursements.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average .5 hours (1/2 hour) per response.

Respondents: Individual producers.

Estimated Number of Respondents: 4,000.

Estimated Number of Responses per Respondent: one.

Estimated Total Annual Burden on Respondents: 2,000.

Proposed topics for comment include: (a) 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; (b) the accuracy of the agency's estimate of burden including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility and clarity of the information collected; or (d) ways to minimize the burden of the collection 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. Comments should be sent to the Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503 and to David Tidwell, Agricultural Program Specialist, Production, Emergencies, and Compliance Division, USDA, FSA, STOP 0517, 1400 Independence Avenue, SW., Washington, DC 20250–0517, (202)720–4542.

Copies of the information collection may be obtained from David Tidwell, at the above address.

A comment to OMB is best assured of having its full effect if OMB receives it within 30 days of publication. This does not affect the deadline for the public to comment to the Department of Agriculture on the substantive regulations that may be the subject of other notices.

Signed at Washington, DC, on October 26, 2000.

George Arredondo,

Acting Executive Vice President, Commodity Credit Corporation.

[FR Doc. 00–28264 Filed 11–2–00; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

Commodity Credit Corporation

Request for Extension and Revision of a Currently Approved Information Collection

AGENCY: Commodity Credit Corporation, USDA.

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the intention of the Commodity Credit Corporation (CCC) and the Farm Service Agency (FSA) to request an extension and revision for the Highly Erodible Land Conservation and Wetland Conservation certification requirements. This information is collected in support of the conservation provisions of Title XII of the Food Security Act of 1985, as amended by the Food, Agriculture, Conservation, and Trade Act of 1990 and the Federal Agriculture, Improvement and Reform Act of 1996 (the Statute).

DATES: Comments on this notice must be received on or before January 2, 2001 to be assured consideration.

ADDITIONAL INFORMATION OR COMMENTS: Contact Sharon Biastock, Agricultural Program Specialist, Production, Emergencies, and Compliance Division, USDA, FSA, STOP 0517, 1400 Independence Avenue, SW., Washington, DC 20250–0517, telephone (202)720–6336.

SUPPLEMENTARY INFORMATION:

Title: Highly Erodible Land Conservation and Wetland Conservation Certification.

OMB Control Number: 0560–0185.

Expiration Date: December 31, 2000.

Type of Request: Extension and revision of a currently approved information collection.

Abstract: Rules governing those requirements under Title XII of the Food Security Act of 1985, as amended by the Food, Agriculture, Conservation, and Trade Act of 1990 and the Federal Agriculture, Improvement and Reform Act of 1996 relating to highly erodible lands and wetlands are codified in 7 CFR part 12. In order to ensure that persons who request benefits subject to conservation restrictions get the necessary technical assistance and are informed regarding the compliance requirements on their land, information is collected with regard to their intended activities on their land which could affect their eligibility for requested USDA benefits. Once technical determinations are made, producers are required to certify that they will comply with the conservation requirements on their land to maintain their eligibility for certain programs.

Persons may request that certain activities be exempt according to provisions of the Statute. Information is collected from those who seek these exemptions for the purpose of evaluating whether the exempted conditions will be met.

Estimate of Burden: Public reporting burden for this collection of information is estimated to average .16 hours (10 minutes) per response.

Respondents: Individual producers.

Estimated Number of Respondents: 250,000

Estimated Number of Responses per Respondent: 1.

Estimated Total Annual Burden on Respondents: 40,000.

Proposed topics for comment include: (a) Whether the collection 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 burden, including the validity of the methodology and assumptions used; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) ways to minimize the burden of the collection of the information on those who are to respond, including the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology. Comments should be sent to the Desk Officer for Agriculture, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503 and to Sharon Biastock, Agricultural Program Specialist, Production, Emergencies, and Compliance Division, USDA, FSA, STOP 0517, 1400 Independence Avenue, SW., Washington, DC 20250–0517, telephone (202)720–6336.

Signed at Washington, DC, on October 26, 2000.

George Arredondo,

Acting Executive Vice President, Commodity Credit Corporation.

[FR Doc. 00–28265 Filed 11–2–00; 8:45 am]

BILLING CODE 3410–05–P

DEPARTMENT OF AGRICULTURE

Grain Inspection, Packers and Stockyards Administration

Protein Certification

AGENCY: Grain Inspection, Packers and Stockyards Administration, USDA.

ACTION: Final notice.

SUMMARY: The Grain Inspection, Packers and Stockyards Administration (GIPSA) will begin certifying wheat protein content results on any specified moisture basis requested by applicants, in addition to certifying results on the current 12.0 percent moisture basis. This change was requested by importers of U.S. wheat.

EFFECTIVE DATES: May 1, 2001.

FOR FURTHER INFORMATION CONTACT: Paul Manol at GIPSA, USDA, STOP 3632, 1400 Independence Avenue, SW., Washington, DC, 20250–3632; FAX (202) 720–1015; or E-mail *Pmanol@Gipsadc.usda.gov.*

SUPPLEMENTARY INFORMATION: On May 1, 1978, GIPSA (then the Federal Grain Inspection Service or FGIS) began offering official wheat protein testing for Hard Red Winter and Hard Red Spring wheat to interested parties in the grain industry. An ''as-is'' moisture basis was used to calculate protein content, though it could also be determined and recorded using any specified moisture basis if requested by the applicant for inspection. GIPSA received numerous complaints, mostly from foreign buyers, about calculating protein content on an as-is moisture basis. These complaints were generally about low protein levels which, in part, appeared due to the difference between the U.S. and Canadian methods for computing and stating protein content. Canada was using a fixed 13.5 percent moisture basis; the U.S. an as-is moisture basis calculation. When using an as-is moisture basis to certify protein, the certified protein result depends directly on the moisture level of the wheat—it is inversely proportional to the moisture content. Consequently, as the moisture content of the wheat gets lower, the protein content reported on an as-is basis gets higher. This phenomenon can give the perception that the protein level increased when, in fact, it remained unchanged.

To address these concerns and increase the uniformity of official protein reporting procedures, FGIS proposed, in 1986, to revise its Grain Inspection Handbook to certify protein content on a constant 12.0 percent moisture basis. A 12.0 percent moisture basis was recommended by various grower and processor organizations, as well as the Grain Quality Workshops, because this percentage represented the average moisture content of wheat exported from the United States. Certifying protein content on a constant 12.0 percent moisture basis would provide buyers and sellers of U.S. wheat results that could be easily evaluated and compared with results from other major wheat exporting countries. For example, Canada uses a 13.5 percent moisture basis, Australia uses either 11.0 percent or ''as-is'', England and Sweden use 15.0 percent, and many Eastern European and other countries around the world use the dry matter basis. This proposal, announced in the May 30, 1986, **Federal Register** (51 FR 19556), solicited industry comment on this action.

Comments on the May 30, 1986, proposal generally favored a constant moisture basis for protein determination. Some commentors suggested using either a dry matter (0.0 percent moisture basis) or a 14.0 percent moisture basis as the constant. European flour mill purchase specifications typically use a dry matter reporting basis, whereas American mills rely on a 14.0 percent moisture basis. The majority of commentors, including foreign buyers, supported the proposal to certificate protein on a constant 12.0 percent moisture basis. Consequently, FGIS announced this change in the August 26, 1986, **Federal Register** (51 FR 30323) to become effective May 1, 1987.

Moving to a constant 12.0 percent moisture basis eliminated varying protein results caused by fluctuating wheat moisture levels. To date, GIPSA only certifies protein results on a 12.0 percent moisture basis.

The current 12.0 percent moisture basis requirement for protein analysis in wheat may not be fully facilitating the marketing of export wheat. A number of U.S. wheat importers have asked GIPSA to provide optional certification of wheat protein content results on any specified moisture basis requested by applicants, in addition to the current 12.0 percent moisture basis.

To address these requests, GIPSA published a Notice in the October 1, 1998, **Federal Register** (63 FR 52681) that solicited comments on introducing flexible certification in our protein testing program, in addition to maintaining the standardization of results. Allowing certification on the 12.0 percent moisture basis and, optionally, on a moisture basis requested by the applicant would provide sufficient information on the inspection certificate to facilitate the marketing of wheat. Although this certification option was developed to address the export market's need, it could be used for domestic shipments as well. This would be especially true in situations when an exporter is originating wheat to fulfill an export contract that requires a moisture basis other than 12.0 percent. Therefore, this certification option would be available from GIPSA field offices, delegated States, and designated agencies. Adopting this action would allow GIPSA and the grain industry the greatest flexibility in the certification of wheat protein. Protein results would continue to be certified on a constant 12.0 percent moisture basis on all certificates, but GIPSA also would have the flexibility to meet customers' requests for additional information.

Discussion of Comments Received

A total of 22 comments were received from several foreign wheat millers and governments (Jordan, Syria, India, and Poland); State Wheat Boards/Commissions (California, Idaho, Nebraska, and Oregon); a State Department of Agriculture (Wisconsin); U.S. Wheat Associates; and U.S. grain industry trade groups (National Grain & Feed Association (NGFA) and North American Export Grain Association (NAEGA)). One domestic miller also commented on the proposal.

Thirteen comments favored the notice as it was written; that is, to allow for protein certification on any moisture basis requested by an applicant as well as the current 12.0 percent moisture basis. These comments were from the State Wheat Boards/Commissions, the State Department of Agriculture, U.S. Wheat Associates, and several foreign entities.

Two comments (NGFA and NAEGA) opposed the proposal as written. They suggested that reporting protein results on 12 percent and alternative moisture bases would likely create documentation problems for processing letters of credit. They suggested using one basis or the other, but not both.

The remaining seven comments, from foreign entities, suggested reporting results on any moisture basis requested; a 12 percent basis; an ''as-is'' basis; or a dry matter basis. One commentor suggested certifying the testing methodology.

Producer groups tend to favor certifying protein content on a 12-percent and any requested moisture basis. Their rationale is that dual certification would alleviate any ''misperception'' that a grain handler could purchase grain on a 12-percent basis and subsequently re-market the same lot of grain using a lower moisture basis, thereby ''increasing'' the protein content. This was one of the concerns about GIPSA's original policy that certified protein content on an ''as-is'' basis.

Other comments in support of the change concurred that it would add flexibility to the U.S. wheat marketing system and allow the U.S. industry to

better meet its customers needs. The change would allow buyers to better compare U.S. wheat to that of other wheat exporting countries and reflect the U.S. wheat industry's commitment to meet customers' needs. Further, it was suggested that the change would allow the national protein certification system to retain its uniformity and meet customers' specific contract needs.

GIPSA believes that introducing flexible certification in the protein testing program, in addition to maintaining standardization of results, will have a positive impact on export and domestic markets. We do not believe that this change would create documentation problems for processing letters of credit as two commentors suggested. On the contrary, providing for this option in the certification program will give the market the flexibility that it needs. Further, alternative protein reporting would be only used on a request basis. The effective date of this change is May 1, 2001. This will allow sufficient time for interested persons to become familiar with this option and allow the industry to make any adjustments deemed necessary.

Protein analysis and certification by GIPSA has always been optional; that is, buyers and sellers contractually agree whether or not to request official protein testing services. Wheat protein content would be certified on an alternative moisture basis only upon specific request by an applicant. In lieu of such a request, wheat protein would continue to be certified on the current 12.0-percent moisture basis. Overall, this certification option would allow GIPSA and the grain industry the greatest flexibility in the certification of wheat protein.

Accordingly, GIPSA will begin certifying protein content in wheat using the current 12.0 percent moisture basis and any other moisture basis requested by an applicant. This certification option will go into effect May 1, 2001. GIPSA field offices, delegated States, and designated agencies will be responsible for the applicable mathematical calculations for certification using the following industry recognized formula:

$$X = \frac{P\,(100 - PX)}{88}$$

Where:

X = the protein content at a moisture basis other than 12.0 percent requested by an applicant.

P = the protein content determined at a 12.0-percent moisture basis.

PX = the moisture basis specified by the applicant (using the ''official'' moisture meter results if the applicant requests protein content be certified on an ''as-is'' basis).

For example, if an applicant requests that protein results also be certified on a dry matter or 0.0 percent moisture basis and the protein content of the lot was determined to be 13.5 percent on a 12.0 percent moisture basis, the following calculation would be used to obtain the alternate protein result:

$$X = \frac{13.5 \times (100 - 0)}{88}$$

$$X = \frac{13.5 \times 100}{88}$$

$$X = \frac{1350}{88}$$

$$X = 15.3$$

Further, the statement on the certificate would read as follows:

Protein 15.3%, dry matter basis, which converts to 13.5% protein, 12.0% moisture basis. Protein content reported on an alternative moisture basis in addition to the U.S. standard 12.0 percent moisture basis at applicant's request.

Authority: Pub. L. 94–582, 90 Stat. 2867, as amended (7 U.S.C. 71 *et seq.*)

Dated: October 30, 2000.

David Orr,

Acting Administrator, Grain Inspection, Packers and Stockyards Administration.

[FR Doc. 00–28146 Filed 11–2–00; 8:45 am]

BILLING CODE 3410–EN–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 is proposing to add to the Procurement List a commodity and services to be furnished by nonprofit agencies employing persons who are blind or have other severe disabilities, and to delete commodities and a service previously furnished by such agencies.

COMMENTS MUST BE RECEIVED ON OR BEFORE: December 4, 2000.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia 22202–3259.

FOR FURTHER INFORMATION CONTACT: Louis R. Bartalot, (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 commodity and 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 commodity and services to the Government.

2. The action will result in authorizing small entities to furnish the commodity and services to the Government.

3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the commodity and 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 commodity and services have been proposed for addition to Procurement List for production by the nonprofit agencies listed:

Commodity

Rake, Forest Fire
4210–00–540–4512
NPA: Tuscola County Community Mental Health Services, Caro, Michigan

Services:

Administrative Services (Religious Services Technician)
Department of Justice, Federal Bureau of Prisons, Federal Correctional Institution, Cumberland, Maryland

NPA: Columbia Lighthouse for the Blind, Washington, DC
Base Supply Center
Trident Refit Facility, Naval Submarine Base, Kings Bay, Georgia
NPA: L.C. Industries for the Blind, Inc., Durham, North Carolina
Janitorial/Custodial
U.S. Border Patrol Compound, Davis Monthan AFB, Arizona
NPA: J.P. Industries, Inc., Tucson, Arizona
Linen Service
Hickam Air Force Base, Hickam AFB, Hawaii
NPA: Network Enterprises, Inc., Honolulu, Hawaii

Deletions

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities.
2. The action will result in authorizing small entities to furnish the commodity and the service to the Government.
3. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the commodity and the service proposed for deletion from the Procurement List.

The following commodity and service have been proposed for deletion from the Procurement List:

Commodity

Water Bag, Nylon Duck
8465–01–321–1678
8465–01–321–1678F

Service

Janitorial/Custodial
Drug Dependence Treatment Center, 2320 West Roosevelt Road, Chicago, Illinois

Louis R. Bartalot,

Deputy Director (Operations).

[FR Doc. 00–28271 Filed 11–02–00; 8:45 am]

BILLING CODE 6353–01–P

COMMITTEE FOR PURCHASE FROM PEOPLE WHO ARE BLIND OR SEVERELY DISABLED

Procurement List, Additions

AGENCY: Committee for Purchase From People Who Are Blind or Severely Disabled.

ACTION: Additions to the Procurement List.

SUMMARY: This action adds to the Procurement List commodities and a service to be furnished by nonprofit agencies employing persons who are blind or have other severe disablities.

EFFECTIVE DATE: December 4, 2000.

ADDRESSES: Committee for Purchase From People Who Are Blind or Severely Disabled, Jefferson Plaza 2, Suite 10800, 1421 Jefferson Davis Highway, Arlington, Virginia 22202–3259.

FOR FURTHER INFORMATION CONTACT: Louis R. Bartlot, (703) 603–7740.

SUPPLEMENTARY INFORMATION: On August 25, September 1and 15, 2000 the Committee for Purchase From People Who Are Blind or Severely Disabled published notices (65 FR 51794, 53267 and 55939) of proposed additions to the Procurement List.

After consideration of the material presented to it concerning capability of qualified nonprofit agencies to provide the commodities and service and impact of the additions on the current or most recent contractors, the Committee has determined that the commodities and service listed below are suitable for procurement by the Federal Government under 41 U.S.C. 46–48c and 41 CFR 51–2.4.

I certify that the following action will not have a significant impact on a substantial number of small entities. The major factors considered for this certification were:

1. The action will not result in any additional reporting, recordkeeping or other compliance requirements for small entities other than the small organizations that will furnish the commodities and service to the Government.
2. The action will not have a severe economic impact on current contractors for the commodities and service.
3. The action will result in authorizing small entities to furnish the commodities and service to the Government.
4. There are no known regulatory alternatives which would accomplish the objectives of the Javits-Wagner-O'Day Act (41 U.S.C. 46–48c) in connection with the commodities and service proposed for addition to the Procurement List.

Accordingly, the following commodities and service are hereby added to the Procurement List:

Commodities

CRT and Keyboard Cleaner
7045–01–247–6020
Strip, Door
3920–02–000–1916

Service

Janitorial/Custodial
Department of Veterans Affairs, BRECC VA Clinic, 3800 Loch Raven Boulevard, Baltimore, Maryland

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.

Louis R. Bartalot,

Deputy Director (Operations).

[FR Doc. 00–28272 Filed 11–02–00; 8:45 am]

BILLING CODE 6353–01–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Order No. 1124]

Expansion of Foreign-Trade Zone 78 and Authority To Conduct Manufacturing Authority (Computer Products); Nashville, Tennessee

Pursuant to its authority under the Foreign-Trade Zones Act of June 18, 1934, as amended (19 U.S.C. 81a–81u), the Foreign-Trade Zones Board (the Board) adopts the following Order:

Whereas, the Metropolitan Government of Nashville and Davidson County (Tennessee), grantee of Foreign-Trade Zone 78, submitted an application to the Board for authority to expand FTZ 78 to include two new sites, as well as for manufacturing authority (computer products) within those sites for Dell Computer Corporation (FTZ Docket 23–2000; filed 6/1/2000);

Whereas, notice inviting public comment was given in **Federal Register** (65 FR 36888, 6/12/2000) and the application has been processed pursuant to the FTZ Act and the Board's regulations; and,

Whereas, the Board adopts the findings and recommendations of the examiner's report, and finds that the requirements of the FTZ Act and Board's regulations are satisfied, and that the proposal is in the public interest;

Now, Therefore, the Board hereby orders:

The application to expand FTZ 78, and for manufacturing authority for Dell Computer Corporation, is approved, subject to the Act and the Board's regulations, including Section 400.28.

Signed at Washington, DC, this 24th day of October 2000.

Troy H. Cribb,

Acting Assistant Secretary of Commerce for Import Administration, Alternate Chairman, Foreign-Trade Zones Board.

Attest:

Dennis Puccinelli,

Executive Secretary.

[FR Doc. 00–28287 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

Foreign-Trade Zones Board

[Order No. 1123]

Approval for Expanded Manufacturing Authority; (Automobile Transmissions) Within Foreign-Trade Subzone 229A; Toyota Motor Manufacturing West Virginia, Inc., Buffalo, West Virginia

Pursuant to its authority under the Foreign-Trade Zones Act of June 18, 1934, as amended (19 U.S.C. 81a–81u), the Foreign-Trade Zones Board (the Board) adopts the following Order:

Whereas, the West Virginia Economic Development Authority, grantee of FTZ 229, has requested authority on behalf of Toyota Motor Manufacturing West Virginia, Inc. (TMMWV), operator of FTZ 229A, at the TMMWV automobile engine manufacturing plant in Buffalo, West Virginia, to expand the scope of authority to include the manufacture of automobile transmissions under FTZ procedures within Subzone 229A (FTZ Doc. 52–99, filed 10–25–99);

Whereas, notice inviting public comment was given in the **Federal Register** (64 FR 59160, 11–2–99);

Whereas, the Board adopts the findings and recommendations of the examiner's report, and finds that the requirements of the FTZ Act and the Board's regulations are satisfied, and that approval of the application is in the public interest;

Now Therefore, the Board hereby approves the request subject to the FTZ Act and the Board's regulations, including § 400.28.

Signed at Washington, DC, this 24th day of October 2000.

Troy H. Cribb,

Acting Assistant Secretary of Commerce for Import Administration, Alternate Chairman, Foreign-Trade Zones Board.

Attest:

Dennis Puccinelli,

Executive Secretary.

[FR Doc. 00–28286 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

[A–557–805]

Extruded Rubber Thread From Malaysia; Preliminary Results of Antidumping Duty Administrative Review

AGENCY: Import Administration, International Trade Administration, Department of Commerce.

SUMMARY: In response to a request by the petitioner and two producers/exporters of the subject merchandise, the Department of Commerce is conducting an administrative review of the antidumping duty order on extruded rubber thread from Malaysia. This review covers three manufacturers/exporters of the subject merchandise to the United States (Filati Lastex Sdn. Bhd., Heveafil Sdn. Bhd./Filmax Sdn. Bhd, and Rubberflex Sdn. Bhd.). The period of review is October 1, 1998, through September 30, 1999.

We have preliminarily determined that sales have been made below the normal value by each of the three companies subject to this review. If these preliminary results are adopted in the final results of this administrative review, we will instruct the Customs Service to assess antidumping duties on all appropriate entries.

We invite interested parties to comment on these preliminary results. Parties who wish to submit comments in this proceeding are requested to submit with each argument: (1) A statement of the issue; and (2) a brief summary of the argument.

EFFECTIVE DATE: November 3, 2000.

FOR FURTHER INFORMATION CONTACT: Irina Itkin, Office of AD/CVD Enforcement, Office 2, Import Administration, International Trade Administration, U.S. Department of Commerce, 14th Street and Constitution Avenue, NW, Washington, DC 20230; telephone (202) 482–0656.

SUPPLEMENTARY INFORMATION:

Background

On October 20, 1999, the Department of Commerce (the Department) published in the **Federal Register** a notice of ''Opportunity to Request an Administrative Review'' of the antidumping duty order on extruded rubber thread from Malaysia (64 FR 56485).

In accordance with 19 CFR 351.213(b)(1), on October 21, 1999, the petitioner, North American Rubber Thread, requested an administrative review of the antidumping order covering the period October 1, 1998, through September 30, 1999, for the following producers and exporters of extruded rubber thread: Filati Lastex Sdn. Bhd. (Filati), Heveafil Sdn. Bhd./Filmax Sdn. Bhd. (Heveafil), and Rubberflex Sdn. Bhd. (Rubberflex). On October 29, 1999, Filati and Heveafil also requested an administrative review.

On November 23, 1999, the Department initiated an administrative review for Filati, Heveafil, and Rubberflex (64 FR 67846 (Dec. 3, 1999)). The Department also issued questionnaires to each of these companies in November.

In March 2000, we received responses from Filati, Heveafil, and Rubberflex.

In June, July, and September 2000, we issued supplemental questionnaires to Filati, Heveafil, and Rubberflex. We received responses to these questionnaires in September 2000.

In October 2000, we issued additional supplemental questionnaires to Rubberflex. We received responses to these questionnaires in October 2000.

Scope of the Review

The product covered by this review is extruded rubber thread. Extruded rubber thread is defined as vulcanized rubber thread obtained by extrusion of stable or concentrated natural rubber latex of any cross sectional shape, measuring from 0.18 mm, which is 0.007 inch or 140 gauge, to 1.42 mm, which is 0.056 inch or 18 gauge, in diameter. Extruded rubber thread is currently classifiable under subheading 4007.00.00 of the Harmonized Tariff Schedule of the United States (HTSUS). The HTSUS subheadings are provided for convenience and customs purposes. The written description of the scope of this review is dispositive.

Period of Review

The period of review (POR) is October 1, 1998, through September 30, 1999.

Normal Value Comparisons

To determine whether sales of extruded rubber thread from Malaysia to the United States were made at less than normal value (NV), we compared the export price (EP) to the NV for Rubberflex, as specified in the ''Export Price and Constructed Export Price'' and ''Normal Value'' sections of this notice, below. We compared the constructed export price (CEP) to the NV for Filati and Heveafil, also as specified in those sections.

When making comparisons in accordance with section 771(16) of the Act, we considered all products sold in the home market as described in the ''Scope of the Review'' section of this

notice, above, that were in the ordinary course of trade for purposes of determining appropriate product comparisons to U.S. sales. Where there were no sales of identical merchandise in the home market made in the ordinary course of trade (*i.e.,* sales within the contemporaneous window which passed the cost test), we compared U.S. sales to sales of the most similar foreign like product made in the ordinary course of trade, based on the characteristics listed in sections B and C of our antidumping questionnaire, or constructed value (CV), as appropriate.

Level of Trade and CEP Offset

In accordance with section 773(a)(1)(B) of the Act, to the extent practicable, we determine NV based on sales in the comparison market at the same level of trade as EP or CEP. The NV level of trade is that of the starting-price sales in the comparison market or, when NV is based on CV, that of the sales from which we derive selling, general and administrative expenses (SG&A) and profit. For EP, the U.S. level of trade is also the level of the starting-price sale, which is usually from the exporter to the importer. For CEP, it is the level of the constructed sale from the exporter to the importer.

To determine whether NV sales are at a different level of trade than EP or CEP sales, we examine stages in the marketing process and selling functions along the chain of distribution between the producer and the unaffiliated customer. If the comparison market sales are at a different level of trade and the difference affects price comparability, as manifested in a pattern of consistent price differences between the sales on which NV is based and comparison-market sales at the level of trade of the export transaction, we make a level of trade adjustment under section 773(a)(7)(A) of the Act. Finally, for CEP sales, if the NV level is more remote from the factory than the CEP level and there is no basis for determining whether the difference in the levels between NV and CEP affects price comparability, we adjust NV under section 773(a)(7)(B) of the Act (the CEP offset provision). *See Notice of Final Determination of Sales at Less Than Fair Value: Certain Cut-to-Length Carbon Steel Plate from South Africa,* 62 FR 61731 (Nov. 19, 1997).

We note that the U.S. Court of International Trade (CIT) has held that the Department's practice of determining levels of trade for CEP transactions after CEP deductions is an impermissible interpretation of section 772(d) of the Act. *See Borden, Inc.* v. *United States,* 4 F. Supp. 2d 1221, 1241–42 (CIT 1998) *(Borden).* The Department believes, however, that its practice is in full compliance with the statute. On June 4, 1999, the CIT entered final judgement in *Borden* on the level of trade issue. *See Borden Inc.* v. *United States,* Court No. 96–08–01970, Slip Op. 99–50 (CIT June 4, 1999). The government has filed an appeal of *Borden* which is pending before the U.S. Court of Appeals for the Federal Circuit. Consequently, the Department has continued to follow its normal practice of adjusting CEP under section 772(d) prior to starting a level of trade analysis, as articulated by the Department's regulations at section 351.412.

Filati, Heveafil, and Rubberflex claimed that they made home market sales at only one level of trade (*i.e.,* sales to original equipment manufacturers). Because each of these respondents performed the same selling activities for sales to all customers in the home market, we determined that all home market sales by each of these companies were at the same level of trade.

Both Filati and Heveafil made CEP sales during the POR. In order to determine whether NV was established at a level of trade which constituted a more advanced stage of distribution than the level of trade of the CEP for these companies, we compared the selling functions performed for home market sales with those performed with respect to the CEP transaction, which excludes economic activities occurring in the United States. We found that Filati and Heveafil performed essentially the same selling functions in their sales offices in Malaysia for both home market and U.S. sales. Therefore, the respondents' sales in Malaysia were not at a more advanced stage of marketing and distribution than the constructed U.S. level of trade, which represents a F.O.B. foreign port price after the deduction of expenses associated with U.S. selling activities. Because we find that no difference in level of trade exists between markets, we have not granted a CEP offset for Filati or Heveafil.

Regarding Rubberflex, we compared the selling functions performed for its home market and export price transactions in order to determine whether a level of trade adjustment was warranted. We found that Rubberflex performed essentially the same selling functions for its U.S. and home market sales and that, therefore, no level of trade adjustment is warranted for this company.

Export Price and Constructed Export Price

For Rubberflex, we based the U.S. price on EP, in accordance with section 772(a) of the Act, when the subject merchandise was sold directly to the first unaffiliated purchaser in the United States prior to importation and CEP methodology was not otherwise warranted.

For Filati and Heveafil, we based the U.S. price on CEP where sales to the unaffiliated purchaser took place after importation into the United States, in accordance with section 772(b) of the Act. We also based U.S. price on CEP for Filati and Heveafil where the merchandise was shipped directly to certain unaffiliated customers because we found that the extent of the affiliates' activities performed in the United States in connection with those sales was significant.

A. Filati

We calculated CEP based on the starting price to the first unaffiliated purchaser in the United States. In accordance with section 772(c)(1)(B) of the Act, we added an amount for uncollected import duties in Malaysia. We made deductions from the starting price, where appropriate, for rebates. In addition, where appropriate, we made deductions for foreign inland freight, foreign brokerage and handling expenses, ocean freight, marine insurance, U.S. customs duty, U.S. brokerage and handling expenses, U.S. inland freight, and U.S. warehousing expenses, in accordance with section 772(c)(2)(A) of the Act.

We made additional deductions from CEP, where appropriate, for commissions, credit expenses, and U.S. indirect selling expenses, including U.S. inventory carrying costs, in accordance with section 772(d)(1) of the Act. We disallowed an offset claimed by Filati relating to imputed costs associated with financing antidumping and countervailing duty deposits, in accordance with the Department's practice. *See Extruded Rubber Thread from Malaysia; Final Results of Antidumping Duty Administrative Review,* 65 FR 6140, 6142 (Feb. 8, 2000) (*Thread Sixth Review*); *Extruded Rubber Thread from Malaysia; Final Results of Antidumping Duty Administrative Review,* 64 FR 12967, 12968 (Mar. 16, 1999); *Extruded Rubber Thread from Malaysia; Final Results of Antidumping Duty Administrative Review,* 63 FR 12752, 12754 (Mar. 16, 1998); and *Antifriction Bearings (Other Than Tapered Roller Bearings) and Parts Thereof from France, Germany, Italy,*

Japan, Romania, Singapore, Sweden and the United Kingdom; Final Results of Antidumping Duty Administrative Reviews, 62 FR 54043, 54075 (Oct. 17, 1997).

Pursuant to section 772(d)(3) of the Act, we further reduced the starting price by an amount for profit to arrive at CEP. In accordance with section 772(f) of the Act, we calculated the CEP profit rate using the expenses incurred by Filati and its affiliate on their sales of the subject merchandise in the United States and the foreign like product in the home market and the profit associated with those sales.

B. Heveafil

We calculated CEP based on the starting price to the first unaffiliated customer in the United States. In accordance with section 772(c)(1)(B) of the Act, we added an amount for uncollected import duties in Malaysia. We made deductions from the starting price, where appropriate, for rebates. We also made deductions for foreign inland freight, foreign brokerage and handling expenses, ocean freight, marine insurance, U.S. customs duty, U.S. brokerage and handling expenses, U.S. inland freight, and U.S. warehousing expenses, in accordance with section 772(c)(2)(A) of the Act.

We made additional deductions to CEP, where appropriate, for credit expenses and U.S. indirect selling expenses, including U.S. inventory carrying costs, in accordance with section 772(d)(1) of the Act.

Pursuant to section 772(d)(3) of the Act, we further reduced the starting price by an amount for profit to arrive at CEP. In accordance with section 772(f) of the Act, we calculated the CEP profit rate using the expenses incurred by Heveafil and its affiliate on their sales of the subject merchandise in the United States and the foreign like product in the home market and the profit associated with those sales.

C. Rubberflex

We based EP on the starting price to the first unaffiliated purchaser in the United States. We made deductions from the starting price, where appropriate, for rebates. We also made deductions, where appropriate, for foreign inland freight, foreign brokerage and handling expenses, ocean freight, marine insurance, U.S. customs duty, U.S. inland freight, and U.S. warehousing expenses, in accordance with section 772(c)(2)(A) of the Act.

Normal Value

In order to determine whether there was a sufficient volume of sales in the home market to serve as a viable basis for calculating NV (*i.e.,* the aggregate volume of home market sales of the foreign like product is greater than five percent of the aggregate volume of U.S. sales), we compared the volume of each respondent's home market sales of the foreign like product to the volume of U.S. sales of subject merchandise, in accordance with section 773(a)(1)(C) of the Act. Based on this comparison, we determined that each respondent had a viable home market during the POR. Consequently, we based NV on home market sales.

Pursuant to section 773(b)(2)(A)(ii) of the Act, there were reasonable grounds to believe or suspect that Filati, Heveafil, and Rubberflex had made home market sales at prices below their costs of production (COPs) in this review because the Department had disregarded sales below the COP for these companies in the most recent administrative review. *See Thread Sixth Review,* 65 FR at 6143. As a result, the Department initiated an investigation to determine whether the respondents made home market sales during the POR at prices below their respective COPs.

We calculated the COP based on the sum of each respondent's cost of materials and fabrication for the foreign like product, plus amounts for SG&A and packing costs, in accordance with section 773(b)(3) of the Act.

We compared the COP figures to home market prices of the foreign like product, as required under section 773(b) of the Act, in order to determine whether these sales had been made at prices below the COP. On a product-specific basis, we compared the COP to home market prices, less any applicable movement charges, discounts, rebates, and packing costs.

In determining whether to disregard home market sales made at prices below the COP, we examined whether such sales were made: (1) In substantial quantities within an extended period of time; and (2) at prices which permitted the recovery of all costs within a reasonable period of time in the normal course of trade. *See* section 773(b)(1) of the Act.

Pursuant to section 773(b)(2)(C)(i) of the Act, where less than 20 percent of a respondent's sales of a given product were at prices less than the COP, we did not disregard any below-cost sales of that product because we determined that the below-cost sales were not made in ''substantial quantities.'' Where 20 percent or more of a respondent's sales of a given product were at prices below the COP, we found that sales of that model were made in ''substantial quantities'' within an extended period of time (as defined in section 773(b)(2)(B) of the Act), in accordance with section 773(b)(2)(C)(i) of the Act. In such cases, we also determined that such sales were not made at prices which would permit recovery of all costs within a reasonable period of time, in accordance with section 773(b)(2)(D) of the Act. Therefore, we disregarded the below-cost sales. Where all sales of a specific product were at prices below the COP, we disregarded all sales of that product.

We found that, for certain models of extruded rubber thread, more than 20 percent of each respondent's home market sales within an extended period of time were at prices less than COP. Further, the prices did not provide for the recovery of costs within a reasonable period of time. We therefore disregarded the below-cost sales and used the remaining sales as the basis for determining NV, in accordance with section 773(b)(1) of the Act. For those U.S. sales of extruded rubber thread for which there were no comparable home market sales in the ordinary course of trade, we compared EP or CEP, as appropriate, to CV, in accordance with section 773(a)(4) of the Act.

In accordance with section 773(e) of the Act, we calculated CV based on the sum of each respondent's cost of materials, fabrication, SG&A, profit, and U.S. packing costs. In accordance with section 773(e)(2)(A) of the Act, we based SG&A and profit on the amounts incurred and realized by each respondent in connection with the production and sale of the foreign like product in the ordinary course of trade for consumption in the foreign country.

Company-specific calculations are discussed below.

A. Filati

Where NV was based on home market sales, we based NV on the starting price to unaffiliated customers. For all price-to-price comparisons, we made deductions from the starting price for rebates, where appropriate. We also made deductions, where appropriate, for foreign inland freight, pursuant to section 773(a)(6)(B) of the Act. Pursuant to section 773(a)(6)(C)(iii) of the Act, we also made deductions for home market credit expenses and bank charges. Where applicable, in accordance with 19 CFR 351.410(e), we offset any commission paid on a U.S. sale by reducing the NV by the amount of home market indirect selling expenses and inventory carrying costs, up to the amount of the U.S. commission.

In addition, we deducted home market packing costs and added U.S. packing costs, in accordance with

section 773(a)(6) of the Act. Where appropriate, we made adjustments to NV to account for differences in physical characteristics of the merchandise, in accordance with section 773(a)(6)(C)(ii) of the Act and 19 CFR 351.411.

For CV-to-CEP comparisons, we made an adjustment, where appropriate, for differences in credit expenses, in accordance with sections 773(a)(6)(C)(iii) and 773(a)(8) of the Act. Where applicable, in accordance with 19 CFR 351.410(e), we offset any commission paid on a U.S. sale by reducing the NV by the amount of home market indirect selling expenses and inventory carrying costs, up to the amount of the U.S. commission.

B. Heveafil

Where NV was based on home market sales, we based NV on the starting price to unaffiliated customers. We made deductions from the starting price for discounts. We also made deductions for foreign inland freight and foreign inland insurance, pursuant to section 773(a)(6)(B) of the Act. Pursuant to section 773(a)(6)(C)(iii) if the Act, we also made deductions for home market credit expenses.

In addition, we deducted home market packing costs and added U.S. packing costs, in accordance with section 773(a)(6) of the Act. Where appropriate, we made adjustments to NV to account for differences in physical characteristics of the merchandise, in accordance with section 773(a)(6)(c)(ii) of the Act and 19 CFR 351.411.

C. Rubberflex

Where NV was based on home market sales, we based NV on the starting price to unaffiliated customers. We made deductions from the starting price for foreign inland freight expenses, pursuant to section 773(a)(6)(B) of the Act.

Pursuant to section 773(a)(6)(C)(iii) if the Act, we made circumstance of sale adjustments for differences in credit expenses.

In addition, we deducted home market packing costs and added U.S. packing costs, in accordance with section 773(a)(6) of the Act. Where appropriate, we made adjustments to NV to account for differences in physical characteristics of the merchandise, in accordance with section 773(a)(6)(C)(ii) of the Act and 19 CFR 351.411.

For CV-to-EP comparisons, we made circumstance of sale adjustments, where appropriate, for differences in credit expenses, in accordance with sections 773(a)(6)(C)(iii) and 773(a)(8) of the Act.

Currency Conversion

We made currency conversions into U.S. dollars based on the exchange rates in effect on the dates of the U.S. sales as certified by the Federal Reserve Bank.

Section 773A of the Act directs the Department to use a daily exchange rate in order to convert foreign currencies into U.S. dollars unless the daily rate involves a fluctuation. It is the Department's practice to find that a fluctuation exists when the daily exchange rate differs from the benchmark rate by 2.25 percent. The benchmark is defined as the moving average of rates for the past 40 business days. When we determine a fluctuation to have existed, we substitute the benchmark for the daily rate, in accordance with established practice.

Preliminary Results of Review

As a result of our review, we preliminarily determine that the following margins exist for the period October 1, 1998, through September 30, 1999:

Manufacturer/exporter	Percent margin
Filati Lastex Sdn. Bhd.	18.49
Heveafil Sdn. Bhd./	
Filmax Sdn. Bhd.	0.04
Rubberflex Sdn. Bhd	0.14

The Department will disclose to parties the calculations performed in connection with these preliminary results within five days of the date of publication of this notice. Interested parties may request a hearing within 30 days of the publication. Any hearing, if requested, will be held seven days after the date rebuttal briefs are filed. Interested parties may submit case briefs not later than 30 days after the date of publication of this notice. Rebuttal briefs, limited to issues raised in the case briefs, may be filed not later than 37 days after the date of publication of this notice. The Department will publish a notice of the final results of this administrative review, which will include the results of its analysis of issues raised in any such case briefs, within 120 days of the publication of these preliminary results.

Upon completion of this administrative review, the Department shall determine, and the Customs Service shall assess, antidumping duties on all appropriate entries. We calculate importer-specific assessment rates based on the ratio of the total amount of antidumping duties calculated for the examined sales to the total entered value of those sales, where available. Where the entered value is not available, we calculate a quantity-based assessment rate. These rates will be assessed uniformly on all entries of particular importers made during the POR. Pursuant to 19 CFR 351.106(c)(2), we will instruct the Customs Service to liquidate without regard to antidumping duties all entries for any importer for whom the assessment rate is *de minimis* (*i.e.,* less than 0.50) percent. The Department will issue appraisement instructions directly to the Customs Service.

Further, the following deposit requirements will be effective for all shipments of extruded rubber thread from Malaysia entered, or withdrawn from warehouse, for consumption on or after the publication date of the final results of this administrative review, as provided for by section 751(a)(1) of the Act: (1) The cash deposit rates for Filati, Heveafil, and Rubberflex will be the rates established in the final results of this review, except if the rate is less than 0.50 percent and, therefore, *de minimis* within the meaning of 19 CFR 351.106, the cash deposit will be zero; (2) for previously reviewed or investigated companies not listed above, the cash deposit rate will continue to be the company-specific rate published for the most recent period; (3) if the exporter is not a firm covered in this review, a prior review, or the less-than-fair-value (LTFV) investigation, but the manufacturer is, the cash deposit rate will be the rate established for the most recent period for the manufacturer of the merchandise; and (4) the cash deposit rate for all other manufacturers or exporters will continue to be 15.16 percent, the all others rate established in the LTFV investigation.

These deposit requirements, when imposed, shall remain in effect until publication of the final results of the next administrative review.

This notice serves as a preliminary reminder to importers of their responsibility under 19 CFR 351.402(f) to file a certificate regarding the reimbursement of antidumping duties prior to liquidation of the relevant entries during this review period. Failure to comply with this requirement could result in the Secretary's presumption that reimbursement of antidumping duties occurred and the subsequent assessment of double antidumping duties.

This administrative review and notice are in accordance with section 751(a)(1) of the Act and 777(i)(1) of the Act.

Dated: October 30, 2000.

Troy H. Cribb,

Assistant Secretary for Import Administration.

[FR Doc. 00–28285 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–DS–P

DEPARTMENT OF COMMERCE

International Trade Administration

Export Trade Certificate of Review

AGENCY: International Trade Administration, Commerce.

ACTION: Notice of revocation of Export Trade Certificate of Review No. 86–00002.

SUMMARY: The Secretary of Commerce issued an export trade certificate of review to National Association of Export Companies, Inc. (''NEXCO''). Because this certificate holder has failed to file an annual report as required by law, the Secretary is revoking the certificate. This notice summarizes the notification letter sent to NEXCO.

FOR FURTHER INFORMATION CONTACT: Morton Schnabel, Director, Office of Export Trading Company Affairs, International Trade Administration, 202/482–5131 (This is not a toll-free number) or E-mail at oetca@ita.doc.gov.

SUPPLEMENTARY INFORMATION: Title III of the Export Trading Company Act of 1982 (''the Act'') (Pub. L. 97–290, 15 U.S.C. 4011–21) authorizes the Secretary of Commerce to issue export trade certificates of review. The regulations implementing Title III (''the Regulations'') are found at 15 CFR part 325 (1999). Pursuant to this authority, a certificate of review was issued on July 9, 1986 to NEXCO.

A certificate holder is required by law to submit to the Department of Commerce annual reports that update financial and other information relating to business activities covered by its certificate (section 308 of the Act, 15 U.S.C. 4018, § 325.14 (a) of the Regulations, 15 CFR 325.14 (a)). The annual report is due within 45 days after the anniversary date of the issuance of the certificate of review (§ 325.14 (b) of the Regulations, 15 CFR 325.14 (b)). Failure to submit a complete annual report may be the basis for revocation (§§ 325.10(a) (3) and 325.14(c) of the Regulations, 15 CFR 325.10(a) (3) and 325.14(c)).

On June 29, 1999, the Department of Commerce sent to NEXCO a letter containing annual report questions with a reminder that its annual report was due on August 23, 1999. Additional reminders were sent on September 27, 1999 and on December 1, 1999. The Department has received no written response from NEXCO to any of these letters.

On September 25, 2000, and in accordance with § 325.10(c)(1) of the regulations, (15 CFR 325.10(c)(1)), the Department of Commerce sent a letter by certified mail to notify NEXCO that the Department was formally initiating the process to revoke its certificate for failure to file an annual report. In addition, a summary of this letter allowing NEXCO thirty days to respond was published in the **Federal Register** on September 29, 2000 at 65 FR 58512. Pursuant to § 325.10(c)(2) of the regulations (15 CFR 325.10(c)(2)), the Department considers the failure of NEXCO to respond to be an admission of the statements contained in the notification letter.

The Department has determined to revoke the certificate issued to NEXCO for its failure to file an annual report. The Department has sent a letter, dated October 30, 2000, to notify NEXCO of its determination. The revocation is effective thirty (30) days from the date of publication of this notice. Any person aggrieved by this decision may appeal to an appropriate U.S. district court within 30 days from the date on which this notice is published in the **Federal Register** (325.10(c)(4) and 325.11 of the regulations, 15 CFR 324.10(c)(4) and 325.11 of the regulations, 15 CFR 325.10(c)(4) and 325.11).

Dated: October 30, 2000.

Morton Schnabel,

Director, Office of Export Trading, Company Affairs.

[FR Doc. 00–28212 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–DR–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

[I.D. 103000D]

Mid-Atlantic Fishery Management Council; Public Meeting

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Notice of public meeting.

SUMMARY: The Mid-Atlantic Fishery Management Council's Spiny Dogfish Monitoring Committee will hold a public meeting.

DATES: The meeting will be held on Friday, November 17, 2000, from 10 a.m. until 5 p.m.

ADDRESSES: This meeting will be held at the Comfort Inn at the Airport (Providence), 1940 Post Road, Warwick, RI; telephone: 401–732–0470.

Council address: Mid-Atlantic Fishery Management Council, Room 2115, 300 S. New Street, Dover, DE 19904.

FOR FURTHER INFORMATION CONTACT: Daniel T. Furlong, Executive Director, Mid–Atlantic Fishery Management Council; telephone: 302–674–2331, ext. 19.

SUPPLEMENTARY INFORMATION: The following agenda items will be discussed: Update current stock status, yield estimates based on F= 0.027 and current stock size, review 2000–01 measures and fishery performance, recommended management measures for 2001–02.

Although non-emergency issues not contained in this agenda may come before this group for discussion, those issues may not be the subject of formal action during this meeting. Action will be restricted to those issues specifically identified in this notice and any issues arising after publication of this notice that require emergency action under section 305(c) of the Magnuson-Stevens Fishery Conservation and Management Act, provided the public has been notified of the Council's intent to take final action to address the emergency.

Special Accommodations

This meeting is physically accessible to people with disabilities. Requests for sign language interpretation or other auxiliary aids should be directed to Joanna Davis at the Council office (see **ADDRESSES**) at least 5 days prior to the meeting date.

Dated: October 31, 2000.

Richard W. Surdi,

Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service.

[FR Doc. 00–28303 Filed 11–2–00; 8:45 am]

BILLING CODE: 3510–22–S

COMMITTEE FOR THE IMPLEMENTATION OF TEXTILE AGREEMENTS

Adjustment of Import Limits for Certain Cotton, Man-Made Fiber, Silk Blend and Other Vegetable Fiber Textiles and Textile Products Produced or Manufactured in Bangladesh

October 31, 2000.

AGENCY: Committee for the Implementation of Textile Agreements (CITA).

ACTION: Issuing a directive to the Commissioner of Customs adjusting limits.

EFFECTIVE DATE: November 3, 2000.

FOR FURTHER INFORMATION CONTACT: Ross Arnold, International Trade Specialist, Office of Textiles and Apparel, U.S. Department of Commerce, (202) 482–4212. For information on the quota status of these limits, refer to the Quota Status Reports posted on the bulletin boards of each Customs port, call (202) 927–5850, or refer to the U.S. Customs website at http://www.customs.gov. For information on embargoes and quota re-openings, call (202) 482–3715.

SUPPLEMENTARY INFORMATION:

Authority: Section 204 of the Agricultural Act of 1956, as amended (7 U.S.C. 1854); Executive Order 11651 of March 3, 1972, as amended.

The current limits for certain categories are being adjusted for swing, special shift and carryforward.

A description of the textile and apparel categories in terms of HTS numbers is available in the CORRELATION: Textile and Apparel Categories with the Harmonized Tariff Schedule of the United States (see **Federal Register** notice 64 FR 71982, published on December 22, 1999). Also see 64 FR 68333, published on December 7, 1999.

D. Michael Hutchinson,

Acting Chairman, Committee for the Implementation of Textile Agreements.

Committee for the Implementation of Textile Agreements

October 31, 2000.

Commissioner of Customs,
Department of the Treasury, Washington, DC 20229.

Dear Commissioner: This directive amends, but does not cancel, the directive issued to you on December 1, 1999, by the Chairman, Committee for the Implementation of Textile Agreements. That directive concerns imports of certain cotton, man-made fiber, silk blend and other vegetable fiber textiles and textile products, produced or manufactured in Bangladesh and exported during the twelve-month period which began on January 1, 2000 and extends through December 31, 2000.

Effective on November 3, 2000, you are directed to adjust the limits for the following categories, as provided for under the Uruguay Round Agreement on Textiles and Clothing:

Category	Adjusted twelve-month limit [1]
237	386,264 dozen.
331	1,500,150 dozen pairs.
334	190,433 dozen.
335	216,371 dozen.
336/636	570,082 dozen.
338/339	1,986,641 dozen.
340/640	4,065,662 dozen.
341	3,376,739 dozen.
351/651	965,092 dozen.
352/652	12,908,618 dozen.
363	32,816,179 numbers.
369–S [2]	2,161,838 kilograms.
634	630,639 dozen.
635	424,623 dozen.
638/639	2,193,755 dozen.
641	738,723 dozen.
645/646	435,322 dozen.
847	380,252 dozen.

[1] The limits have not been adjusted to account for any imports exported after December 31, 1999.

[2] Category 369–S: only HTS number 6307.10.2005.

The Committee for the Implementation of Textile Agreements has determined that these actions fall within the foreign affairs exception of the rulemaking provisions of 5 U.S.C. 553(a)(1).

Sincerely,

D. Michael Hutchinson,

Acting Chairman, Committee for the Implementation of Textile Agreements.

[FR Doc.00–28267 Filed 11–2–00; 8:45 am]

BILLING CODE 3510–DR–F

COMMODITY FUTURES TRADING COMMISSION

Sunshine Act Meeting

''FEDERAL REGISTER'' CITATION OF PREVIOUS ANNOUNCEMENT: 65 FR 65843; 65 FR 64687.

PREVIOUSLY ANNOUNCED TIME AND DATE OF MEETING: 1 p.m., Wednesday, November 1, 2000.

CHANGES IN THE MEETING: The open meeting previously scheduled for 1 p.m., Wednesday, November 1, 2000 has been postponed until 1 p.m., Monday, November 6, 2000.

CONTACT PERSON FOR MORE INFORMATION: Jean A. Webb, 418–5100.

Jean A. Webb,

Secretary of the Commission.

[FR Doc. 00–28351 Filed 11–1–00; 11:24 am]

BILLING CODE 6351–01–M

CONSUMER PRODUCT SAFETY COMMISSION

[CPSC Docket No. 01–C0002]

Tropitone Furniture Co., Inc., a Corporation, Provisional Acceptance of a Settlement Agreement and Order

AGENCY: Consumer Product Safety Commission.

ACTION: Notice.

SUMMARY: It is the policy of the Commission to publish settlements which it provisionally accepts under the Consumer Product Safety Act in the **Federal Register** in accordance with the terms of 16 CFR 1118.20(e). Published below is a provisionally-accepted Settlement Agreement with Tropitone Furniture Co., Inc., a corporation, containing a civil penalty of $750,000.

DATES: Any interested person may ask the Commission not to accept this agreement or otherwise comment on its contents by filing a written request with the Office of the Secretary by November 20, 2000.

ADDRESSES: Persons wishing to comment on this Settlement Agreement should send written comments to the Comment 01–C0002, Office of the Secretary, Consumer Product Safety Commission, Washington, DC 20207.

FOR FURTHER INFORMATION CONTACT: Deborah S. Orlove, Trial Attorney, Office of Compliance and Enforcement, Consumer Product Safety Commission, Washington, DC 20207; telephone (301) 504–0626, 1347.

SUPPLEMENTARY INFORMATION: The text of the Agreement and Order appears below.

Dated: October 30, 2000.

Sadye E. Dunn,

Secretary.

Settlement Agreement and Order

1. This Settlement Agreement, made by and between the staff (''the staff'') of the U.S. Consumer Product Safety Commission (''the Commission'') and Tropitone Furniture Co., Inc. (''Tropitone''), a corporation, in accordance with 16 CFR 1118.20 of the Commission's Procedures for Investigations, Inspections, and Inquiries under the Consumer Product Safety Act (''CPSA''), is a settlement of the staff allegations set forth below.

I. The Parties

2. The Commission is an independent federal regulatory agency responsible for the enforcement of the Consumer Product Safety Act, 15 U.S.C. 2051–2084.

3. Tropitone is a corporation organized and existing under the laws of the State of Florida. Its principal offices are located at 5 Marconi, Irvine, California 92618.

II. Staff Allegations

4. The following models of chaise lounge chairs manufactured by Tropitone are the subject of this Settlement Agreement:

Model name	Model No.	Dates manufactured	Dimensions (width × length × height)
TropiKai	935	1985–1991	24″ × 77.5″ × 41.5″.
	935HYA	1991–April 1992	
Verrazano	4332	1987–1992	27.5″ × 78.5″ × 39.75″.
Cotillion	4032	1986–1987	29″ × 81.75″ × 42″.
Cayman	5932	1989–April 1992	27.5″ × 80″ × 44″.
Colony	4932	1987–1991	29.75″ × 80″ × 42″.
Seychelle	4432	1986–April 1992	25″ × 79″ × 40″.

5. Beginning in 1985, Tropitone manufactured, distributed and/or sold into United States commerce more than 123,000 chaise lounge chairs, described in paragraph 4 above. Tropitone is, therefore, a manufacturer, distributor and/or retailer of a consumer product distributed in U.S. commerce, pursuant to 15 U.S.C. 2052(a)(1), (4), (5) and (6).

6. The chaise lounge chairs, described in paragraph 4 above, contained a nylon ratchet system that controlled the height of the headrest on the chaise lounge. The nylon ratchets were prone to break, causing the headrest to collapse and injure consumers. Consumers who reached behind the headrest to adjust its height by placing their fingers between the headrest frame and the chaise bed suffered injuries when the nylon ratchet failure caused the headrest to forcefully collapse and ''scissor'' their fingers.

7. By mid 1988, Tropitone had begun receiving injury claims and complaints regarding the nylon ratchet failure of the chaise lounges described in paragraph 4. Injuries included finger amputations (multiple, full or partial), finger fractures, crushed fingers, pinched fingers, severe finger lacerations, back injury, skull fracture, and facial injuries. CPSC's records indicate that Tropitone learned of at least 170 incidents of nylon ratchet failure that occurred on the chaise lounge chairs described in paragraph 4 between approximately January 1987 and January 1999.

8. Tropitone obtained information which reasonably supported the conclusion that the chaise lounge chairs described in paragraph 4 contained defects which could create a substantial product hazard, but failed to report to the Commission in a timely manner as required by section 15(b)(2) of the CPSA, 15 U.S.C. 2064(b)(2). Tropitone also obtained information which reasonably supported the conclusion that the chaise lounge chairs described in paragraph 4 created an unreasonable risk of serious injury or death, but failed to report to the Commission in a timely manner as required by Section 15(b)(3) of the CPSA, 15 U.S.C. 2064(b)(3).

9. Over a period of several years, Tropitone also failed to report to the Commission information about approximately 30 settlements and plaintiff's judgments in lawsuits concerning the chaise lounge chairs described in paragraph 4. Tropitone failed to report those lawsuit settlements and judgments in a timely manner as required by section 37 of the CPSA, 15 U.S.C. 2084.

10. By failing to furnish information as required by section 15(b) of the CPSA, 15 U.S.C. 2064(b), and section 37 of the CPSA, 15 U.S.C. 2084. Tropitone committed prohibited acts under section 19(a)(4) and (11) of the CPSA, 15 U.S.C. 2068(a)(4) and (11).

11. The staff alleges these violations were committed ''knowingly'' as that term is defined in section 20(d) of the CPSA, 15 U.S.C. 2069(d).

III. Response of Tropitone

12. Tropitone denies each and every staff allegation set forth in paragraphs 6–11 above. Tropitone further denies that the lounge chairs described in paragraph 4 above contain any defect which could create a substantial product hazard described in section 15(a) of the CPSA, 15 U.S.C. 2064(a), and that these lounge chairs create an unreasonable risk of serious injury or death. Tropitone further denies that it violated the reporting requirements of section 15(b) of the CPSA, 15 U.S.C. 2064(b), section 37 of the CPSA, 15 U.S.C. 2084, or 16 CFR part 1115.

13. In 1977 Tropitone, of its own initiative, reported to the CPSC concerning breakage of nylon ratchets associated with the lounge chairs described in paragraph 4. In addition, beginning in 1991, and in subsequent years including after Tropitone's 1997 report to the CPSC, Tropitone conducted recalls of these lounge chairs. Since its 1997 report to the CPSC, Tropitone has worked cooperatively with the CPSC staff to conduct recall activities and to resolve this matter.

14. Tropitone enters this Settlement Agreement and Order for settlement purposes only, to avoid incurring additional legal costs and expenses.

IV. Agreement of the Parties

15. The Commission has jurisdiction over this matter and over Tropitone under the consumer Product Safety Act (CPSA), 15 U.S.C. 2051 *et seq.*

16. Upon final acceptance by the CPSC of this Settlement Agreement and Order, Tropitone knowingly, voluntarily and completely waives any rights it may have in the above captioned matter (1) to the issuance of a Complaint in this matter; (2) to an administrative or judicial hearing with respect to the staff allegations cited herein; (3) to judicial review, or any other challenge or contest, of the validity of this Settlement Agreement and Order as issued and entered; (4) to a determination by the commission as to whether Tropitone violated section 15(b) of the CPSA, 15 U.S.C. 2064(b), and section 37 of the CPSA, 15 U.S.C. 2084; and (5) to a statement of findings of fact and conclusions of law with regard to the staff allegations.

17. Upon provisional acceptance of this Settlement Agreement and Order by the Commission, this Settlement Agreement and Order shall be placed on the public record and shall be published in the **Federal Register** in accordance with 16 CFR 1118.20(e).

18. This Settlement Agreement and Order shall become effective upon final acceptance by the Commission and its service upon Tropitone. Tropitone shall pay a civil penalty in the amount of seven hundred and fifty thousand and no/dollars ($750,000.00) to the United States Treasury. Tropitone shall pay two hundred thousand dollars ($200,000.00) within 10 calendar days of receiving service of the final Settlement Agreement and Order, and shall pay the remaining five hundred fifty thousand dollars ($550,000.00) on or before June 15, 2001.

19. In the event of default in any of the payments as set forth in paragraph 18 above, which default continues for ten (10) calendar days beyond the due date of payment, Tropitone shall pay the United States Treasury the entire amount of civil penalty due and owing as well as interest on the amount owing at a rate computed pursuant to 28 U.S.C. 1961(a), as well as a penalty in the amount of five hundred dollars ($500.00) per day until full payment is made, calculated beginning on the first

day after payment is due; provided, in its sole discretion the CPSC may waive Tropitone's obligation to pay some or all of any interest and penalty due and owing under this paragraph 19. In addition, in the event of default, Tropitone shall raise no defense or objection to any collection action the Commission deems appropriate, and Tropitone shall pay all the costs incurred in such action.

20. This Settlement Agreement and Order is not deemed or construed as an admission by Tropitone (a) of any liability or wrongdoing by Tropitone; (b) that Tropitone violated any law or regulation; (c) that the lounge chairs described in paragraph 4 are defective or create a substantial product hazard, or are unreasonably dangerous; (d) that the lounge chairs described in paragraph 4 have caused any injuries; (e) of the truth of any claims or other matters stated in this Settlement Agreement and Order (except as set forth in paragraph 15), or alleged or otherwise stated by the commission or any other person either against Tropitone or with respect to the lounge chairs described in paragraph 4. Nothing contained in this Settlement Agreement and Order precludes Tropitone from raising any defenses in any future litigation not arising out of the terms of this Settlement Agreement and Order.

21. Upon final acceptance of this Settlement Agreement by the Commission, the issuance of the Order, and the full and timely payment by Tropitone to the United States Treasury of a civil penalty in the amount of seven hundred fifty thousand dollars ($750,000.00), the Commission specifically waives its right to initiate, either by referral to the Department of Justice or bringing in its own name, any action for civil penalties relating to any of the events that gave rise to the CPSC staff's allegations in paragraphs four through eleven, against (a) Tropitone; (b) any of Tropitone's current or former subsidiaries, affiliates, divisions or related entities; (c) any shareholder, director, officer, employee, agent or attorney of any entity referenced in (a) or (b) above; and (d) any successor, heir, or assign of any entity referenced in (a), (b) or (c) above.

22. Upon final acceptance by the Commission, the parties agree that the Commission may publicize the terms of this Settlement Agreement and Order.

23. Tropitone agrees to the entry of the attached Order, which is incorporated herein by reference, and agrees to be bound by its terms. This Settlement Agreement and Order is binding upon, and shall inure to the benefit of, Tropitone and the assigns and successors of Tropitone.

24. Agreements, understandings, representations, or interpretations made outside this Settlement Agreement and Order may not be used to vary or contradict its terms.

25. This Settlement Agreement and Order have been negotiated by the parties at arms' length. Tropitone is not relying on the advice of the CPSC staff, nor anyone associated with the CPSC staff, as to legal, tax or other consequences of any kind arising out of this Settlement Agreement and Order, and Tropitone specifically assumes the risk of all such legal, tax and other consequences.

26. For all purposes, this Settlement and Order shall constitute an enforceable judgment obtained in an action or proceeding by a governmental unit to enforce its police or regulatory power. This settlement Agreement and Order are pursuant to the Commission's police or regulatory power to remedy the alleged risk created by, and protect the public from, a substantial product hazard which the Commission believes is presented by the lounge chairs described in paragraph 4 above, and this Settlement Agreement and Order are not subject to an automatic stay if Tropitone becomes the subject of a bankruptcy proceeding.

27. If any provision of this Settlement Agreement and Order is held to be illegal, invalid or unenforceable under present or future laws effective during the term of this Settlement Agreement and Order, such provision shall be fully severable. In such event, there shall be added as part of this Settlement Agreement and Order a provision as similar in terms to such illegal, invalid or unenforceable provision as may be possible and may be legal, valid and enforceable. The effective date of the added provision shall be the date upon which the prior provision was held to be invalid, illegal or unenforceable. The rest of this Settlement Agreement and Order shall remain in full effect, unless the CPSC determines, after providing Tropitone with notice and a reasonable opportunity to comment, that severing the provision materially impacts the payment of civil penalties as set forth in this Settlement Agreement and Order. The CPSC determination shall constitute the final agency decision and shall be subject to judicial review, such review to be based upon the record of any such CPSC proceeding and according to law.

28. This Settlement Agreement and Order shall not be waived, changed, amended, modified, or otherwise altered, except in writing signed by both parties.

29. Tropitone's obligations under this Settlement Agreement and Order shall terminate when Tropitone makes the final payment required under the Order.

Tropitone Furniture Co., Inc.

Dated: September 25, 2000.

Michael L. Echolds,

President.

The Consumer Product Safety Commission.

Alan H. Schoem,

Assistant Executive Director, Office of Compliance.

Eric L. Stone,

Director, Legal Division, Office of Compliance.

Dated: October 10, 2000.

Deborah S. Orlove,

Attorney, Legal Division, Office of Compliance.

Order

Upon consideration of the Settlement Agreement entered into between Tropitone Furniture Co., Inc. and the staff of the U.S. Consumer Product Safety Commission; and the Commission having jurisdiction over the subject matter and Tropitone Furniture Co., Inc., and it appearing that the Settlement Agreement and Order is in the public interest, it is

Ordered, that the Settlement Agreement be, and hereby is, accepted, and it is

Further Ordered, that, upon final acceptance of the Settlement Agreement and Order, Tropitone Furniture Co., Inc., shall pay to the U.S. Treasury a civil penalty under the Consumer Product Safety Act in the amount of SEVEN HUNDRED FIFTY THOUSAND AND no/100 dollars, ($750,000.00). Tropitone shall pay two hundred thousand dollars ($200,000.00) within 10 calendar days of receiving service to this final Settlement Agreement and Order, and the remaining five hundred and fifty thousand and dollars ($550,000.00) on or before June 15, 2001.

Provisionally accepted and Provisional Order issued on the 30th day of October, 2000.

By Order of the Commission.

Sadye E. Dunn,

Secretary, U.S. Consumer Product Safety Commission.

[FR Doc. 00–28203 Filed 11–2–00; 8:45 am]

BILLING CODE 6355–01–M

DEPARTMENT OF DEFENSE

Office of the Secretary

Meeting of the DoD Healthcare Quality Initiative Review Panel

AGENCY: Department of Defense.

ACTION: Notice.

SUMMARY: On October 26, 2000, the DoD Healthcare Quality Initiatives Review panel published notice on an upcoming meeting (65 FR 64204). This notice is being published to change meeting dates due to the Federal holiday on November 10th.

DATES: November 8 & 9, 2000.

ADDRESSES: Sheraton Crystal City, 1800 Jefferson Davis Hwy, Arlington, VA 22202.

TIME: November 8th, 8 a.m. to 5:30 p.m.; November 9th, 8 a.m. to 5:30 p.m.

FOR FURTHER INFORMATION CONTACT: Gia Edmonds at (703) 933–8325.

Dated: October 30, 2000.

L.M. Bynum,

Alternate OSD Federal Register Officer, Department of Defense.

[FR Doc. 00–28213 Filed 11–2–00; 8:45 am]

BILLING CODE 5001–10–M

DEPARTMENT OF ENERGY

Federal Energy Regulatory Commission

Notice of Second Interstate Natural Gas Facility-Planning Seminar

October 27, 2000.

The Office of Energy Projects will hold the second in a series of public meetings around the country for the purposes of exploring and enhancing strategies for constructive public participation in the earliest stages of natural gas facility planning. This meeting will be held in Romeoville, Illinois on Thursday, December 7, 2000. We are inviting interstate natural gas companies; Federal, state and local agencies; landowners and non-governmental organizations with an interest in developing a new way of doing business to join us in this effort. We will discuss the facility planning process, not the merits of any pending or planned pipeline projects.

Join us as we continue to explore new strategies being employed by the natural gas industry, agencies, and citizens to learn about each others' concerns and to engage the public and agencies in participatory project design. Interactive discussions with panelists from various Federal and state agencies, representatives from natural gas companies, and private landowners or citizen representatives who have had relevant experiences will be held. There will be substantial opportunity for the sharing of experiences and knowledge during both the panel discussions and in the interactive ''brainstorming'' session. So, bring your ideas with you and prepare to share them. In addition, a summary of the first seminar in Albany, NY will be given by the staff of the Commission's Office of Energy Projects.

The objectives of the meetings are:

- Build upon the discussions from the first meeting in Albany, NY.
- To explore steps taken to identify the parties directly involved with and affected by natural gas facility siting and/or permitting, so they can work together and resolve issues.
- To explore the best avenues for involving people and agencies toward fostering settlements through creative issue resolution.
- To encourage the submission of filings with no or few contested issues in order to reduce the Commission's processing time.

We are building on what was learned at our Albany meeting and continuing to work towards developing a toolbox of the best available techniques for increasing public involvement in the pre-filing planning process. This will help to plan projects with less opposition that can achieve faster action from the Commission with less controversy and fewer conditions.

The meeting in Joliet, Illinois will be held at the Sancta Alberta Convocation Center at Lewis University, located in Romeoville, Illinois. The meeting is scheduled to start at 10:00 AM and finish at 4:00 PM. A preliminary agenda and directions to Lewis University are enclosed. Also, see attachment 2 regarding the selection of locations of future meetings.

If you plan to attend, please respond by November 22, 2000 via facsimile to Pennie Lewis-Partee at 202–208–0353, or you can email our team at: gasoutreach@ferc.fed.us. Please include in the response the names, addresses, and telephone numbers of all attendees from your organization. We will send acknowledgment of your request.

To help us enhance our panel discussions, please consider issues and/or questions you would like to have addressed at the meetings and email them to us. If you have any questions, you may contact any of the staff listed below:

Richard Hoffmann 202/208–0066
Lauren O'Donnell 202/208–0325
Jeff Shenot 202/219–2178
Howard Wheeler 202/208–2299

J. Mark Robinson,

Director, Division of Environmental & Engineering Review, Office of Energy Projects.

Appendix 1—Agenda

2nd Interstate Natural Gas Facility Planning Seminar

Federal Energy Regulatory Commission, Lewis University, Romeoville, Illinois, December 7, 2000, 10:00 am to 4:00 pm

10:00 Introductions
Welcome: Mark Robinson, Director, Division of Environmental & Engineering Review, Office of Energy Projects, FERC
Rich Hoffmann, Office of Energy Projects, FERC

10:15 The Pipeline Planning/Approval Process
Where FERC fits in
Who's involved and when

10:30 Summary of Comments from the Albany Meeting

10:45 Panel 1. Perspectives on Initial Project Announcement and General Route Planning

[Discussion of factors surrounding announcement and general planning of the project route/sites & alternatives, types of surveys needed; who to tell and when. What are the needs of the various stakeholders?]

Howard Heffler, Alliance Pipeline Company
Marian Gibson, Administrator, Village of Channahon, Illinois (citizen)
Jim Hartwig, Office of Farmland Protection, Illinois Department of Agriculture

[10 minute discussion by each panelist with interactive Q&A session with panelists and audience for remainder of Panel]

11:45 Lunch

12:50 Panel 2. Perspectives on Detailed Pipeline Route Planning [Discussion of details of how landowners and agencies hear about facility locations; where disturbance would occur; aboveground facility sites, and alternatives? What timing and mitigation is involved? How best to be involved?]
Brian Smith, Chicago District, U.S. Corps of Engineers?
John Hopkins, ANR Pipeline Company
_____, Citizen/NGO

[10 minute discussion by each panelist with interactive Q&A session with panelists and audience for remainder of Panel]

2:00 Discussion by Kearns & West, Inc. on Stakeholder Involvement

2:15 Brainstorming Session * * * OEP Staff will lead an all-participants discussion of issues regarding:
Pre-filing Best Management Practices (BMPs) from an Industry Perspective

- How best to work with landowners and communities.

Pre-filing BMPs from an Agency Perspective

- How best to work with applicants and agencies:
- How to coordinate with multiple agencies/jurisdictions.

Pre-filing BMPs from a Citizen Perspective

• How best to engage landowners;
• How to get information on the need for a project;
• How to describe workspace/right-of-way requirements.

3:45 Summary of the Day

DIRECTIONS TO LEWIS UNIVERSITY, Romeoville, IL:

• Lewis University is located on route 53 about 5 miles north of Joliet, IL.
• From the North, take I–55 to exit 267 (RT53). Take Route 53 south for approx. 8 miles to Lewis University on the right.

Appendix 2—Future Meetings?

By September of 2001, we will hold subsequent seminars at other locations around the country. Locations for the meetings will be selected based on the history of past, present and especially future pipeline projects where interstae natural gas markets are developing or expanding.

Areas we are considering for meetings include:

Tampa area, Florida—Jan/Feb, 2001
Boston, Massachusetts/Portland, Maine area—Mar/April, 2001
Seattle/Puget Sound Washington—_____ or
Reno/Tahoe, Nevada or Salt Lake City, Utah—_____or
Other—_____.

If you care to voice your opinion about these or other areas, please follow the instructions for contacting us in the notice.

[FR Doc. 00–28256 Filed 11–2–00; 8:45 am]

BILLING CODE 6717–01–M

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6896–2]

Agency Information Collection Activities: Submission for OMB Review; Comment Request, National Emission Standards for Hazardous Air Pollutants (NESHAP) for Chromium Emissions From Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: Title: National Emission Standards for Hazardous Air Pollutants (NESHAP) for Chromium Emissions from Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks OMB Control Number 2060–0327, expiration date 12/31/00. The ICR describes the nature of the information collection and its expected burden and cost, where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 4, 2000.

ADDRESSES: Send comments, referencing EPA ICR No.1611.04 and OMB Control No. 2060–0327, to the following addresses: Sandy Farmer, U.S. Environmental Protection Agency, Collection Strategies Division (Mail Code 2822), 1200 Pennsylvania Avenue, NW., Washington, DC 20460; and to Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR contact Sandy Farmer at EPA by phone at (202) 260–2740, by E-Mail at *Farmer.Sandy@epamail.epa.gov* or download off the Internet at *http://www.epa.gov/icr* and refer to EPA ICR No. 1611.04. For technical questions about the ICR, contact Scott Throwe at (202) 564–7013.

SUPPLEMENTARY INFORMATION:

Title: National Emission Standards for Chromium Emissions from Hard and Decorative Chromium Electroplating and Chromium Anodizing Tanks, OMB Control Number 2060–0327, EPA ICR Number 1611.04, expiration date 12/30/00. This is a request for extension of a currently approved collection.

Abstract: The Administrator has judged that Hazardous Air Pollutants (HAP) emissions from Chromium emissions from hard and decorative chromium Electroplating and chromium anodizing tanks cause or contribute to air pollution that may reasonably be anticipated to endanger public health or welfare. Owners/operators of affected hard and decorative chromium electroplating, modification, startups, shut down, date and results of initial performance test and provide reports of excess emissions. They must also develop startup, shutdown, malfunction plans and develop an operations and maintenance plan for their control system. Affected facilities also must provide notification of compliance status and report monitoring exceedances.

In order to ensure compliance with the standards promulgated to protect public health, adequate reporting and recordkeeping is necessary. In the absence of such information, enforcement personnel would be unable to determine whether the standards are being on a continuous basis, as required by the Clean Air Act.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR Chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on 04/18/00 (65 FR 20813) and no comments were received.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 272 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirements; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities: Owners/operators of hard and decorative chromium electroplating plants.

Estimated Number of Respondents: 948.

Frequency of Response: Quarterly, Semi-annually, Annually.

Estimated Total Annual Hour Burden: 516,186.

Estimated Total Annualized Capital, O&M Cost Burden: $62,920,921.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the addresses listed above. Please refer to EPA ICR No. 1611.04 and OMB Control No. 2060–0327 in any correspondence.

Dated: October 26, 2000.

Oscar Morales,

Director, Collection Strategies Division.

[FR Doc. 00–28273 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6896–1]

Agency Information Collection Activities: Submission for OMB Review; Comment Request, National Emission Standards for Hazardous Air Pollutants (NESHAP), Magnetic Tape Manufacturing Operations

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this document announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: National Emission Standards for Hazardous Air Pollutants (NESHAP) 40 CFR part 63, subpart EE, OMB Control No. 2060–0326, expiration date 12/31/2000. The ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 4, 2000.

ADDRESSES: Send comments, referencing EPA ICR No. 1678.04 and OMB Control No. 2060–0326, to the following addresses: Sandy Farmer, U.S. Environmental Protection Agency, Collection Strategies Division (Mail Code 2822), 1200 Pennsylvania Avenue, NW., Washington, DC 20460; and to Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), Attention: Desk Officer for EPA, 725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR contact Sandy Farmer at EPA by phone at (202) 260–2740, by E-Mail at Farmer.Sandy@epamail.epa.gov or download off the Internet at *http://www.epa.gov/icr* and refer to EPA ICR No. 1678.04. For technical questions about the ICR, contact Steven Hoover at (202) 564–7007.

SUPPLEMENTARY INFORMATION:

Title: NESHAP subpart EE, Magnetic Tape Manufacturing Operations, OMB Control No. 2060–0326; EPA ICR No. 1678.04, expiring 12/31/2000. This is a request for extension of a currently approved collection.

Abstract: This NESHAP standard requires initial notification, performance tests, and periodic reports. Owners or operators are also required to maintain records of the occurrence and duration of any startup, shutdown, or malfunction in the operation of an affected facility, or any period during which the monitoring system is inoperative. These notifications, reports, and records are essential in determining compliance and are required, in general, of all sources subject to NESHAP.

Any owner or operator subject to the provisions of this part shall maintain a file of these measurements, and retain the file for at least 5 years following the date of such measurements, maintain reports, and records. All reports are sent to the delegated State or Local authority. In the event that there is no such delegated authority, the reports are sent directly to the EPA Regional Office. This information is being collected to assure compliance with 40 CFR part 63, subpart EE as authorized in sections 112 and 114(a) of the Clean Air Act. The required information consists of emissions data and other information that have been determined not to be private.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR Chapter 15. The **Federal Register** document required under 5 CFR 1320.8(d), soliciting comments on this collection of information, was published on April 18, 2000 (65 FR 20183). No comments were received.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average 271 hours per response. Burden means the total time, effort, or financial resources expended by persons to generate, maintain, retain, or disclose or provide information to or for a Federal agency. This includes the time needed to review instructions; develop, acquire, install, and utilize technology and systems for the purposes of collecting, validating, and verifying information, processing and maintaining information, and disclosing and providing information; adjust the existing ways to comply with any previously applicable instructions and requirement; train personnel to be able to respond to a collection of information; search data sources; complete and review the collection of information; and transmit or otherwise disclose the information.

Respondents/Affected Entities: Magnetic Tape Manufacturing Operations.

Estimated Number of Respondents: 13.

Frequency of Response: On occasion, Quarterly, Semi-Annually.

Estimated Total Annual Hour Burden: 7,042.

Estimated Total Annualized Capital and O&M Cost Burden: $89,400.

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the of automated collection techniques to the following addresses. Please refer to EPA ICR No. 1678.04 and OMB Control No. 2060–0326 in any correspondence.

Dated: October 26, 2000.

Oscar Morales,

Director, Collection Strategies Division.

[FR Doc. 00–28274 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6895–9]

Agency Information Collection Activity: Questionnaire for Nominees for the Annual National Clean Water Act Recognition Awards Program (National Wastewater Management Excellence Awards Program)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*), this notice announces that the following Information Collection Request (ICR) has been forwarded to the Office of Management and Budget (OMB) for review and approval: Questionnaire for the Nominees for the Annual National Clean Water Act Recognition Awards Program (National Wastewater Management Excellence Awards Program), OMB Control No. 2040–0101, expires December 31, 2000. This ICR describes the nature of the information collection and its expected burden and cost; where appropriate, it includes the actual data collection instrument.

DATES: Comments must be submitted on or before December 4, 2000.

ADDRESSES: Send comments, referencing EPA ICR No. 2040–0101, to the following addresses: Sandy Farmer, U.S. Environmental Protection Agency, Collection Strategies Division (Mail Code 2822), 1200 Pennsylvania Avenue, NW., Washington, DC 20460; and to Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: Desk Officer for EPA,

725 17th Street, NW., Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: For a copy of the ICR contact Sandy Farmer at EPA, (202) 260–2740, by E-mail at *farmer.sandy@epamail.epa.gov,* or download off the Internet at *http://www.epa.gov/icr* and refer to EPA ICR No. 1287.06. For technical questions about the ICR contact Maria Campbell, (202) 260–5815 in the Office of Water.

SUPPLEMENTARY INFORMATION:

Title: Questionnaire for Nominees for the Annual National Clean Water Act Recognition Awards Program (National Wastewater Management Excellence Awards Program) (OMB Control No. 2040–0101; EPA ICR No. 1287.06) expires December 31, 2000. This ICR is a re-approval to collect data from EPA's National Clean Water Act Recognition Awards nominees. EPA requests that the currently approved 2800 burden hours be re-approved for the next three years.

Abstract: This ICR requests re-approval to collect information from EPA's National Clean Water Act Recognition Awards nominees. The awards are for the following program categories: Operations and Maintenance (O&M), Beneficial Use of Biosolids (Biosolids), Combined Sewer Overflow Controls (CSO) and Storm Water (SW) management. (Note: Information collection approval for the Pretreatment awards program is included in the National Pretreatment Program ICR (OMB No. 2040–0009, EPA ICR No. 0002.09), approved through September 30, 2003). The Awards Program is managed by EPA's Office of Wastewater Management (OWM). The Awards Program is authorized under section 501(e) of the Clean Water Act, as amended. The Awards Program is intended to provide recognition to municipalities and industries which have demonstrated outstanding technological achievements, innovative processes, devices or other outstanding methods in their waste treatment and pollution abatement programs. Approximately 50 awards are presented annually. The achievements of these award winners are summarized in reports, news articles and national publications.

Submission of information on behalf of the respondents is voluntary. No confidential information is requested. The agency only collects information from award nominees under a currently valid OMB control number. The OMB control numbers for EPA's regulations are listed in 40 CFR part 9 and 48 CFR Chapter 15. The **Federal Register** Notice required under 5 CFR 1320.8(d), soliciting comments on this collection of information was published on May 18, 2000 (65 FR 31550–31551); No comments were received.

Burden Statement: The annual public reporting and recordkeeping burden for this collection of information is estimated to average eight hours per response. This estimate of burden includes the total time, effort, or financial resources expended to generate, maintain, retain, disclose, or provide information to EPA. This estimate includes the time needed to review instructions; collect, validate, and verify information, complete and review the collection of information; and transmit the information to EPA.

Respondents/Affected Entities: Wastewater Treatment Industries and Municipalities.

Estimated Number of Respondents: 400.

Frequency of Response: Once annually.

Estimated Total Annual Hour Burden: 2800 hours (1600 hours for the recipients time and 1200 hours for the States' review time).

Estimated Total Annualized Cost Burden: $79,200 per year ($46,600 for the respondents and $33,200 for the States' review time).

Send comments on the Agency's need for this information, the accuracy of the provided burden estimates, and any suggested methods for minimizing respondent burden, including through the use of automated collection techniques to the following addresses. Please refer to EPA ICR No. 1287.06 and OMB Control No. 2040–0101 in any correspondence.

Dated: October 26, 2000.

Oscar Morales,

Director, Collection Strategies Division.

[FR Doc. 00–28275 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[ER–FRL–6612–3]

Environmental Impact Statements; Notice of Availability

Responsible Agency: Office of Federal Activities, General Information, (202) 564–7167 or www.epa.gov/oeca/ofa.

Weekly receipt of Environmental Impact Statements

Filed October 23, 2000 through October 27, 2000

Pursuant to 40 CFR 1506.9.

EIS No. 000369, Draft EIS, IBR, ID, Arrowrock Dam Outlet Works Rehabilitation, Construction and Operation, To Remove 10 Lower Level Ensign Valves and Replace with 10 Clamshell Gates, Boise River, City of Boise, ID, Due: January 05, 2001, Contact: John Tiedeman (208) 378–5034.

EIS No. 000370, Draft EIS, BOP, ID, Terre Haute United States Penitentiary (USP), Proposal to Construct and Operate 960 Beds Facilities along with a Special Confinement Unit of 100–120 Beds to Alleviating Overcrowding, Vigo County, Terra Haute, ID, Due: December 18, 2000, Contact: David J. Dorworth (202) 514–6470.

EIS No. 000371, Final EIS, COE, NJ, Raritan Bay and Sandy Hook Bay, Hurricane and Storm Damage Reduction Project, Flood Control and Storm Damage Protection, Port Monmouth, Middletown Township, Monmouth County, NJ, Due: December 04, 2000, Contact: Mark H. Burles (212) 264–4663.

EIS No. 000372, Final EIS, COE, CA, Lower Mission Creek Flood Control Project, Proposed Plan for Flood Control, City of Santa Barbara, Santa Barbara County, CA, Due: December 04, 2000, Contact: Joy Jaiswal (213) 452–3871.

EIS No. 000373, Final EIS, AFS, ID, Brown Creek Timber Sale Project, Implementation, Payette National Forest, New Meadow Ranger District, Adam County, ID, Due: December 20, 2000, Contact: Jack Irish (208) 347–0300.

Dated: October 31, 2000.

Joseph C. Montgomery,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 00–28282 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–U

ENVIRONMENTAL PROTECTION AGENCY

(ER–FRL–6612–4)

Environmental Impact Statements and Regulations; Availability of EPA Comments

Availability of EPA comments prepared October 16, 2000 through October 20, 2000 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 14, 2000 (65 FR 20157).

Draft EISs

ERP No. D–AFS–L65366–AK Rating EC2, Woodpecker Project Area, Timber Harvesting, Dispersed Recreation Opportunities and Watershed Improvements, Implementation, Tongass National Forest, Petersburg Ranger District, Mitkof Island, Petersburg, AK.

Summary: EPA expressed environmental concerns with the greater potential for impacts to water, soil and wildlife resources under Alternative 2, the preferred alternative. Alternative 2 calls for the highest level of road construction and the second highest level of harvesting. EPA recommended additional analysis and changes in the final EIS to further address and mitigate impacts to water quality and fish habitat.

ERP No. D–AFS–L67038–ID Rating EO2, Genesis Placer Claim Gold Suction Dredging, Plan of Operations, Nez Perce National Forest, Red River Ranger District, Red River a Tributary to the South Fork Clearwater River, ID.

Summary: EPA expressed environmental objections on the proposed suction dredging project because of the potential to violate applicable water quality standards for turbidity and sediment, and as well as degrade aquatic habitat, and result in adverse effects to listed and sensitive fish species. Alternative 2 lacks mitigation measures and EPA recommends that the final EIS include additional site-specific information on project reach, potential impacts to aquatic resources, compliance with standards and environmental thresholds, monitoring, and estimated risk and uncertainties of project implementation as well as detailed mitigation measures.

ERP No. D–BLM–J65325–WY Rating EC2, Jack Morrow Hills Coordinated Activity Plan, Implementation, Rock Springs, Portions of Sweetwater, Fremont and Subelette Counties, WY.

Summary: EPA expressed environmental concerns based on the need to fully disclose environmental impacts, especially for the preferred alternative, project objectives which are not consistent with the Green River Management Plan and level of detail for the proposed adaptive management plan, such as including threshold values to protect wildlife.

ERP No. D–BLM–K67052–NV Rating EO2, Newmont Gold Mining, South Operations Area Project Amendment, Operation and Expansion, Plan of Operations, Elko and Eureka Counties, NV.

Summary: EPA expressed environmental objections to the proposed expansion of Newmont's South Operations Area, due to potential significant adverse impacts to water and air quality. Specifically, potential acid rock drainage, contaminated pit lake water and mercury emissions to the air. EPA requests that the final EIS include additional acid generating potential analysis, pollution prevention measures, mitigation, and project monitoring.

ERP No. D–NPS–F61019–MN Rating EC2, Voyageurs National Park General Management, Visitor Use and Facilities Plans, Implementation, Koochiching and St. Louis Counties, MN.

Summary: EPA expressed environmental concerns with the consistency of NPS actions related to proposed wilderness designation, scope of decisions to be made, characterization of existing conditions and impacts associated with the alternatives, and alternatives analysis.

ERP No. D–SFW–K39063–CA Rating EC2, Bolsa Chica Lowlands Restoration Project, Creation of Wetland Habitat Areas, Approval and Issuance of USCOE Section 404 and USCGD Bridge Permits, Orange County, CA.

Summary: EPA has expressed concerns with the proposal because the probability of success of the preferred alternative is unknown. Implementation would result in irreversible destruction of the existing wetland complex and irretrievable commitment of project funds in the construction of an ocean inlet and 6-lane highway bridge. EPA recommended that less-structural and less-costly alternatives be considered as interim measures to enhance the existing wetland and aquatic habitats at Bolsa Chica, while the probabilities associated with the preferred alternative modeling studies are tested and validated further. EPA also recommended the FEIS consider an evaluation of alternative mitigation sites which could fulfill the Ports mitigation requirements if the preferred alternative is not selected.

Final EISs

ERP No. F–AFS–K65227–CA 64-Acre Tract Intermodal Transit Center, Construction and Operation, Lake Tahoe Basin Management Unit, Tahoe City, Placer County, CA.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. F–BLM–G65069–NM Rio Puerco Resource Management Plan Amendment, Managing Land and Resource for EL Malpais National Conservation Area and Chain of Craters Wilderness Study Area, Lies South of the City of Grants, Cibola County, NM.

Summary: EPA expressed no objections to the preferred alternative.

ERP No. F–BLM–G65071–NM Albuquerque Field Office Riparian and Aquatic Habitats Management, To Restore and Protect, Rio Puerco Resource Management Plan Amendment (RMPA), Cibola, Sandoval, McKinley, Rio Arriba, Bernalillo, Valencia and Santa Fe Counties, NM.

Summary: EPA had no objections.

ERP No. F–BLM–L65339–OR North Bank Habitat Management Area (NBHMA)/Area of Critical Environmental Concern (ACEC), Federally Endangered Columbian White-Tailed Deer (CWTD) and Special Status Species Habitat Enhancements to Ensure Viability Over Time, Implementation, OR.

Summary: No formal comment letter was sent to the preparing agency.

ERP No. F–NPS–J65285–MT Interagency Bison Management Plan for State of Montana and Yellowstone National Park, Implementation, Maintain a wild, Free Ranging Population, Address the risk of Brucellosis Transmission, Park and Gallatin Counties, MT.

Summary: EPA continues to express environmental objections with adverse impacts to the Yellowstone Bison herd, excluding elk from the Brucellosis management plan, segmentation of NEPA, and the level of action being taken given the extremely low risk to livestock from Brucellosis.

ERP No. F–SFW–J64007–00 Plum Creek Native Fish Habitat Conservation Plan, Issuance of an Incidental Take Permit for Federally Protected Native Fish Species, MT, ID and WA.

Summary: EPA has reviewed the Native Fish Habitat Conservation Plan (NFHCP) and Proposed Permit for Taking of Federally Protected Native Fish Species on Plum Creek Timber Company Land. The EPA expressed environmental concerns regarding integration of the NFHCP with the overall conservation efforts in the entire project area; adequacy of resources for the Services for oversight and evaluation of the Permit and NFHCP; the level of protection of proposed riparian management prescriptions; NFHCP–TMDL consistency; and the adequacy of the proposed monitoring and adaptive management program.

Dated: October 31, 2000.

Joseph C. Montgomery,

Director, NEPA Compliance Division, Office of Federal Activities.

[FR Doc. 00–28283 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

[OPP–00687; FRL–6753–4]

FIFRA Scientific Advisory Panel; Notice of Public Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of public meeting.

SUMMARY: There will be a 3–day meeting of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and Food Quality Protection Act (FQPA) Scientific Advisory Panel (SAP) to review a set of issues being considered by the Agency pertaining to the following topics: (1) LifeLine™ Model Review, and (2) A Case Study of the Cumulative Risk of 24 Organophosphate Pesticides.

The meeting is open to the public. Seating at the meeting will be on a first-come basis. Individuals requiring special accommodations at this meeting, including wheelchair access, should contact Olga Odiott at the address listed under **FOR FURTHER INFORMATION CONTACT** at least 5 business days prior to the meeting so that appropriate arrangements can be made.

DATES: The meeting will be held on December 6, 7, and 8, 2000 from 8:30 a.m. to 5:30 p.m.

ADDRESSES: The meeting will be held at the Sheraton Crystal City Hotel, 1800 Jefferson Davis Highway, Arlington, VA. The telephone number for the Sheraton Hotel is (703) 486–1111. Requests to participate may be submitted by mail, electronically, or in person. Please follow the detailed instructions for each method as provided in Unit I.C. of the **SUPPLEMENTARY INFORMATION.** To ensure proper receipt by EPA, your request must identify docket control number OPP–00687 in the subject line on the first page of your response.

FOR FURTHER INFORMATION CONTACT: Olga Odiott, Designated Federal Official, Office of Science Coordination and Policy, (7101C), Office of Prevention, Pesticides and Toxic Substances, Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460; telephone number: (703) 305–5369; fax number: (703) 605–0656; e-mail address: odiott.olga@epa.gov.

SUPPLEMENTARY INFORMATION:

I. General Information

A. Does this Action Apply to Me?

This action is directed to the public in general. This action may, however, be of interest to those persons who are or may be required to conduct testing of chemical substances under the Federal Food, Drug and Cosmetic Act (FFDCA), FIFRA, and FQPA. Since other entities may also be interested, the Agency has not attempted to describe all the specific entities that may be affected by this action. If you have any questions regarding the applicability of this action to a particular entity, consult the person listed under **FOR FURTHER INFORMATION CONTACT.**

B. How Can I Get Additional Information, Including Copies of this Document and Other Related Documents?

1. *Electronically.* A meeting agenda and copies of EPA primary background documents for the meeting will be available by November 6, 2000. You may obtain electronic copies of these documents, and certain other related documents that might be available electronically, from the FIFRA/SAP Internet Home Page at http://www.epa.gov./scipoly/sap/. To access this document, on the Home Page, select ''**Federal Register** Notice Announcing This Meeting.'' You can also go directly to the **Federal Register** listings at http://www.epa.gov/fedregstr/.

2. *In person.* The Agency has established an administrative record for this meeting under docket control number OPP–00687. The administrative record consists of the documents specifically referenced in this notice, any public comments received during an applicable comment period, and other information related to the (1) LifeLine™ Model review, and (2) A Case Study of the Cumulative Risk of 24 Organophosphate Pesticides, including any information claimed as Confidential Business Information (CBI). This administrative record includes the documents that are physically located in the docket, as well as the documents that are referenced in those documents. The public version of the administrative record, which includes printed, paper versions of any electronic comments that may be submitted during an applicable comment period, is available for inspection in the Public Information and Records Integrity Branch (PIRIB), Rm. 119, Crystal Mall # 2 (CM #2), 1921 Jefferson Davis Hwy., Arlington, VA, from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The PIRIB telephone number is (703) 305–5805.

C. How Can I Request to Participate in this Meeting?

You may submit a request to participate in this meeting through the mail, in person, or electronically. Do not submit any information in your request that is considered CBI. To ensure proper receipt by EPA, it is imperative that you identify docket control number OPP–00687 in the subject line on the first page of your request. Members of the public wishing to submit comments should contact the person listed under **FOR FURTHER INFORMATION CONTACT** to confirm that the meeting date and agenda have not been modified. Interested persons are permitted to file written statements before the meeting. To the extent that time permits, and upon advance written request to the persons listed under **FOR FURTHER INFORMATION CONTACT**, interested persons may be permitted by the Chair of the FIFRA SAP to present oral statements at the meeting. The request should identify the name of the individual making the presentation, the organization (if any) the individual will represent, and any requirements for audiovisual equipment (e.g., overhead projector, 35 mm projector, chalkboard, etc.). There is no limit on the extent of written comments for consideration by the Panel, but oral statements before the panel are limited to approximately 5 minutes. The Agency also urges the public to submit written comments in lieu of oral presentations. Persons wishing to make oral or written statements at the meeting should contact the persons listed under **FOR FURTHER INFORMATION CONTACT** and submit 30 copies of their presentation and/or remarks to the Panel. The Agency encourages that written statements be submitted before the meeting to provide Panel Members the time necessary to consider and review the comments.

1. *By mail.* You may submit a request to: Public Information and Records Integrity Branch (PIRIB), Information Resources and Services Division (7502C), Office of Pesticide Programs (OPP), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460.

2. *In person or by courier.* Public Information and Records Integrity Branch (PIRIB), Information Resources and Services Division (7502C), Office of Pesticide Programs (OPP), Environmental Protection Agency, Rm. 119, CM #2, 1921 Jefferson Davis Hwy., Arlington, VA. The PIRIB is open from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The

PIRIB telephone number is (703) 305–5805.

3. *Electronically*. You may submit your request electronically by e-mail to: ''opp-docket@epa.gov.'' Do not submit any information electronically that you consider to be CBI. Use WordPerfect 6.1/8.0 or ASCII file format and avoid the use of special characters and any form of encryption. Be sure to identify by docket control number OPP–00687. You may also file a request online at many Federal Depository Libraries.

II. Background

A. Purpose of the Meeting

This 3–day meeting concerns several scientific issues undergoing consideration within the EPA Office of Prevention, Pesticides and Toxic Substances (OPPTS), as follows.

1. *LifeLine™ Model review*. Review key features of the LifeLine™ Model to include the software code, data requirements, data inputs, and output reports. To assist the Panel in their evaluation of LifeLine™ each Panel member will be provided a CD containing the LifeLine™ software and supporting documentation. The Panel will be evaluating hypothetical, yet representative, residue and toxicological data sets for assessing aggregate and cumulative exposure and risk via the dietary, residential and drinking water pathways.

2. *A Case Study of the Cumulative Risk of 24 Organophosphate Pesticides*. The case study will illustrate data use and the process for integrating multi-pathway exposures to 24 organophosphate pesticides from food, drinking water and residential sources. This topic will be divided in 4 sessions: (1) Cumulative risk assessment method for dietary (food) exposure, (2) Cumulative risk assessment for residential exposure, (3) Cumulative risk assessment for drinking water, and (4) Integrated cumulative risk assessment. The first three sessions will illustrate how the Agency applied the principles described in the exposure sections of the cumulative risk assessment guidance to monitoring data for residues of organophosphates on food and water. This approach uses available surrogate data on residential/institutional uses to estimate cumulative exposures/risk using the Relative Potency Factor Method as reviewed by the FIFRA SAP in September, 2000. The background material will describe the assumptions, procedures, and methods employed in the assessment to estimate the cumulative exposures resulting from each of the three pathways. An illustration of an approach to integrate exposures from the three pathways into a complete cumulative assessment will be described in session 4.

B. Panel Report

Copies of the Panel's report of their recommendations will be available approximately 45 working days after the meeting, and will be posted on the FIFRA SAP web site or may be obtained by contacting PIRIB at the address and telephone listed below under Unit I.B. of this document.

List of Subjects

Environmental protection.

Dated: October 27, 2000.

Steven K. Galson,

Director, Office of Science Coordination and Policy.

[FR Doc. 00–28279 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[OPP–00439G; FRL–6753–1]

Pesticide Program Dialogue Committee (PPDC): Inert Disclosure Stakeholder Workgroup; Open Meeting

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of meeting.

SUMMARY: This notice announces a conference call meeting of the Inert Disclosure Stakeholder Workgroup. The workgroup was established to advise the Pesticide Program Dialogue Committee on ways of making information on inert ingredients more available to the public while working within the mandates of the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA) and related Confidential Business Information concerns.

DATES: The meeting will be held by conference call on Monday, November 20, 2000 from 12:00 pm to 3:00 pm EST.

ADDRESSES: Members of the public may listen to the meeting discussions on site at: Crystal Mall #2 (CM #2), 1921 Jefferson Davis Highway, Arlington, VA; conference Room 1123. Seating is limited and will be available on a first come first serve basis.

FOR FURTHER INFORMATION CONTACT: By mail: Cameo Smoot, Office of Pesticide Programs (7506C), U.S. Environmental Protection Agency, 1200 Pennsylvania Avenue, NW., Washington, DC 20460, telephone: (703) 305–5454. Office locations: 11th floor, CM #2, 1921 Jefferson Davis Highway, Arlington, VA. E-mail smoot.cameo@epa.gov.

SUPPLEMENTARY INFORMATION: The Inert Disclosure Stakeholder Workgroup is composed of a participants from the following sectors: environmental/public interest and consumer groups; industry and pesticide users; Federal, State and local governments; the general public; academia and public health organizations.

The Inert Disclosure Stakeholder Workgroup, will advise the EPA through the Pesticide Program Dialogue Committee (PPDC), on potential measures to increase the availability to the public of information about inert ingredients (also called ''other ingredients'') under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA). Among the factors the workgroup has been asked to consider in preparing its recommendations are: existing law regarding inert ingredients and Confidential Business Information (CBI); current Agency processes and policies for disseminating inert ingredient information to the public, including procedures for the protection of CBI; informational needs for a variety of stakeholders; and business reasons for limiting the disclosure of inert ingredient information.

The Inert Disclosure Stakeholder Workgroup meeting is open to the public. Written public statements are welcome and should be submitted to the OPP administrative docket OPP–00439A. Any person who wishes to file a written statement can do so before or after the conference call. These statements will become part of the permanent file and will be provided to the Workgroup members for their information.

How and to Whom Do I Submit the Comments?

You may submit comments through the mail, in person, or electronically. To ensure proper receipt by EPA, it is imperative that you identify docket control number OPP–00439A in the subject line on the first page of your response.

1. *By mail*. Submit your comments to: Public Information and Records Integrity Branch (PIRIB), Information Resources and Services Division (7502C), Office of Pesticide Programs (OPP), Environmental Protection Agency, 1200 Pennsylvania Ave., NW., Washington, DC 20460.

2. *In person or by courier*. Deliver your comments to: Public Information and Records Integrity Branch (PIRIB), Information Resources and Services

Division (7502C), Office of Pesticide Programs (OPP), Environmental Protection Agency, Rm. 119, CM #2, 1921 Jefferson Davis Hwy., Arlington, VA. The PIRIB is open from 8:30 a.m. to 4 p.m., Monday through Friday, excluding legal holidays. The PIRIB telephone number is (703) 305–5805.

3. *Electronically.* You may submit your comments and/or data electronically by e-mail to: ''*opp-docket@epa.gov,*'' or you can submit a computer disk as described above in paragraphs 1. and 2. of this section. Do not submit any information electronically that you consider to be CBI. Avoid the use of special characters and any form of encryption. Electronic submissions will be accepted in WordPerfect 6.1/8.0 or ASCII file format. All comments in electronic form must be identified by docket control number OPP–00439A. Electronic comments may also be filed online at many Federal Depository Libraries.

List of Subjects

Environmental protection, Pesticides, Inerts, PPDC.

Dated: October 25, 2000.

Susan B. Hazen,

Acting Director, Office of Pesticide Programs.

[FR Doc. 00–28281 Filed 11–2–00; 8:45 am]

BILLING CODE 6560–50–S

ENVIRONMENTAL PROTECTION AGENCY

[FRL–6894–5]

Clean Water Act Class II: Proposed Administrative Penalty Assessment and Opportunity to Comment Regarding Sharpe and Associates, and Palisades Development Company

AGENCY: Environmental Protection Agency (''EPA'').

ACTION: Notice.

SUMMARY: EPA is providing notice of a proposed administrative penalty assessment for alleged violations of the Clean Water Act (''Act''). EPA is also providing notice of opportunity to comment on the proposed assessment.

EPA is authorized under section 309(g) of the Act, 33 U.S.C. 1319(g), to assess a civil penalty after providing the person subject to the penalty notice of the proposed penalty and the opportunity for a hearing, and after providing interested persons notice of the proposed penalty and a reasonable opportunity to comment on its issuance. Under section 309(g), any person who without authorization discharges a pollutant to a navigable water, or who has violated the conditions of a National Pollutant Discharge Elimination System permit, as those terms are defined in section 502 of the Act, 33 U.S.C. 1362, may be assessed a penalty in a ''Class II'' administrative penalty proceeding.

Class II proceedings under section 309(g) are conducted in accordance with the ''Consolidated Rules of Practice Governing the Administrative Assessment of Civil Penalties, Issuance of Compliance or Corrective Action Orders, and the Revocation, Termination or Suspension of Permits,'' 40 CFR part 22 (''Consolidated Rules''), published at 64 FR 40138, 40177 (July 23, 1999). The procedures through which the public may submit written comment on a proposed Class II order or participate in a Class II proceeding, and the procedures by which a respondent may request a hearing, are set forth in the Consolidated Rules. The deadline for submitting public comment on a proposed Class II order is thirty (30) days after publication of this notice.

On September 29, 2000, EPA commenced the following Class II proceeding for the assessment of penalties by filing with Danielle Carr, Regional Hearing Clerk, U.S. EPA, Region IX, 75 Hawthorne Street, San Francisco, California 94105, (415) 744–1391, the following Complaint:

In the Matter of Sharpe and Associates, and Palisades Development Company, Oro Valley, Arizona, Docket No. CWA–09–2000–0013.

The Complaint proposes a penalty of up to One Hundred Thirty Seven Thousand, Five Hundred Dollars ($137,500) for violations of NPDES Permit No. AZR100000, the reissued NPDES Permit No. AZR10*### and Section 301(a) of the Act, 33 U.S.C. 1311(a), at the Catalina Shadows Development Phase 4, Oro Valley, Arizona.

The Complainant in this action is EPA Region IX.

Complainant's address is: EPA Region IX, Attn: Hugh Barroll (ORC2), 75 Hawthorne St., San Francisco, CA 94105.

Respondents in this action are Sharpe and Associates and Palisades Development Company.

Respondents addresses are:

Sharpe and Associates, Inc., 4780 Rocky Crest Place, Tucson, AZ 85750

Palisades Development Company, Attn: Sidney Y. Kohn, 1200 N. El Dorado Place, Suite H–810, Tucson, AZ 85715

Procedures by which the public may comment on a proposed Class II penalty or participate in a Class II penalty proceeding are set forth in the Consolidated Rules. The deadline for submitting public comment on a proposed Class II penalty is thirty days after issuance of public notice. The Regional Administrator of EPA, Region 9 may issue an order upon default if the respondent in the proceeding fails to file a response within the time period specified in the Consolidated Rules.

FOR FURTHER INFORMATION: Persons wishing to receive a copy of EPA's Consolidated Rules, review the Complaint or other documents filed in this proceeding, comment upon the proposed assessment, or otherwise participate in the proceeding should contact Danielle Carr, Regional Hearing Clerk, U.S. EPA, Region IX, 75 Hawthorne Street, San Francisco, California 94105, (415) 744–1391. The administrative record for this proceeding is located in the EPA Regional Office identified above, and the file will be open for public inspection during normal business hours. All information submitted by Sharpe and Associates, and Palisades Development Company is available as part of the administrative record, subject to provisions of law restricting public disclosure of confidential information. In order to provide opportunity for public comment, EPA will issue no final order assessing a penalty in these proceedings prior to thirty (30) days after the date of publication of this notice.

Dated: October 24, 2000.

Mike Schulz,

Acting Director, Water Division.

[FR Doc. 00–28276 Filed 11–2–00; 8:45 am]

BILLING CODE 5650–50–P

FEDERAL DEPOSIT INSURANCE CORPORATION

Notice of Agency Meeting

Pursuant to the provisions of the ''Government in the Sunshine Act'' (5 U.S.C. 552b), notice is hereby given that the Federal Deposit Insurance Corporation's Board of Directors will meet in open session at 10:00 a.m. on Tuesday, November 7, 2000, to consider the following matters:

Summary Agenda: No substantive discussion of the following items is anticipated. These matters will be resolved with a single vote unless a member of the Board of Directors requests that an item be moved to the discussion agenda.

Disposition of minutes of previous Board of Directors' meetings.

Summary reports, status reports, and reports of actions taken pursuant to authority delegated by the Board of Directors.

Discussion Agenda:

Memorandum re: BIF Assessment Rates for the First Semiannual Assessment Period of 2001.

Memorandum re: SAIF Assessment Rates for the First Semiannual Assessment Period of 2001.

The meeting will be held in the Board Room on the sixth floor of the FDIC Building located at 550—17th Street, NW., Washington, DC.

The FDIC will provide attendees with auxiliary aids (*e.g.,* sign language interpretation) required for this meeting. Those attendees needing such assistance should call (202) 416–2089 (Voice); (202)416–2007 (TTY), to make necessary arrangements. Requests for further information concerning the meeting may be directed to Mr. Robert E. Feldman, Executive Secretary of the Corporation, at (202)898–6757.

Dated: October 31, 2000

Federal Deposit Insurance Corporation.

Robert E. Feldman,

Executive Secretary.

[FR Doc. 00–28308 Filed 10–31–00; 4:07 pm]

BILLING CODE 6714–01–M

FEDERAL EMERGENCY MANAGEMENT AGENCY

Agency Information Collection Activities: Submission for OMB Review; Comment Request

ACTION: Notice and request for comments.

SUMMARY: The Federal Emergency Management Agency has submitted the following proposed information collection to the Office of Management and Budget for review and clearance in accordance with the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3507).

Title: Request for Federal Assistance Form (How to Process Mission Assignments).

Type of Information Collection: Extension of a currently approved collection.

OMB Number: 3067–0278.

Abstract: Information on the Request for Federal Assistance (RFA) form is required to document requests for Federal assistance and any resulting mission assignments to other Federal agencies. Other methods used to obtain the request portion of the RFA include internal existing State forms. No alternative exists to obligate a mission assignment in FEMA's official integrated financial management system.

Affected Public: Federal Government, State, Local or Tribal Government.

Number of Respondents: 56.

Estimated Time per Respondent: 20 minutes.

Estimated Total Annual Burden Hours: 182 hours.

Frequency of Response: After a disaster.

COMMENTS: Interested persons are invited to submit written comments on the proposed information collection to the Desk Officer for the Federal Emergency Management Agency, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503 within 30 days of the date of this notice.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection should be made to Muriel B. Anderson, Chief, Records Management Branch, Program Services Division, Operations Support Directorate, Federal Emergency Management Agency, 500 C Street, SW, Room 316, Washington, DC 20472, telephone number (202) 646–2625, FAX number (202) 646–3524, or e-mail address: muriel.anderson@fema.gov.

Mike Bozzelli,

Acting Director, Program Services Division, Operations Support Directorate.

[FR Doc. 00–28259 Filed 11–2–00; 8:45 am]

BILLING CODE 6718–01–P

FEDERAL EMERGENCY MANAGEMENT AGENCY

Agency Information Collection Activities: Submission for OMB review; Comment Request

ACTION: Notice and request for comments.

SUMMARY: The Federal Emergency Management Agency has submitted the following proposed information collection to the Office of Management and Budget for review and clearance in accordance with the requirements of the Paperwork Reduction Act of 1995 (44 U.S.C. 3507).

Title: EMI Independent Study Course Enrollment Application.

Type of Information Collection: Revision of a currently approved collection.

OMB Number: 3067–0277.

Abstract: FEMA Form 95–23 is used to provide independent study course materials to students that enroll in the Independent Study Program. These courses are offered in residence at the Emergency Management Institute (EMI), through State Emergency Management Agencies. The Independent Study Program provides valuable training to emergency management personnel and to the general citizenry of the United States, without having to attend a resident course at EMI, or at a state-sponsored course.

Affected Public: Individuals or households.

Number of Respondents: 90,000.

Estimated Time per Respondent: 1 minute.

Estimated Total Annual Burden Hours: 1500.

Frequency of Response: On Occasion.

COMMENTS: Interested persons are invited to submit written comments on the proposed information collection to the Desk Officer for the Federal Emergency Management Agency, Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, DC 20503 within 30 days of the date of this notice.

FOR FURTHER INFORMATION CONTACT: Requests for additional information or copies of the information collection should be made to Muriel B. Anderson, Chief, Records Management Branch, Program Services Division, Operations Support Directorate, Federal Emergency Management Agency, 500 C Street, SW, Room 316, Washington, DC 20472, telephone number (202) 646–2625, FAX number (202) 646–3524, or e-mail address: muriel.anderson@fema.gov.

Mike Bozzelli,

Acting Director, Program Services Division, Operations Support Directorate.

[FR Doc. 00–28260 Filed 11–2–00; 8:45 am]

BILLING CODE 6718–01–P

FEDERAL RESERVE SYSTEM

Formations of, Acquisitions by, and Mergers of Bank Holding Companies

The companies listed in this notice have applied to the Board for approval, pursuant to the Bank Holding Company Act of 1956 (12 U.S.C. 1841 *et seq.*) (BHC Act), Regulation Y (12 CFR Part 225), and all other applicable statutes and regulations to become a bank holding company and/or to acquire the assets or the ownership of, control of, or the power to vote shares of a bank or bank holding company and all of the banks and nonbanking companies owned by the bank holding company, including the companies listed below.

The applications listed below, as well as other related filings required by the Board, are available for immediate

inspection at the Federal Reserve Bank indicated. The application also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the standards enumerated in the BHC Act (12 U.S.C. 1842(c)). If the proposal also involves the acquisition of a nonbanking company, the review also includes whether the acquisition of the nonbanking company complies with the standards in section 4 of the BHC Act (12 U.S.C. 1843). Unless otherwise noted, nonbanking activities will be conducted throughout the United States. Additional information on all bank holding companies may be obtained from the National Information Center website at www.ffiec.gov/nic/.

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 November 27, 2000.

A. Federal Reserve Bank of Atlanta (Cynthia C. Goodwin, Vice President) 104 Marietta Street, N.W., Atlanta, Georgia 30303–2713:

1. Capital City Bank Group, Inc., Tallahassee, Florida; to acquire 20.75 percent of the voting shares of First Peoples Bankshares, Inc., Pine Mountain, Georgia, and thereby indirectly acquire voting shares of First Peoples Bank, Pine Mountain, Georgia.

B. Federal Reserve Bank of Chicago (Phillip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. Northwest Suburban Bancorp, Inc., Mount Prospect, Illinois; to acquire 100 percent of the voting shares of Village Bank and Trust, North Barrington, Illinois.

Board of Governors of the Federal Reserve System, October 30, 2000.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 00–28229 Filed 11–2–00; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Notice of Proposals To Engage in Permissible Nonbanking Activities or To Acquire Companies That Are Engaged in Permissible Nonbanking Activities

The companies listed in this notice have given notice under section 4 of the Bank Holding Company Act (12 U.S.C. 1843) (BHC Act) and Regulation Y, (12 CFR part 225) to engage *de novo,* or to acquire or control voting securities or assets of a company, including the companies listed below, that engages either directly or through a subsidiary or other company, in a nonbanking activity that is listed in § 225.28 of Regulation Y (12 CFR 225.28) or that the Board has determined by Order to be closely related to banking and permissible for bank holding companies. Unless otherwise noted, these activities will be conducted throughout the United States.

Each notice is available for inspection at the Federal Reserve Bank indicated. The notice also will be available for inspection at the offices of the Board of Governors. Interested persons may express their views in writing on the question whether the proposal complies with the standards of section 4 of the BHC Act. Additional information on all bank holding companies may be obtained from the National Information Center website at www.ffiec.gov/nic/.

Unless otherwise noted, comments regarding the applications must be received at the Reserve Bank indicated or the offices of the Board of Governors not later than November 17, 2000.

A. Federal Reserve Bank of Chicago (Phillip Jackson, Applications Officer) 230 South LaSalle Street, Chicago, Illinois 60690–1414:

1. *Midwest Banc Holdings, Inc.,* Melrose Park, Illinois; to acquire through its subsidiary, Midwest Financial and Investment Services, Inc., Elmwood Park, Illinois, Service 1st Financial Corporation, Elmwood Park, Illinois, and thereby engage in securities brokerage activities, pursuant to § 225.28(b)(7)(i) of Regulation Y.

Board of Governors of the Federal Reserve System, October 30, 2000.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 00–28230 Filed 11–2–00; 8:45 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

[Docket No. R–1037]

Federal Reserve ACH Deposit Deadlines and Pricing Practices for Transactions Involving Private-Sector ACH Operators

AGENCY: Board of Governors of the Federal Reserve System.

ACTION: Notice.

SUMMARY: The Board has approved a new approach to pricing automated clearing house transactions that the Federal Reserve Banks exchange with intermediaries that are defined as operators under the operating rules of the National Automated Clearing House Association. The Reserve Banks will initiate discussions with the private-sector ACH operators (PSOs) to negotiate the structure and level of fees that will be charged by the Reserve Banks for processing interoperator transactions as well as those fees that the Reserve Banks will pay the PSOs. The Reserve Banks will work collaboratively with the PSOs to establish deposit deadlines by which they would exchange interoperator transactions with each other and to address other operational issues. To permit time for necessary software modifications, the new interoperator deposit deadlines will be implemented by the Reserve Banks no later than June 2001 while the new fees will be implemented no later than September 2001.

FOR FURTHER INFORMATION CONTACT: Jack K. Walton II, Manager, Retail Payments Section (202/452–2660); Michele Braun, Project Leader, Retail Payments Section (202/452–2819); or Jeffrey S. H. Yeganeh, Senior Financial Services Analyst, Retail Payments Section, Division of Reserve Bank Operations and Payment Systems (202/728–5801); for the hearing impaired only, contact Janice Simms, Telecommunication Device for the Deaf (202/872–4984).

SUPPLEMENTARY INFORMATION:

I. Background

The Federal Reserve Banks are collectively the nation's largest automated clearing house (ACH) operator and process more than 80 percent of commercial interbank ACH transactions. PSOs process the remaining transactions and typically provide services, including processing and settling ACH transactions, similar to those offered by the Reserve Banks. PSOs and the Reserve Banks rely on each other for the processing of some transactions in which either the originating depository financial institution (ODFI) or receiving depository financial institution (RDFI) is not their customer. These interoperator transactions are settled by the Reserve Banks.

Some industry representatives have expressed concerns that the Reserve Banks' price and service level policies have created barriers to open and vigorous competition among ACH operators because the policies do not recognize the role played by operators in the ACH system.[1] Specifically, these representatives have maintained that the Reserve Banks' deposit deadlines and

[1] *ACH Vision 2000 Task Force Recommendations,* NACHA, 1997; *The Role of the Federal Reserve and the Banking Industry in the Retail Electronic Payments Systems of the Future,* The Bankers Roundtable, April 1998.

price structure do not permit the PSOs to compete effectively in the provision of ACH services to depository institutions.

In response to the industry's concerns, the Board requested comment last year on the benefits and drawbacks of modifying the Reserve Banks' deposit deadlines and pricing practices for ACH transactions exchanged with PSOs (64 FR 27793, May 21, 1999). Specifically, the Board requested comment on whether the Reserve Banks should (1) modify their deposit deadlines and processing schedules, (2) modify their price structure for interoperator transactions, and (3) limit any modifications to PSOs only. Based on comments received, the Board concluded that adopting certain modifications to the Reserve Banks' deposit deadlines and price structure for ACH transactions exchanged with PSOs would enhance competition in the provision of ACH operator services to depository institutions.

In May 2000, the Board requested comment on a proposal to modify the Reserve Banks' deadlines and pricing practices for ACH interoperator transactions that would promote competition in the provision of ACH services and address the concerns raised by some commenters (65 FR 34183, May 26, 2000). Specifically, the Board proposed the following modifications to the deadlines and price structure for ACH interoperator transactions that are processed by the Reserve Banks:

- *Deposit deadlines:* The Board proposed that the Reserve Banks work collaboratively with ACH operators to establish interoperator deposit deadlines by which the Reserve Banks and the PSOs would exchange interoperator transactions.
- *Price structure:* The Board proposed the following price structure for interoperator transactions processed by the Reserve Banks with price ranges based on preliminary cost analyses by the Reserve Banks.[2] Further, the Reserve Banks indicated that they planned to maintain the current fee structure for their customers and did not anticipate any increases in fees resulting from this proposal.

—First, the Reserve Banks would charge ACH operators a monthly network access fee of between $5 and $10 for each routing number they access on the Reserve Banks' ACH network.

—Second, the Reserve Banks would charge ACH operators a per-item fee of between $0.002 and $0.004 for transactions they send through the Reserve Banks' ACH network.

—Third, the Reserve Banks would charge depository institutions that send and receive all their transactions through PSOs a monthly settlement fee of about $20 rather than the current monthly account servicing fee of $25.[3]

—Fourth, the Reserve Banks would pay PSOs for commercial and government ACH transactions they send to depository institutions through those PSOs. Fees paid by the Reserve Banks to the PSOs would compensate the PSOs for the services they provide the Reserve Banks by delivering transactions to RDFIs. PSOs would not be required to adopt the Reserve Banks' price structure and fees for transactions sent to them by Reserve Banks but rather could establish their own price structure and fees.

- *Eligibility:* The Board proposed limiting the modified deadlines and price structure to intermediaries that are defined as ACH operators in the operating rules of the National Automated Clearing House Association (NACHA).

II. Summary and Analysis of Comments

The Board received twenty-nine responses to its request for comment. The following table shows the number of comments received by category of commenter:[4]

Commenters	Number
Small banks, thrifts, and credit unions	9
Large banks	6
ACH associations	3
Bankers' banks and corporate credit unions	3
Private-sector operators	3
Federal Reserve Banks	2
Trade associations	2
Clearing houses	1
Total	29

Overall, fifteen commenters supported and fourteen commenters opposed the Board's proposal. Those supporting the proposal generally tended to be smaller depository institutions; however, the American Bankers Association, two large banks, a bankers' bank, and the Reserve Banks supported the proposal as well. These commenters believed the proposal would enhance competition. They also believed that the proposal reflected a balanced approach towards addressing the competitive concerns of PSOs and the pricing concerns of small banks. Those opposing the proposal generally tended to be PSOs, ACH associations, and larger banks; however, two corporate credit unions, a clearing house, and the Association for Financial Professionals opposed the proposal as well. These commenters believed that the proposed modifications would not improve competition in the provision of ACH services and were primarily concerned that the proposed price structure would exacerbate current competitive imbalances.

A. Deposit Deadlines

Summary of Comments—In its May 2000 request for comment, the Board proposed that the Reserve Banks work collaboratively with ACH operators to establish interoperator deposit deadlines by which the Reserve Banks and the PSOs would exchange interoperator transactions. The Reserve Banks' preliminary recommendation was that one interoperator deposit deadline be established at 2:30 p.m. eastern time for immediate settlement items and that another interoperator deposit deadline for next-day settlement items be established at 3 a.m. eastern time.[5] Under the proposal, PSOs would continue to be free to establish other deadlines by which they would exchange interoperator transactions among themselves. Further, all ACH operators, including the Reserve Banks, would be free to establish deposit and delivery deadlines for their customers.

Almost all commenters supported the Board's proposal to modify deposit deadlines. Commenters indicated that

[2] In developing the proposed price structure for interoperator transactions, the Reserve Banks used a cost-based approach to set fees. The Reserve Banks attempted to identify costs related to network access, processing, and settlement and to price those components separately. Further, the Reserve Banks excluded certain costs that might not be incurred when services are provided to ACH operators so that the interoperator fee structure would reflect, as closely as possible, the cost structure for interoperator transactions.

[3] The Reserve Banks would no longer provide customer service to depository institutions for transactions they send or receive through a PSO. These institutions would have to direct transaction and service-related inquiries to their PSOs. The Reserve Banks, however, would continue to provide customer service on settlement-related questions.

[4] Responses from trade associations were included with the organizations they present. Two trade associations (The American Bankers Association and The Association for Financial Professionals), however, did not fall into one specific category and are listed separately.

[5] Immediate settlement items are settled on the same banking day as they are received while next-day settlement items are settled one or two banking days after they are received. The Reserve Banks' banking day for the receipt of ACH items is from 3 a.m. eastern time to 2:59 a.m. eastern time on the next calendar day. Only return items and National Association of Check Safekeeping items are eligible for immediate settlement.

the proposal provided an excellent starting point for discussions between the Reserve Banks and PSOs to establish deposit deadlines for interoperator transactions. These commenters believed that the preliminary recommendation would help level the playing field between Reserve Banks and PSOs and thus improve competition. Further, they believed that because the Reserve Banks currently receive almost all of their next-day item deposits well in advance of the 3 a.m. deposit deadline, most Reserve Bank customers would not be adversely affected. Most commenters believed that the deposit deadline modifications could be implemented independent of the remainder of the proposed modifications and that the Reserve Banks and PSOs would have to address a number of technical issues, such as how to handle requests for deadline extensions.

One commenter, however, indicated that it would not be in favor of modifications that would shorten current deposit deadlines for Reserve Bank customers. Wachovia Bank noted that while the adverse impact of changes in deposit deadlines on Reserve Bank customers might be minimal, the Board should avoid any adverse impact. Another commenter, ABN AMRO, also voiced concerns about the potential earlier Reserve Bank customer deposit deadline for next-day items and suggested that the Board's long-term goal should be to make the deadline later than it is today.

When it requested comment, the Board noted the problems posed by transactions that involve three operators. Currently, some of the transactions that PSOs deposit with the Reserve Banks are destined to other PSOs, which results in some transactions being processed by three operators.[6] With interoperator deposit deadlines, however, if an operator receives a transaction from another operator at the interoperator deposit deadline that is destined to a third operator, the middle operator would be unable to forward the transaction timely because the deadline to deposit transactions with the third operator would have already passed. To address this issue, the Board suggested that NACHA evaluate whether its ACH operator definition should be revisited to require operators to exchange interoperator transactions directly with the operator serving the RDFI. In any case, to ensure that the Reserve Banks are able to forward the transactions to the RDFI's operator by the interoperator deposit deadline, the Board proposed that the Reserve Banks require all ACH transactions that need to be forwarded to another operator, including transactions deposited by a PSO, be deposited by the Reserve Banks' customer deposit deadline.

Commenters believed that the three-operator transaction issue could be addressed through NACHA operating rules but were careful to note that any NACHA operating rule modifications should not result in a degradation of service to RDFIs. The Chicago Reserve Bank, however, suggested that files deposited with the Reserve Banks by a PSO that contain transactions destined to a third operator should not be eligible for modified deadlines and pricing.

Board Analysis—The Board has concluded that the Reserve Banks should work collaboratively with ACH operators to establish interoperator deposit deadlines by which the Reserve Banks and the PSOs would exchange interoperator transactions. The PSOs would continue to be free to establish other deadlines by which they would exchange interoperator transactions among themselves. Further, the Reserve Banks and the PSOs would be free to establish deposit and delivery deadlines for their customers.

Based on the comments received in response to its request for comment, the Board believes that establishing interoperator deposit deadlines by which Reserve Banks and the PSOs would exchange transactions would enhance the competitive environment with minimal operational impact on Reserve Bank customers. Preliminary discussions between the Reserve Banks and the PSOs suggest that the interoperator deposit deadline for immediate settlement items would likely be set at 2:30 p.m. eastern time and the interoperator deposit deadline for next-day settlement items would be set at 3:00 a.m. eastern time. As a result, PSOs should be able to deliver transactions to RDFIs earlier than they do today, which should result in competitive RDFI delivery schedules between the Reserve Banks and PSOs. Assuming these deadlines are adopted, the Reserve Banks' customer deposit deadline for next-day items will be adjusted to permit the Reserve Banks to forward interoperator transactions to PSOs by the 3:00 a.m. deadline. Reserve Bank customer deposit deadlines will be finalized after the Reserve Banks and the PSOs set the interoperator deposit deadlines. In addition, the Reserve Banks and the PSOs will work together to address technical operational issues to ensure that the ACH system operates as efficiently and effectively as possible. The new interoperator exchange deadlines will be implemented no later than June 2001.

The Board agrees with commenters that the three-operator transaction issue should be addressed through NACHA operating rules. Accordingly, the Board recommends that NACHA revisit its ACH operator definition and require operators to exchange interoperator transactions directly with the operator serving the RDFI. Further, to ensure that the Reserve Banks are able to forward interoperator transactions by the interoperator deposit deadline, the Reserve Banks will require all ACH transactions that need to be forwarded to another operator, including transactions deposited by a PSO, be deposited by the Reserve Banks' regular customer deposit deadline. The Board anticipates that the adoption of interoperator exchange deadlines will enable the Reserve Banks and PSOs to offer RDFIs competitive delivery schedules and believes that ODFIs will be able to modify their deadlines or operational procedures to meet an earlier Reserve Bank customer deposit deadline for next-day items.

B. Price Structure for Interoperator Transactions

Summary of Comments.—Commenters were split on the appropriateness of the proposed price structure for interoperator transactions processed by the Reserve Banks. Supporters believed that the proposed price structure would promote competition in the provision of ACH operator services. Some supporters of the proposal, however, indicated that their support was premised on the assumption that these pricing changes would not result in higher fees to Reserve Bank customers, a result they would oppose.

Commenters opposing the proposed price structure believed that it would not correct the current competitive inequities and could possibly harm competition. These commenters suggested that the proposed price structure would permit the Reserve Banks to continue to dominate the market for ACH operator services. These commenters believed that the proposal's use of network access fees based on the

[6] The Board understands that some depository institutions that use a PSO prefer to minimize the number of settlement entries they receive for their ACH transactions. Most of these institutions already receive and reconcile two settlements—one from their PSO, another from the Reserve Banks—and do not want to receive a third settlement for ACH transactions that PSOs exchange directly using the Private ACH Exchange (PAX) system. Thus, PSOs use the Reserve Banks to send some transactions destined to other PSOs, which minimizes the number of settlement entries for a given institution but results in three-operator transactions.

number of RDFI routing numbers accessed and per-item fees based on the volume of transactions processed did not accurately reflect the Reserve Banks' cost structure. As a result, these commenters believed that the proposed structure would threaten the viability of PSOs and would result in PSO customers subsidizing Reserve Bank customers. These commenters recommended that the Reserve Banks and the PSOs exchange interoperator transactions at par, i.e., with no fees being assessed. If par exchange were not possible, commenters suggested recovering the network access costs through per-item fees.[7]

The Board also requested comment on how the fees that operators would charge each other might be restrained. The Board was concerned that an operator might be able to charge other operators excessive fees for access to RDFIs on its network if RDFIs were unwilling to accept the delivery of ACH transactions directly from multiple operators. The Board was also concerned about fee increases to Reserve Bank and PSO customers that could result from potentially spiraling interoperator fees as the Reserve Banks and PSOs attempted to cover the costs of interoperator transactions by charging each other higher fees. The Board noted that it believed that maintaining low, cost-based interoperator fees would enhance the continued growth of the ACH network.

Commenters stated that the Federal Reserve does not have the legal authority to restrain or impose the fees that PSOs charge the Reserve Banks. These commenters noted that the potential need for fee restraints suggested that the proposed price structure was not economically viable. These commenters believed that the only restraints on interoperator pricing should be market-based. If interoperator fees become unreasonable, operators could establish direct connections to its competitors' customers thereby bypassing the operator assessing the unreasonable fees. These commenters, nevertheless, believed that restraints would not be necessary because it is likely that PSOs would charge Reserve Banks the same fees they are charged by the Reserve Banks. Other commenters, however, suggested that the Reserve Banks should negotiate interoperator fees with the PSOs and that Reserve Banks should not pay PSOs a higher fee than they charge the PSOs. By adopting these approaches, these commenters indicated that the Reserve Banks could ensure that their customers are not subsidizing the PSOs' operations.

Board Analysis—The Board has approved a new approach to pricing interoperator transactions. As the Board noted in its request for comment, the Reserve Banks expend resources when they receive, process, and deliver interoperator transactions. Thus, exchanging interoperator transactions at no charge, as suggested by some commenters, could lead to inefficiencies in the processing of ACH transactions. The Board, however, has determined that the proposal to recover network costs through a network access fee based on the number of routing numbers accessed by PSOs would not be an appropriate component of a price structure for interoperator transactions.

Based on its analysis of comments, the Board has concluded that the Reserve Banks should initiate discussions with the PSOs to negotiate the structure and level of fees that would be charged by the Reserve Banks for interoperator transactions as well as those fees that the Reserve Banks would pay the PSOs. The Board believes that negotiations between the Reserve Banks and PSOs should result in interoperator fees that would enhance competition in the provision of ACH operator services.[8]

The Board has also approved, as originally proposed, the settlement fee that would be assessed to depository institutions that send and receive all their transactions that are processed by the Reserve Banks through PSOs. Specifically, the Reserve Banks would charge a monthly settlement fee of about $20 per routing number, rather than the current monthly account servicing fee of $25, to settle interoperator transactions processed by the Reserve Banks for institutions that do not send ACH transactions directly to or receive ACH transactions directly from the Reserve Banks. This fee would enable Reserve Banks to recover the costs associated with settling interoperator transactions processed by the Reserve Banks.

In addition, the Board has determined that PSOs should pay a reduced electronic connection fee. PSOs are currently charged electronic connection fees in accordance with the Reserve Banks' fee schedules. PSOs use their electronic connections to send interoperator transactions to the Reserve Banks. The Reserve Banks, however, also use these electronic connections to send interoperator transactions to the PSOs. As a result, Reserve Banks derive benefits from these electronic connections similar to those derived by the PSOs. Thus, the Board believes that the Reserve Banks should charge the PSOs only half the electronic connection fees they are being charged currently.

The Board anticipates that the new price structure would be implemented no later than September 2001. The specific implementation date of prices for interoperator transactions will be announced well in advance of the effective date.

C. Eligibility

Summary of Comments—The primary distinction between ACH operators, as defined by NACHA rules, and other intermediaries is that operators provide clearing, delivery, and settlement services for intraoperator transactions and exchange interoperator transactions with other operators.[9] Third-party

[7] Several commenters appeared to have misconceptions about the proposed price structure. For example, Visa USA misunderstood the Board's proposed network access fee as applying to all routing numbers on the Reserve Banks' ACH network. The Board's proposal, however, stated that the Reserve Banks would charge PSOs a network access fee only for those routing numbers to which they actually sent transactions. Due to this misinterpretation, Visa significantly overestimated the fees that PSOs would pay for access to the Reserve Banks' ACH network under the proposed price structure. Similarly, the American Clearing House Association (ACHA) misinterpreted the Board's proposal as restricting how PSOs could establish fees they would charge Reserve Banks for interoperator transactions and as requiring PSOs to adopt a price structure that was based on the Reserve Banks' ACH cost structure. The Board's proposal indicated that the proposed price structure was how the Reserve Banks would charge PSOs for accessing the Reserve Banks' ACH network. The proposal did not require, as suggested in ACHA's response, that the PSOs adopt the proposed price structure when they set fees for Reserve Bank access to the PSOs' ACH networks. Indeed, the Board's concern about a potential escalation in the fees that operators might charge each other indicates that the Board recognized that operators would likely charge each other different fees under different price structures.

[8] The negotiated fees would apply to both commercial and government ACH transactions that the Reserve Banks send to depository institutions through PSOs.

[9] NACHA recently adopted modifications to its definition of an ACH operator (NACHA Operating Rules, section 13.1.1). To qualify as a private-sector ACH operator, an entity must execute an agreement with NACHA to comply with or perform all of the following: adhere to NACHA operating rules and other applicable laws and regulations; execute agreements with a minimum of twenty independent depository institutions that bind the depository institutions to NACHA operating rules and the ACH operator's rules; provide clearing, delivery, and settlement services for intraoperator transactions; exchange interoperator transactions with other ACH operators; process and edit files based on the requirements of NACHA operating rules; evaluate the creditworthiness of and apply risk control measures to their customers; adhere to the Federal Reserve's Policy Statement on Privately Operated Multilateral Settlement Systems; and adhere to any NACHA performance standards for ACH operators. Under this definition, Electronic Payments Network, Visa, and American Clearing House Association are considered to be private-sector ACH operators. The Reserve Banks reserve the right to establish their own operator definition should they

processors typically do not provide settlement services for transactions they process while correspondent banks typically do not provide the comprehensive clearing and delivery services provided by operators. Thus, the Reserve Banks tend to compete with PSOs, and not third-party processors or correspondent banks, in providing services to depository institutions.

Commenters strongly supported the use of NACHA's operator definition to determine eligibility for deadline and price structure modifications. The Federal Reserve Banks of Chicago and Richmond, however, opposed the use of NACHA's operator definition. The Chicago Reserve Bank believed that, given some of the arbitrary aspects of NACHA's operator definition, limiting eligibility for deadline and price structure modifications to intermediaries that meet NACHA's operator definition could worsen the competitive position of other ACH intermediaries vis-a-vis operators and the Reserve Banks. The Richmond Reserve Bank believed that limiting eligibility to only a certain group of intermediaries that provide all of components of the bundle of services that comprise ACH operator services would be inconsistent with the spirit of the proposal, which recognizes the improved competitive environment associated with unbundling services.

Board Analysis—The Board has concluded that the Reserve Banks' deadline and price structure modifications be limited to any intermediary that is defined as an operator under NACHA rules. The Board believes that the role of Reserve Banks in the ACH system is analogous to the role played by PSOs. ACH operators play a significant role in protecting the integrity of the overall ACH network and ensuring its interoperability and efficiency, a role that is separate and distinct from the role of other ACH intermediaries. Further, while the Board believes that certain aspects of NACHA's operator definition could be strengthened, the current definition does not preclude other entities from becoming new operators and competing with established operators.

II. Competitive Impact

The Board conducts a competitive impact analysis when it considers a major operational change, such as that being proposed for ACH interoperator transactions.[10] Specifically, in its analysis, the Board has assessed whether the interoperator deadlines and price structure would have a direct and material adverse effect on the ability of other service providers to compete effectively with the Reserve Banks in providing similar services, and if so, whether the adverse effect on competition is due to differing legal powers or constraints, or due to a dominant market position deriving from such legal differences.

The purpose of the deadline and price structure modifications discussed above is to further enhance the competitive environment for ACH operator services. These modifications should enhance the ability of PSOs to compete with the Reserve Banks in providing ACH operator services to depository institutions. Specifically, PSOs will be able to establish customer deposit deadlines similar to those of Reserve Banks. Further, the Reserve Banks and PSOs will have the same ability to charge each other for the processing and delivery of ACH transactions to RDFIs that they serve. Moreover, depository institutions and other intermediaries might benefit from lower ACH transaction fees that could result from a more competitive market for the provision of ACH operator services. Thus, the Board does not anticipate any adverse effects on competition resulting from this proposal.

IV. Conclusion

The Board has decided on the following modifications to the Reserve Banks' deposit deadlines and price structure for interoperator transactions that the Reserve Banks exchange with PSOs.

• First, the Board has decided that the Reserve Banks should work collaboratively with ACH operators to establish interoperator deposit deadlines by which the Reserve Banks and the PSOs would exchange interoperator transactions. The PSOs would continue to be free to establish other deadlines by which they would exchange interoperator transactions among themselves. The interoperator deposit deadlines will be implemented no later than June 2001.

• Second, the Board has approved a new approach to pricing interoperator transactions that PSOs send to RDFIs on the Reserve Banks' ACH network.

—The Reserve Banks will charge depository institutions that send and receive all their transactions through PSOs a monthly settlement fee of $20 per routing number, rather than the monthly account servicing fee (currently set at $25), to settle interoperator transactions processed by the Reserve Banks.

—The Reserve Banks will initiate discussions with the PSOs to negotiate the structure and level of fees that will be charged by the Reserve Banks as well as those fees that the Reserve Banks will pay the PSOs.

—The Reserve Banks will charge ACH operators half the published electronic connection fee to reflect the use of the connection by both ACH operators and the Reserve Banks to send each other interoperator transactions.

The new prices for interoperator transactions will be implemented by the Reserve Banks no later than September 2001.

• Third, the Board has decided that the Reserve Banks' deadline and price structure modifications be limited to any intermediary that is defined as an operator under NACHA rules.

The specific implementation date for each of the modifications outlined above will be announced well in advance of the effective dates.

By order of the Board of Governors of the Federal Reserve System, October 30, 2000.

Jennifer J. Johnson,

Secretary of the Board.

[FR Doc. 00–28228 Filed 11–2–00; 8:45 am]

BILLING CODE 6210–01–P

object to any future modifications to NACHA's definition of an ACH operator.

[10] Federal Reserve Regulatory Service, 7–145.2.

FEDERAL RESERVE SYSTEM

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Board of Governors of the Federal Reserve System.

TIME AND DATE: 10 a.m., Wednesday, November 8, 2000.

PLACE: Marriner S. Eccles Federal Reserve Board Building, C Street entrance between 20th and 21st Streets, NW., Washington, DC 20551.

STATUS: Open.

MATTERS TO BE CONSIDERED:

Summary Agenda: Because of its routine nature, no discussion of the following item is anticipated. The matter will be voted on without discussion unless a member of the Board requests that the item be moved to the discussion agenda.

1. Proposed 2001 Private Sector Adjustment Factor.

Discussion Agenda:

2. Proposed 2001 fee schedules for priced services.
3. Any items carried forward from a previously announced meeting.

Note: This meeting will be recorded for the benefit of those unable to attend. Cassettes

will be available for listening in the Board's Freedom of Information Office, and copies may be ordered for $6 per cassette by calling 202–452–3684 or by writing to: Freedom of Information Office, Board of Governors of the Federal Reserve System, Washington, DC 20551.

CONTACT PERSON FOR MORE INFORMATION: Lynn S. Fox, Assistant to the Board, 202–452–3204.

SUPPLEMENTARY INFORMATION: You may call 202–452–3206 for a recorded announcement of this meeting; or you may contact the Board's Web site at http://www.federalreserve.gov for an electronic announcement. (The Web site also includes procedural and other information about the open meeting.)

Dated: November 1, 2000.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 00–28346 Filed 11–1–00; 10:55 am]

BILLING CODE 6210–01–P

FEDERAL RESERVE SYSTEM

Sunshine Act Meeting

AGENCY HOLDING THE MEETING: Board of Governors of the Federal Reserve System.

TIME AND DATE: Approximately 10:30 a.m., Wednesday, November 8, 2000, following a recess at the conclusion of the open meeting.

PLACE: Marriner S. Eccles Federal Reserve Board Building, 20th and C Streets, NW., Washington, DC 20551.

STATUS: Closed.

MATTERS TO BE CONSIDERED:

1. Personnel actions (appointments, promotions, assignments, reassignments, and salary actions) involving individual Federal Reserve System employees.

2. Any matters 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 call 202–452–3206 beginning at approximately 5 p.m. two business days before the meeting for a recorded announcement of bank and bank holding company applications scheduled for the meeting; or you may contact the Board's Web site at http://www.federalreserve.gov for an electronic announcement that not only lists applications, but also indicates procedural and other information about the meeting.

Dated: November 1, 2000.

Robert deV. Frierson,

Associate Secretary of the Board.

[FR Doc. 00–28347 Filed 11–1–00; 10:56 am]

BILLING CODE 6210–01–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Dermatologic and Ophthalmic Drugs Advisory Committee; Notice of Meeting; Correction

AGENCY: Food and Drug Administration, HHS.

ACTION: Notice; correction.

SUMMARY: The Food and Drug Administration (FDA) is correcting a notice that appeared in the **Federal Register** of October 19, 2000 (65 FR 62722). The notice announced a meeting of the Dermatologic and Ophthalmic Drugs Advisory Committee, which was scheduled for November 16, 2000. The document was 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 FR Doc. 00–26787, appearing on page 62722 in the **Federal Register** of Thursday, October 19, 2000, the following correction is made:

1. On page 62722, in the first column, under the ''Location'' caption, ''Holiday Inn, Grand Ballroom, Two Montgomery Village Ave., Gaithersburg, MD.'' is corrected to read ''CDER Advisory Committee, conference room 1066, 5630 Fishers Lane, Rockville, MD.''

Dated: October 31, 2000.

Linda A. Suydam,

Senior Associate Commissioner.

[FR Doc. 00–28349 Filed 11–01–00; 2:45 pm]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Food and Drug Administration

Clinical Chemistry and Clinical Toxicology 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). At least one portion of the meeting will be closed to the public.

Name of Committee: Clinical Chemistry and Clinical Toxicology 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 November 13, 2000, 10 a.m. to 4:30 p.m., and November 14, 2000, 8:30 a.m. to 4 p.m.

Location: Hilton, Salons C, D, and E, 620 Perry Pkwy., Gaithersburg, MD.

Contact Person: Veronica J. Calvin, Center for Devices and Radiological Health (HFZ–440), Food and Drug Administration, 2098 Gaither Rd., Rockville, MD 20850, 301–594–1243, or FDA Advisory Committee Information Line, 1–800–741–8138 (301–443–0572 in the Washington, DC area), code 12514. Please call the Information Line for up-to-date information on this meeting.

Agenda: On November 13, 2000, the committee will discuss two draft guidances: ''Guidance for Prescription Use Drugs of Abuse Assays Premarket Notifications'' and ''Over the Counter (OTC) Screening Tests for Drugs of Abuse: Guidance for Premarket Notifications.'' The prescription use guidance will be available to the public on the Internet at http://www.fda.gov/cdrh/ode/odecl052.html and supersedes the document entitled ''Review Criteria for Assessment of In Vitro Diagnostic Devices for Drugs of Abuse Assays Using Various Methodologies.'' The OTC use guidance will be available to the public on the Internet at http://www.fda.gov/cdrh/ode/91.html and supersedes the document entitled ''Guidance for Premarket Submissions for Kits for Screening Drugs of Abuse To Be Used by the Consumer.'' Draft questions for the committee regarding these guidances will be available to the public on the Internet at http://www.fda.gov/cdrh/panelmtg.html. On November 14, 2000, the committee will discuss and make recommendations on a premarket notification (510(k)) for a first-of-a-kind prescription use screening device for heroin in human hair.

Procedure: On November 13, 2000, from 10 a.m. to 4:30 p.m., and on November 14, 2000, from 9 a.m. to 4 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 November 6, 2000. On November 13, 2000, oral presentations from the public regarding the prescription use guidance will be scheduled between approximately 10:45 a.m. and 11:15 a.m., and oral presentations from the public regarding the OTC use guidance will be scheduled between approximately 1:15 p.m. and 2 p.m. On November 14, 2000, oral presentations from the public will be scheduled between approximately 9:15 a.m. and 9:45 a.m. and between approximately 3 p.m. and 3:30 p.m. Time allotted for each presentation may be limited. Those desiring to make formal oral presentations should notify the contact person before November 6, 2000, 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 November 14, 2000, from 8:30 a.m. to 9 a.m., the meeting will be closed to permit discussion and review of trade secret and/or confidential commercial information (5 U.S.C. 552b(c)(4)) relating to present and future agency issues.

FDA regrets that it was unable to publish this notice 15 days prior to the November 13 and 14, 2000, Clinical Chemistry and Clinical Toxicology Devices Panel of the Medical Devices Advisory Committee meeting. Because the agency believes there is some urgency to bring these issues to public discussion and qualified members of the Clinical Chemistry and Clinical Toxicology Devices Panel of the Medical Devices Advisory Committee were available at this time, the Commissioner of Food and Drugs concluded that it was in the public interest to hold this meeting even if there was not sufficient time for the customary 15-day public notice.

Notice of this meeting is given under the Federal Advisory Committee Act (5 U.S.C. app. 2).

Dated: October 27, 2000.

Linda A. Suydam,

Senior Associate Commissioner.

[FR Doc. 00–28350 Filed 11–1–00; 2:45 pm]

BILLING CODE 4160–01–F

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–10018]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration, DHHS.

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: New Collection;

Title of Information Collection: Survey of Medicaid Home and Community-Based Services Waiver and Personal Care Option Recipients for the Multi-Site Study of Medicaid Home and Community-Based Services;

Form No.: HCFA–10018 (OMB# 0938–NEW);

Use: Information collected will pertain to a description of the person, information regarding service use, unmet need for HCBS, quality of life, satisfaction with services, general health and functional status, care management and consumer direction. These data will be combined with secondary data on utilization of health care services to analyze the coordination of care; utilization; outcomes; and cost of providing services.

Frequency: One Time;

Affected Public: Individuals or Households;

Number of Respondents: 4,800; *Total Annual Responses:* 4,800;

Total Annual Hours: 3,200.

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: Melissa Musotto, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: October 24, 2000.

John P. Burke III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–28206 Filed 11–2–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

[Document Identifier: HCFA–565]

Agency Information Collection Activities: Proposed Collection; Comment Request

AGENCY: Health Care Financing Administration, DHHS.

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 previously approved collection for which approval has been expired; *Title of Information Collection:* Medicare Qualification

Statement for Federal Employees and Supporting Regulations in 42 CFR 406.15; *Form No.:* HCFA–565 (OMB# 0938–0501); *Use:* The HCFA–565 is completed by an individual filing for hospital insurance (HI) benefits (Part A) based upon their federal employment. This information is necessary to determine if HCFA/SSA can use federal employment prior to 1983 to qualify for free Part A. The data is passed to the HI master record, the Enrollment Data Base (EDB). An HI record showing appropriate entitlement is established and if applicable, a Medicare card is issued.; *Frequency:* Other (one time only); *Affected Public:* Individuals or Households, Federal Government, and State, Local, or Tribal Government; *Number of Respondents:* 4,300; *Total Annual Responses:* 4,300; *Total Annual Hours:* 731.

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: Melissa Musotto, Room N2–14–26, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Dated: October 24, 2000.

John P. Burke, III,

HCFA Reports Clearance Officer, HCFA Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards.

[FR Doc. 00–28207 Filed 11–2–00; 8:45 am]

BILLING CODE 4120–03–P

DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT

[Docket No. FR–4557–N–44]

Federal Property Suitable as Facilities To Assist the Homeless

AGENCY: Office of the Assistant Secretary for Community Planning and Development, HUD.

ACTION: Notice.

SUMMARY: This Notice identifies unutilized, underutilized, excess, and surplus Federal property reviewed by HUD for suitability for possible use to assist the homeless.

EFFECTIVE DATE: November 3, 2000.

FOR FURTHER INFORMATION CONTACT: Clifford Taffet, Department of Housing and Urban Development, Room 7262, 451 Seventh Street, SW., Washington, DC 20410; telephone (202) 708–1234; TTY number for the hearing- and speech-impaired (202) 708–2565, (these telephone numbers are not toll-free), or call he toll-free Title V information line at 1–800–927–7588.

SUPPLEMENTARY INFORMATION: In accordance with the December 12, 1988 court order in *National Coalition for the Homeless* v. *Veterans Administration*, No. 88–2503–OG (D.D.C.), HUD publishes a Notice, on a weekly basis, identifying unutilized, underutilized, excess and surplus Federal buildings and real property that HUD has reviewed for suitability for use to assist the homeless. Today's Notice is for the purpose of announcing that no additional properties have been determined suitable or unsuitable this week.

Dated: October 27, 2000.

Fred Karnas, Jr.,

Deputy Assistant Secretary for Special Needs Assistance Programs.

[FR Doc. 00–28219 Filed 11–2–00; 8:45 am]

BILLING CODE 4210–29–M

DEPARTMENT OF THE INTERIOR

Office of the Assistant Secretary—Water and Science Central Utah Project Completion Act; Sanpete County, UT

AGENCY: Office of the Assistant Secretary—Water and Science, Department of the Interior.

ACTION: Notice of intent to negotiate agreements among the Central Utah Water Conservancy District (CUWCD), Sanpete Water Conservancy District, Sanpete County, and the Department of the Interior for implementation of Projects in Sanpete County, Utah.

SUMMARY: Public Law 102–575, section 206(a)(1) provides: ''After two years from the date of enactment of this Act, the District shall, at the option of an eligible county as provided in paragraph (2), rebate to such county all of the ad valorem tax contributions paid by such county to the District, with interest but less the value of any benefits received by such county and less the administrative expenses incurred by the District to that date.'' Sanpete County desires to pursue local water development projects and is requesting a rebate of a portion of the ad valorem taxes it has paid to CUWCD, plus interest, to provide the required 35 percent local funding for such projects.

In a letter dated October 7, 1996, Sanpete County requested federal funding, equal to 65 percent of the costs as set forth in section 206(b)(1), to implement the projects. Section 206(b)(1) states: ''Upon the request of any eligible county that elects not to participate in the project as provided in subsection (a), the Secretary shall provide as a grant to such county an amount that, when matched with the rebate received by such county, shall constitute 65 percent of the cost of implementation of measures identified in paragraph (2).''

Sanpete County, located within the Sevier River Basin in Central Utah, is requesting federal funding for the Mayfield New Well Project and the Axtell Culinary Water System Improvement Project. Both projects are municipal improvement projects intended to increase the reliability and stability of their existing culinary water systems. Two agreements will be negotiated—one to provide funding for the Mayfield Project and the other for the Axtell Project.

DATES: Dates for public negotiation sessions will be announced in local newspapers.

FOR FURTHER INFORMATION: Additional information on matters related to this **Federal Register** notice can be obtained at the address and telephone number set forth below: Reed Murray, CUP Completion Act Office, Department of the Interior, 302 East 1860 South, Provo UT 84606–6154, (801) 379–1237, rmurray@uc.usbr.gov.

Dated: October 30, 2000.

Reed R. Murray,

Program Coordinator, Department of the Interior.

[FR Doc. 00–28237 Filed 11–02–00; 8:45 am]

BILLING CODE 4310–RK–P

DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

Intent To Prepare Comprehensive Conservation Plans; National Wildlife Refuges in North Carolina

ACTION: Notice of Intent to Prepare Comprehensive Conservation Plans for Alligator River, Currituck, Mackay Island, Mattamuskeet, Pocosin Lakes, Roanoke River, and Swanquarter

National Wildlife Refuges in North Carolina.

SUMMARY: This notice advises the public that the Fish and Wildlife Service, Southeast Region, intends to gather information necessary to prepare comprehensive conservation plans and associated environmental documents pursuant to the Service's Comprehensive Conservation Planning Policy and the National Environmental Policy Act and implementing regulations to achieve the following:

(1) Advise other agencies and the public of our intentions; and

(2) Obtain suggestions and information on the scope of issues to include in the environmental documents.

DATES: Written comments should be received within 60 days of this publication.

ADDRESSES: Address comments and requests for more information to the following: D. A. Brown, M.S., P.W.S., 1106 West Queen Street, P.O. Box 329, Edenton, North Carolina 27932, (252) 482–2364.

Information concerning these refuges may be found at the following website: http://rtncf-rci.ral.r4.fws.gov

If you wish to comment, you may submit your comments by any one of several methods. You may mail comments to the above address. You may also comment via the Internet to the following address: D_A_Brown@fws.gov. Please submit Internet comments as an ASCII file avoiding the use of special characters and any form of encryption. Please also include your name and return address your Internet message. If you do not receive a confirmation from the system that we have received your Internet message, contact D.A. Brown directly at the above address. Finally, you may hand-deliver comments to Mr. brown at 1106 West Queen Street, Edenton, North Carolina. Our practice is to make comments, including names and home addresses of respondents, available for public review during regular business hours. Individual respondents may request that we withhold their home address from the rulemaking record, which we will honor to the extent allowable by law. There also may be circumstances in which we would withhold from the rulemaking record a respondent's identity, as allowable by law. If you wish us to withhold your name and/or address, you must state this prominently at the beginning of your comment. However, we will not consider anonymous comments. We will make all submissions from organizations or businesses, and from individuals identifying themselves as representatives or officials of organizations or businesses, available for public inspection in their entirety.

SUPPLEMENTARY INFORMATION: It is the policy of the Fish and Wildlife Service to have all lands within the National Wildlife Refuge System managed in accordance with an approved Comprehensive Conservation Plan. The plan guides management decisions and identifies the goals, objections, and strategies for achieving refuge purposes. Public input into this planning process is encouraged. The plan will provide other agencies and the public with a clear understanding of the desired conditions of the refuge and how the Service will implement management strategies.

Dated: October 25, 2000.

H. Dale Hall,

Acting Regional Director.

[FR Doc. 00–28208 Filed 11–2–00; 8:45 am]

BILLING CODE 4310–55–M

DEPARTMENT OF THE INTERIOR

Bureau of Indian Affairs

Information Collection Submitted to the Office of Management and Budget for Review Under the Paperwork Reduction Act

SUMMARY: The proposal for renewal of the collection of information listed below has been submitted to the Office of Management and Budget for approval under the provisions of Paperwork Reduction Act (44 U.S.C. Chapter 25).

DATES: Comments and suggestions on the renewal must be received by December 4, 2000.

ADDRESSES: Copies of the proposed collection of information and related forms may be obtained by contacting the Division of Real Estate Services as listed in the **FOR FURTHER INFORMATION CONTACT** section of this notice. Comments and suggestions should be made directly to the Desk Officer for the Department of the Interior at the Office of Management and Budget, Washington, DC 20503.

FOR FURTHER INFORMATION CONTACT: Larry E. Scrivner or Helen R. Latall, Bureau of Indian Affairs, Division of Real Estate Services, MS–4510/MIB, 1849 C Street, NW., Washington, DC 20240, telephone (202) 208–7737.

SUPPLEMENTARY INFORMATION: The Secretary of the Interior has statutory authority to acquire lands in trust status for individual Indians and Federally recognized Indian tribes. The Secretary requests information in order to identify the party(ies) involved and describe the land in question. Respondents are Native American tribes or individuals who request real property acquisition for trust status. The Secretary also requests additional information necessary to satisfy those pertinent factors listed in 25 CFR 151.10 or 151.11. The information is used to determine whether or not the Secretary will approve an applicant request. No specific form is used, but respondents supply information and data so that the Secretary may make an evaluation and determination in accordance with established Federal factors, rules and policies.

Title: Land Acquisitions.

OMB approval number: 1076–0100.

Frequency: As needed.

Description of respondents: Native American tribes or individuals who request real property acquisition for trust status.

Nature of response: Required for a benefit.

Estimated completion time: 4 hours.

Annual responses: 9,200.

Annual Burden hours: 36,800.

You are asked to comment on whether it is necessary for the proper performance of agency functions; it reduces burden on small entities; it uses plain, coherent, and unambiguous terminology that is understandable to respondents; its implementation will be consistent and compatible with current reporting and recordkeeping practices; why the information is being collected and how it will be used.

Note: Comments, names and addresses of commentors are available for public review during regular business hours. If you wish us to withhold this information, you must state this prominently at the beginning of your comment. We will honor your request to the extent allowable by law. In compliance with the Paperwork Reduction Act of 1995, as amended, the collection has been reviewed by the Office of Management and Budget and assigned a number and expiration date. The number and expiration date are at the top right corner of a form. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless there is a valid OMB clearance number.

Dated: October 30, 2000.

Kevin Gover,

Assistant Secretary—Indian Affairs.

[FR Doc. 00–28284 Filed 11–2–00; 8:45 am]

BILLING CODE 4310–02–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[AK–023–01–1150–DF–035L–241A]

Multiple-Use Activity Management Plan: Fairbanks, Alaska; Notice of Intent To Develop a Multiple-Use Activity Management Plan for the Colville River Special Area

SUMMARY: The BLM is issuing this notice to advise the public that a Multiple-Use Activity Management Plan will be prepared for the Colville River Special Area as directed by the Record of Decision (ROD) for the Northeast National Petroleum Reserve-Alaska (NPR–A) Integrated Activity Plan/Environmental Impact Statement (IAP/EIS). An Environmental Assessment tiered to the 1998 IAP/EIS will be completed in conformance with NEPA, and an ANILCA 810 subsistence evaluation will be completed for this action.

SUPPLEMENTARY INFORMATION: The study area for the plan will comprise the Colville River Special Area, as designated by the Secretary of the Interior in 1977, including designated portions of the Kikiakrorak and Kogosukruk Rivers as described in the April 6, 1999 **Federal Register** Notice (64 FR 16747).

Issues we expect to address in the plan will include subsistence, wildlife (specifically including raptors and other birds) and their habitat, and scenic, recreational, scientific, paleontological and other resources, values and uses of the Colville River planning area that may be identified through this scoping effort. The plan will address management of the Umiat Recreation Land Use Emphasis Area consistent with direction in the IAP/EIS and ROD that emphasizes support of public health and safety. The plan will also address the possible creation of a bird conservation area through a cooperative effort that would include the State of Alaska, the Arctic Slope Regional Corporation, and the BLM.

Proposals for oil and gas-related activities within the Colville River Special Area are outside the scope of this plan and will not be considered. The plan will be tiered to the NPR–A IAP/EIS and ROD, and it will incorporate the detailed analysis and decisions made previously in those documents with respect to oil and gas activities authorized in the Northeast planning area. As indicated in the IAP/EIS, other separate NEPA documents will be prepared to analyze any specific permits and approvals necessary to carry out oil and gas activities authorized in the ROD. The Colville River Plan will focus on issues other than oil and gas in the Special Area.

Scoping meetings will occur during January–February 2001 and will be held in Barrow, Nuiqsut, Fairbanks and Anchorage. The times and locations of the meetings will be announced when determined. The scoping period will end on March 15, 2001, and all comments should be received or postmarked on or before that date.

Comments on the scope of this planning effort, information regarding specific resources, values and uses to be studied, and issues that should be addressed in the plan are sought from all interested parties. To be considered, written comments should be addressed to Gary Foreman, 1150 University Ave., Fairbanks, AK 99709–3844 and must be postmarked or received via e-mail by March 15, 2001.

FOR FURTHER INFORMATION, CONTACT: Gary Foreman, 1–800–437–7021, by mail at 1150 University Avenue, Fairbanks, Alaska 99709, or through the BLM web site at http://aurora.ak.blm.gov.

Robert W. Schneider,

Northern Field Office Manager.

[FR Doc. 00–28238 Filed 11–02–00; 8:45 am]

BILLING CODE 4310–JA–P

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[OR–030–01–1220–PA: GP1–0021]

Notice of Meeting of the Oregon Trail Interpretive Center Advisory Board

AGENCY: National Historic Oregon Trail Interpretive Center, Vale District, Bureau of Land Management, Interior.

ACTION: Notice of meeting.

SUMMARY: Notice is given that a meeting of the Advisory Board for the National Historic Oregon Trail Interpretive Center will be held on Tuesday, December 5, 2000 from 8:30 a.m. to 12:30 p.m. in the Conference Room at the National Historic Oregon Trail Interpretive Center, Oregon Highway 86, Flagstaff Hill, Baker City, Oregon. Public comments will be received from 11 a.m. to 11:15 a.m., December 5, 2000. Topics to be discussed are the review and approval of the updated Strategic Plan, reports from Coordinators of Subcommittees, and the development of Action Plan and Recommendations for FY2001–2002.

DATES: The meeting will begin at 8:30 a.m. and run to 12:30 p.m., December 5, 2000.

FOR FURTHER INFORMATION CONTACT: David B. Hunsaker, Bureau of Land Management, National Historic Oregon Trail, Interpretive Center, P.O. Box 987, Baker City, OR 97814, (Telephone 541–523–1845).

Sandy L. Guches,

Acting Vale District Manager.

[FR Doc. 00–28210 Filed 11–2–00; 8:45 am]

BILLING CODE 4310–33–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[NM–930–1310–01; NMNM 1804]

New Mexico: Proposed Reinstatement of Terminated Oil and Gas Lease

Under the provisions of Public Law 97–451, a petition for reinstatement of oil and gas lease NMNM 1804 for lands in Rio Arriba County, New Mexico, was timely filed and was accompanied by all required rentals and royalties accruing from May 1, 2000, 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 $5.00 per acre or fraction thereof and 16⅔ percent, respectively. The lessee has paid the required $500 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 sections 31(d) and (e) of the Mineral Leasing Act of 1920 (30 U.S.C. 188), and the Bureau of Land Management is proposing to reinstate the lease effective May 1, 2000, subject to the original terms and conditions of the lease and the increased rental and royalty rates cited above.

FOR FURTHER INFORMATION CONTACT: Lourdes B. Ortiz, BLM, New Mexico State Office, (505) 438–7586.

Dated: October 24, 2000.

Lourdes B. Ortiz,

Land Law Examiner.

[FR Doc. 00–28209 Filed 11–2–00; 8:45 am]

BILLING CODE 4310–FB–M

DEPARTMENT OF THE INTERIOR

Bureau of Land Management

[MT–929–00–1420–HE]

Montana: Filing of Plat of Survey

AGENCY: Bureau of Land Management, Montana State Office, Interior.

ACTION: Notice.

SUMMARY: The plat of the following described land is scheduled to be officially filed in the Montana State Office, Billings, Montana, thirty (30) days from the date of this publication.

T. 27 N., R. 56 E., P.M., MT

The plat, representing the dependent resurvey of a portion of the subdivisional lines and the adjusted original meanders of the former right bank of the Missouri River, upstream, through section 7, and the subdivision of section 7 and the survey of certain division of accretion lines in section 7 and a portion of a medial line of an abandoned channel of the Missouri River, upstream, through a portion of section 7, Township 27 North, Range 56 East, Principal Meridian, Montana, was accepted October 20, 2000.

The survey was requested by the Miles City Field Office and was necessary to identify accretion to original lot 6 in section 7 of the subject township.

A copy of the preceding described plat will be immediately placed in the open files and will be available to the public as a matter of information.

If a protest against this survey, as shown on this plat, is received prior to the date of the official filing, the filing will be stayed pending consideration of the protest.

This particular plat will not be officially filed until the day after all protests have been accepted or dismissed and become final or appeals from the dismissal affirmed.

FOR FURTHER INFORMATION CONTACT: Bureau of Land Management, 5001 Southgate Drive, P.O. Box 36800, Billings, Montana 59107–6800.

Dated: October 24, 2000.

Steven G. Schey,

Chief Cadastral Surveyor, Division of Resources.

[FR Doc. 00–28266 Filed 11–2–00; 8:45 am]

BILLING CODE 4310–DN–P

INTERNATIONAL TRADE COMMISSION

[USITC SE–00–049]

Sunshine Act Meeting Notice

AGENCY HOLDING THE MEETING: United States International Trade Commission.

TIME AND DATE: November 13, 2000 at 2:00 p.m.

PLACE: Room 101, 500 E Street SW., Washington, DC 20436, Telephone: (202) 205–2000.

STATUS: Open to the public.

MATTERS TO BE CONSIDERED:

1. Agenda for future meeting: None.
2. Minutes.
3. Ratification List.
4. Inv. Nos. 701–TA–402 and 731–TA–892–893 (Preliminary)(Honey from Argentina and China)—briefing and vote. (The Commission is currently scheduled to transmit its determination to the Secretary of Commerce on November 13, 2000; Commissioners' opinions are currently scheduled to be transmitted to the Secretary of Commerce on November 20, 2000.)
5. Outstanding action jackets:

(1.) Document No. ID–00–019: Approval of final report in Inv. No. 332–411 (Electric Power Services: Recent Reforms in Selected Foreign Markets).

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: November 1 , 2000.

By order of the Commission.

Donna R. Koehnke,

Secretary.

[FR Doc. 00–28369 Filed 11–1–00; 1:43 pm]

BILLING CODE 7020–02–U

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,900, et al.]

OXY USA, Inc., Houston, Texas, et al.; Notice of Revised Determination on Reopening

On October 10, 2000, the company requested Administrative Reconsideration for workers and former workers of the subject firm engaged in the production of crude oil and natural gas.

The initial investigation resulted in a negative determination issued on August 7, 2000, because imports did not contribute importantly to the worker separations. The notice was published in the **Federal Register** on September 12, 2000 (65 FR 55049).

New information submitted to the Department by the company as well as recent information on aggregate U.S. imports of crude oil and natural gas which were not available at the time of the initial investigation revealed that production and employment declined. From 1998 to 1999 aggregate U.S. imports for both natural gas and crude oil increased both absolutely and relative to domestic shipments. Further, imports of crude oil increased in the period January through June 2000 compared to the same time period in 1999.

Workers at OXY USA in Houston, Texas and Liberal, Kansas were covered by a previous certification, (TA–W–34,538) which expired on July 8, 2000. Workers at Aransas Pass, Texas and Venice, Louisiana were not covered by a previous certification.

Conclusion

After careful consideration of the new facts obtained on reopening, it is concluded that increased imports of articles like or directly competitive with crude oil and natural gas produced by the subject firm contributed importantly to the decline in sales and to the total or partial separation of workers of the subject firm. In accordance with the provisions of the Trade Act of 1974, I make the following revised determination:

All workers of OXY USA Inc. Houston, Texas (TA–W–37,900); Liberal, Kansas (TA–W–37,900B) who became totally or partially separated from employment on or after July 9, 2000; and all workers of OXY USA Inc., Aransas Pass, Texas (TA–W–37,900A) and Venice, Louisiana (TA–W–37,900C), who became totally or partially separated from employment on or after June 26, 1999 through two years from the date of this certification are eligible to apply for adjustment assistance under Section 223 of the Trade Act of 1974.

Signed at Washington, DC this 19th day of October 2000.

Linda G. Poole,

Certifying Officer, Division of Trade Adjustment Assistance.

[FR Doc. 00–28239 Filed 11–2–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–W–37,981]

Adirondack Knitting Mills, Amsterdam, NY; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at Adirondack Knitting Mills, Amsterdam, New York. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–37,981; Adirondack Knitting Mills Amsterdam, New York (October 25, 2000).

Signed at Washington, D.C. this 26th day of October, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 00–28243 Filed 11–2–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

[TA–WA–38,072]

Jn Oil and Gas, Incorporated; Billings, MT; Dismissal of Application for Reconsideration

Pursuant to 29 CFR 90.18(C) an application for administrative reconsideration was filed with the Director of the Division of Trade Adjustment Assistance for workers at JN Oil and Gas, Incorporated, Billings, Montana. The application contained no new substantial information which would bear importantly on the Department's determination. Therefore, dismissal of the application was issued.

TA–W–38,072; JN Oil and Gas, Incorporated; Billings, Montana (October 25, 2000).

Signed at Washington, DC this 26th day of October, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

[FR Doc. 00–28242 Filed 11–2–00; 8:45 am]

BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility To Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under Title II, chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than November 13, 2000.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than November 13, 2000.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C–5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, D.C. this 16th day of October, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions instituted on 10/16/2000]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
38,197	Grandoe Corp. (The) (UNITE)	Gloversville, NY	09/29/2000	Leather Gloves.
38,198	Crown Cork and Seal Co (UFCW)	Perrysburg, OH	10/03/2000	Steel Cans and Steel Ends.
38,199	Uniscribe (Wrks)	Wheeling, WV	09/29/2000	Computer Date Entry.
38,200	M. Fine and Son Mfg (Wrks)	Loretto, TN	09/27/2000	Men's Boys, and Ladies' Blue Jeans.
38,201	Tyco Electronics (Comp)	Clinton Twp., MI	09/28/2000	Electronic Connectors.
38,202	Creighton, Inc. (Wrks)	Reidsville, NC	09/29/2000	Military Uniforms.
38,203	Anchor Glass Containers (Comp)	Dayville, CT	10/02/2000	Glass Containers.
38,204	Willamette Industries (WCIW)	Albany, OR	10/02/2000	Mouldings—Cabinets, Doors, Windows.
38,205	Crater Lake Potato (Wrks)	Klamath Falls, OR	09/28/2000	Potatoes.
38,206	Brown Wooten Mills, Inc (Comp)	Mount Airy, NC	10/04/2000	Socks.
38,207	Byrum Concepts, Inc. (Comp)	Lubbock, TX	09/28/2000	Bath Sponges.
38,208	Parana Supplies Corp (Comp)	El Paso, TX	10/09/2000	Ribbon Cartdriges for Printers.
38,209	Chieftain Products (Wrks)	Marine City, MI	09/21/2000	Mini Van Seat Covers.
38,210	Chilton Toys (PACE)	Seymour, WI	09/26/2000	Tea Sets for Children.
38,211	ADM Milling Co. (IBT)	Milwaukee, WI	09/26/2000	Milled Corn Products.
38,212	Echo Bay Minerals Co (Comp)	Republic, WA	09/22/2000	Gold/Silver Compound.
38,213	GE Industrial Systems (Wrks)	Erie, PA	09/26/2000	DC Motors and Component Parts.
38,214	Fleetwood Homes of Ga (Wrks)	Douglas, GA	09/25/2000	Homes.
38,215	EPSG Pixpay Services (Wrks)	Burbank, CA	09/28/2000	Film Production.
38,216	Samsonite Corp (Comp)	Tucson, AZ	09/29/2000	Softside Luggage.

APPENDIX—Continued

[Petitions instituted on 10/16/2000]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
38,217	Union Pacific Resources (Comp)	Fort Worth, TX	10/03/2000	Exploration and Prod. Oil and Gas.
38,218	Swift Denim (Comp.)	Erwin, NC	10/05/2000	Denim Fabric.
38,219	C and M Corp (Wrks)	Wauregan, CT	09/29/2000	Cable Assemblies.
38,220	Avery Dennison (Comp)	Crossville, TN	09/29/2000	Markers and Hi-Liters Highlighters..
38,221	Outer Banks (Comp)	Lumberton, NC	10/03/2000	Automatic Pocket Setting Machine.
38,222	Whatman, Inc. (Wrks)	Clifton, NJ	10/02/2000	Microfiltration.
38,223	GE Capital Card Services (Wrks)	Cincinnati, OHD	10/02/2000	Credit Collection Call Center.
38,224	Utica Cutlery Co. (USWA)	Utica, NY	10/04/2000	Stainless Steel Flatware.
38,225	Alcoa Fujikura Ltd (Comp)	Shelbyville, KY	10/06/2000	Wire Harnesses.
38,226	Stimson Lumber Co (LPIW)	Bonner, MT	10/04/2000	Plywood and Veneer Products.

[FR Doc. 00–28241 Filed 11–2–00; 8:45 am]
BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment and Training Administration

Investigations Regarding Certifications of Eligibility to Apply for Worker Adjustment Assistance

Petitions have been filed with the Secretary of Labor under Section 221(a) of the Trade Act of 1974 (''the Act'') and are identified in the Appendix to this notice. Upon receipt of these petitions, the Director of the Division of Trade Adjustment Assistance, Employment and Training Administration, has instituted investigations pursuant to Section 221(a) of the Act.

The purpose of each of the investigations is to determine whether the workers are eligible to apply for adjustment assistance under title II, Chapter 2, of the Act. The investigations will further relate, as appropriate, to the determination of the date on which total or partial separations began or threatened to begin and the subdivision of the firm involved.

The petitioners or any other persons showing a substantial interest in the subject matter of the investigations may request a public hearing, provided such request is filed in writing with the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than November 13, 2000.

Interested persons are invited to submit written comments regarding the subject matter of the investigations to the Director, Division of Trade Adjustment Assistance, at the address shown below, not later than November 13, 2000.

The petitions filed in this case are available for inspection at the Office of the Director, Division of Trade Adjustment Assistance, Employment and Training Administration, U.S. Department of Labor, Room C–5311, 200 Constitution Avenue, NW., Washington, DC 20210.

Signed at Washington, D.C. this 23rd day of October, 2000.

Edward A. Tomchick,

Director, Division of Trade Adjustment Assistance.

APPENDIX

[Petitions instituted on 10/23/2000]

TA–W	Subject firm (petitioners)	Location	Date of petition	Product(s)
38,227	Vulcan Materials Co (Co.)	Attalla, AL	10/11/2000	Slag.
38,228	Initial Security (Wrks)	Portland, OR	09/27/2000	Provides Security.
38,229	Dana Engine Controls (Wkrs)	Branford, CT	10/05/2000	Packaging, Bar Coding and Shipment.
38,230	Leeds and Northrup (Wkrs)	Ellwood City, PA	10/01/2000	Oven Temperature Sensors.
38,231	SI Cutting Services (Wkrs)	Opalocks, FL	10/04/2000	Fabric Cutting.
38,232	Carolina Shoe Co (Wkrs)	Morganton, NC	10/04/2000	Men and Ladies' Footwear.
38,233	Konica Imaging Int'l (Wkrs)	Glen Cove, NY	10/11/2000	Film Manufacturing.
38,234	North Side Manufacturing (Co.)	Philipsburg, PA	10/06/2000	Men's Suit Jackets.
38,235	Universal Auto Radiator (Co.)	Pittsburg, PA	10/10/2000	Automobile Radiators.
38,236	PACE Industries Puget Div (IAMAW)	Fircrest, WA	10/06/2000	Aluminum Die Castings.
38,237	Steag Hamatech (Co.)	Saco, ME	10/17/2000	Original Equipment for Compact Disc.
38,238	Royal Oak Enterprises (Wkrs)	Paris, AR	10/05/2000	Charcoal.
38,239	Airtherm Manufacturing (Wkrs)	St. Louis, MO	10/01/2000	Central Air Distribution Systems.
38,240	Ashby Industries (Co.)	Martinsville, VA	09/30/2000	Textile Machinery.
38,241	Micromatic Textron (UAW)	Holland, MI	10/10/2000	Honing Machines.
38,242	Homestake Mining Co. (USWA)	Lead, SD	10/09/2000	Gold.
38,243	Color Tex International (Wkrs)	Salisbury, NC	10/04/2000	Dyed and Finished Woven Goods.
38,244	Handy Girl LLC (Wkrs)	Deer Park, MD	10/10/2000	Girl's Apparel.
38,245	Leapwood Apparel (Wkrs)	Adamsville, TN	10/11/2000	Knit Shirts.
38,246	Jakel, Inc (Wkrs)	East Prairie, MO	10/13/2000	Small Electrical Motors.
38,247	North Powder Lumber (Wkrs)	North Powder, OR	10/02/2000	Lumber.

[FR Doc. 00–28240 Filed 11–2–00; 8:45 am]
BILLING CODE 4510–30–M

DEPARTMENT OF LABOR

Employment Standards Administration, Wage and Hour Division

Minimum Wages for Federal and Federally Assisted Construction; General Wage Determination Decisions

General wage determination decisions of the Secretary of Labor are issued in accordance with applicable law and are based on the information obtained by the Department of Labor from its study of local wage conditions and data made available from other sources. They specify the basic hourly wage rates and fringe benefits which are determined to be prevailing for the described classes of laborers and mechanics employed on construction projects of a similar character and in the localities specified therein.

The determinations in these decisions of prevailing rates and fringe benefits have been made in accordance with 29 CFR part 1, by authority of the Secretary of Labor pursuant to the provisions of the Davis-Bacon Act of March 3, 1931, as amended (46 Stat. 1494, as amended, 40 U.S.C. 276a) and of 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 causes procedures to be impractical and contrary to the public interest.

General wage determination decisions, and modifications and supersedes decisions thereto, contain no expiration dates and are effective from their date of notice in the **Federal Register**, or on the date written notice is received by the agency, whichever is earlier. These decisions are to be used in accordance with the provisions of 29 CFR parts 1 and 5. Accordingly, the applicable decision, together with any modifications issued, must be made a part of every contract for performance of the described work within the geographic area indicated as required by an applicable Federal prevailing wage law and 29 CFR part 5. The wage rates and fringe benefits, notice of which is published herein, and which are contained in the Government Printing Office (GPO) document entitled ''General Wage Determinations Issued Under The Davis-Bacon And Related Acts,'' shall be the minimum paid by contractors and subcontractors to laborers and mechanics.

Any person, organization, or governmental agency having an interest in the rates determined as prevailing is encouraged to submit wage rate and fringe benefit information for consideration by the Department. Further information and self-explanatory forms for the purpose of submitting this data may be obtained by writing to the U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, Division of Wage Determinations, 200 Constitution Avenue, NW., Room S–3014, Washington, DC 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

Massachusetts
MA000001 (Feb. 11, 2000)
MA000002 (Feb. 11, 2000)
MA000003 (Feb. 11, 2000)
MA000005 (Feb. 11, 2000)
MA000006 (Feb. 11, 2000)
MA000007 (Feb. 11, 2000)
MA000008 (Feb. 11, 2000)
MA000009 (Feb. 11, 2000)
MA000010 (Feb. 11, 2000)
MA000012 (Feb. 11, 2000)
MA000013 (Feb. 11, 2000)
MA000014 (Feb. 11, 2000)
MA000015 (Feb. 11, 2000)
MA000017 (Feb. 11, 2000)
MA000018 (Feb. 11, 2000)
MA000019 (Feb. 11, 2000)
MA000020 (Feb. 11, 2000)
MA000021 (Feb. 11, 2000)
Maine
ME000022 (Feb. 11, 2000)
New Jersey
NJ000002 (Feb. 11, 2000)
Rhode Island
RI000001 (Feb. 11, 2000)
RI000002 (Feb. 11, 2000)
RI000003 (Feb. 11, 2000)

Volume II

None

Volume III

Florida
FL000001 (Feb. 11, 2000)
FL000002 (Feb. 11, 2000)
FL000066 (Feb. 11, 2000)
Kentucky
KY000002 (Feb. 11, 2000)
KY000007 (Feb. 11, 2000)
KY000025 (Feb. 11, 2000)
KY000027 (Feb. 11, 2000)
KY000029 (Feb. 11, 2000)
KY000035 (Feb. 11, 2000)

Volume IV

Indiana
IN000001 (Feb. 11, 2000)
IN000002 (Feb. 11, 2000)
IN000003 (Feb. 11, 2000)
IN000004 (Feb. 11, 2000)
IN000005 (Feb. 11, 2000)
IN000006 (Feb. 11, 2000)
IN000016 (Feb. 11, 2000)
IN000047 (Feb. 11, 2000)
Ohio
OH000001 (Feb. 11, 2000)
OH000002 (Feb. 11, 2000)
OH000003 (Feb. 11, 2000)
OH000004 (Feb. 11, 2000)
OH000012 (Feb. 11, 2000)
OH000020 (Feb. 11, 2000)
OH000023 (Feb. 11, 2000)
OH000026 (Feb. 11, 2000)
OH000027 (Feb. 11, 2000)
OH000029 (Feb. 11, 2000)
OH000035 (Feb. 11, 2000)
Wisconsin
WI000008 (Feb. 11, 2000)
WI000010 (Feb. 11, 2000)
WI000018 (Feb. 11, 2000)
WI000019 (Feb. 11, 2000)
WI000021 (Feb. 11, 2000)
WI000022 (Feb. 11, 2000)

Volume V

Kansas
KS000006 (Feb. 11, 2000)
KS000007 (Feb. 11, 2000)
KS000018 (Feb. 11, 2000)
KS000019 (Feb. 11, 2000)
KS000020 (Feb. 11, 2000)
KS000021 (Feb. 11, 2000)
KS000022 (Feb. 11, 2000)
KS000023 (Feb. 11, 2000)
KS000026 (Feb. 11, 2000)
Louisiana
LA000005 (Feb. 11, 2000)
LA000014 (Feb. 11, 2000)
Texas
TX000005 (Feb. 11, 2000)
TX000010 (Feb. 11, 2000)
TX000054 (Feb. 11, 2000)
TX000069 (Feb. 11, 2000)
TX000096 (Feb. 11, 2000)

Volume VI

Montana
MT000003 (Feb. 11, 2000)

MT000004 (Feb. 11, 2000)
MT000005 (Feb. 11, 2000)
North Dakota
ND000001 (Feb. 11, 2000)
ND000002 (Feb. 11, 2000)
ND000004 (Feb. 11, 2000)
ND000027 (Feb. 11, 2000)
ND000029 (Feb. 11, 2000)
ND000049 (Feb. 11, 2000)
ND000054 (Feb. 11, 2000)
ND000055 (Feb. 11, 2000)
Oregon
OR000001 (Feb. 11, 2000)
South Dakota
SD000005 (Feb. 11, 2000)
SD000006 (Feb. 11, 2000)
Washington
WA000005 (Feb. 11, 2000)
WA000007 (Feb. 11, 2000)
WA000009 (Feb. 11, 2000)

Volume VII

None

General Wage Determination Publication

General wage determinations issued under the Davis-Bacon and related Acts, including those noted above, may be found in the Government Printing Office (GPO) document entitled ''General Wage Determinations Issued Under The Davis-Bacon and Related Acts.'' This publication is available at each of the 50 Regional Government Depository Libraries and many of the 1,400 Government Depository Libraries across the country.

The general wage determinations issued under the Davis-Bacon and related Acts are available electronically by subscription to the FedWorld Bulletin Board System of the National Technical Information Service (NTIS) of the U.S. Department of Commerce at 1–800–363–2068

Hard-copy subscriptions may be purchased from: Superintendent of Documents, U.S. Government Printing Office, Washington, 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 26 day of October 2000.

Carl J. Poleskey,

Chief, Branch of Construction Wage Determinations.

[FR Doc. 00–27989 Filed 11–2–00; 8:45 am]

BILLING CODE 4510–27–M

DEPARTMENT OF LABOR

Bureau of Labor Statistics

Labor Research Advisory Council; Notice of Meetings and Agenda

The Fall meetings of committees of the Labor Research Advisory Council will be held on November 14 and 16. The Committee on Occupational Safety and Health Statistics will meet on December 12, 2000, and an agenda will be provided at a later date. All of the meetings will be held in the Conference Center, of the Postal Square Building (PSB), 2 Massachusetts Avenue, NE., Washington, DC.

The Labor Research Advisory Council and its committees advise the Bureau of Labor Statistics with respect to technical matters associated with the Bureau's programs. Membership consists of union research directors and staff members. The schedule and agenda of the meetings are as follows:

Tuesday, November 14, 2000

9:30 a.m.—Committee on Employment and Unemployment Statistics—Meeting Room 9

1. Progress of BLS research on disability measurement.
2. Overview of just-completed BLS longitudinal database (LDB), containing the employment and wages of virtually all business establishments in the U.S. linked back to 1990, and review of first tabulation from the LDB of job creation and job destruction by industry and firm size.
3. Occupational Employment Statistics (OES) research results.
   a. Evaluation of OES interval mean estimation procedure.
   b. Evaluation of OES procedures for estimating hourly and annual wages.
   c. Comparison of OES and NCS estimates for Houston.
4. Discussion of agenda items for future meetings.

1:30 p.m.—Committee on Prices and Living Conditions Meeting Room 9

1. Update on program developments.
   a. Consumer Price Index.
   b. International Price Indexes.
   c. Producer Price Indexes.
2. Discussion of agenda items for future meetings.

Thursday, November 16, 2000

9:30 a.m.—Committee on Productivity, Technology and Growth—Meeting Room 8

1. Schedule and assumptions for the 2000–2010 employment projections.
2. New multifactor productivity results: National Income and Product Accounts revisions, high tech capital, and purchased service inputs.
3. Planned multifactor productivity series for 3-digit manufacturing industries.
4. Incorporation of CPI–U–RS indexes into the productivity and costs measures for retail trade industries.
5. Discussion of agenda items for future meetings.

Committee on Foreign Labor Statistics

1. Comparability of BLS comparative manufacturing productivity measures.
2. Discussion of agenda items future meetings.

1:30 p.m.—Committee on Compensation and Working Conditions—Meeting Room 8

1. Employment Cost Index and National Compensation Survey enhancements.
2. Benefits data for union and nonunion workers.
3. Employer-provided educational assistance benefits.
4. Results of BLS pilot survey of stock options.
5. Discussion of agenda items for future meetings.

The meetings are open to the public. Persons planning to attend these meetings as observers may want to contact Wilhelmina Abner on (Area Code 202) 691–5970.

Signed at Washington, D.C. this 25th day of October, 2000.

Katharine G. Abraham,

Commissioner.

[FR Doc. 00–28244 Filed 11–2–00; 8:45 am]

BILLING CODE 4510–24–M

FEDERAL MINE SAFETY AND HEALTH REVIEW COMMISSION

Sunshine Act Meeting

October 30, 2000.

TIME AND DATE: 2 p.m., Thursday, November 9, 2000.

PLACE: Room 6005, 6th Floor, 1730 K Street, NW., Washington, DC.

STATUS: Open.

MATERS TO BE CONSIDERED: The Commission will consider and act upon the following:

1. Target Industries, Inc., Docket Nos. PENN 97–170, etc. (Issues include whether the Secretary of Labor reasonably interpreted her regulations for main mine fans as applying to any fan whose shutdown would immediately impact mine or section ventilation, whether the operator was provided sufficient notice of the Secretary's interpretation of those

regulations, and whether substantial evidence supports the judge's conclusion that the operator's bleeder fans constituted main mine fans within the meaning of the Secretary's interpretation).

TIME AND DATE: 2 p.m., Thursday, November 30, 2000.

PLACE: Room 6005, 6th Floor, 1730 K Street, NW., Washington, DC.

STATUS: Open.

MATTERS TO BE CONSIDERED: The Commission will consider and act upon the following:

1. Excel Mining LLC, Docket Nos. KENT 99–171–R, etc. (Issues include whether the Secretary of Labor can determine compliance with the respirable dust standard for underground coal mines based on an average of multiple samples taken during a single shift).

TIME AND DATE: 2 p.m., Thursday, December 7, 2000.

PLACE: Room 6005, 6th Floor, 1730 K Street, NW., Washington, DC.

STATUS: Open.

MATTERS TO BE CONSIDERED: The Commission will consider and act upon the following:

1. Virginia Slate Co., Docket No. VA 99–8–M (Issues include whether the judge erred in finding that violations were not due to the operator's unwarrantable failure.).

Any person attending an open meeting who requires special accessibility features and/or auxiliary aids, such as sign language interpreters, must inform the Commission in advance of those needs. Subject to 29 CFR 2706.150(a)(3) and 2706.160(d).

CONTACT PERSON FOR MORE INFO: Jean Ellen (202) 653–5629/(202) 708–9300 for TDD Relay/1–800–877–8339 for toll free.

[FR Doc. 00–28444 Filed 11–1–00; 3:43 pm]

BILLING CODE 6735–01–M

MISSISSIPPI RIVER COMMISSION

Sunshine Act Meeting; Notice

AGENCY HOLDING THE MEETING: Mississippi River Commission.

TIME AND DATE: Begin at 1:30 p.m. and adjourn by 4 p.m., November 27, 2000.

PLACE: Mississippi River Commission Headquarters Building, 1400 Walnut Street, Vicksburg, MS.

STATUS: Open to the public for observation but not for participation.

MATTER TO BE CONSIDERED: The Commission will consider the Wolf River, Memphis, Tennessee, Final Feasibility Report and Final Environmental Impact Statement.

CONTACT PERSON FOR MORE INFORMATION: Mr. Stephen Gambrell, telephone 601–634–5766.

Frederick L. Clapp, Jr.,

Colonel, Corps of Engineers, Secretary, Mississippi River Commission.

[FR Doc. 00–28391 Filed 11–1–00; 1:43 pm]

BILLING CODE 3710–GX–M

NATIONAL ARCHIVES AND RECORDS ADMINISTRATION

Records Schedules; Availability and Request for Comments

AGENCY: National Archives and Records Administration (NARA).

ACTION: Notice of availability of proposed records schedules; request for comments.

SUMMARY: The National Archives and Records Administration (NARA) publishes notice at least once monthly of certain Federal agency requests for records disposition authority (records schedules). Once approved by NARA, records schedules provide mandatory instructions on what happens to records when no longer needed for current Government business. They authorize the preservation of records of continuing value in the National Archives of the United States and the destruction, after a specified period, of records lacking administrative, legal, research, or other value.

Notice is published for records schedules in which agencies propose to destroy records not previously authorized for disposal or reduce the retention period of records already authorized for disposal. NARA invites public comments on such records schedules, as required by 44 U.S.C. 3303a(a).

DATES: Requests for copies must be received in writing on or before December 18, 2000. Once the appraisal of the records is completed, NARA will send a copy of the schedule. NARA staff usually prepare appraisal memorandums that contain additional information concerning the records covered by a proposed schedule. These, too, may be requested and will be provided once the appraisal is completed. Requesters will be given 30 days to submit comments.

ADDRESSES: To request a copy of any records schedule identified in this notice, write to the Life Cycle Management Division (NWML), National Archives and Records Administration (NARA), 8601 Adelphi Road, College Park, MD 20740–6001. Requests also may be transmitted by FAX to 301–713–6852 or by e-mail to records.mgt@arch2.nara.gov. Requesters must cite the control number, which appears in parentheses after the name of the agency which submitted the schedule, and must provide a mailing address. Those who desire appraisal reports should so indicate in their request.

FOR FURTHER INFORMATION CONTACT: Marie Allen, Director, Life Cycle Management Division (NWML), National Archives and Records Administration, 8601 Adelphi Road, College Park, MD 20740–6001. Telephone: (301) 713–7110. E-mail: records.mgt@arch2.nara.gov.

SUPPLEMENTARY INFORMATION: Each year Federal agencies create billions of records on paper, film, magnetic tape, and other media. To control this accumulation, agency records managers prepare schedules proposing retention periods for records and submit these schedules for NARA's approval, using the Standard Form (SF) 115, Request for Records Disposition Authority. These schedules provide for the timely transfer into the National Archives of historically valuable records and authorize the disposal of all other records after the agency no longer needs them to conduct its business.

Some schedules are comprehensive and cover all the records of an agency or one of its major subdivisions. Most schedules, however, cover records of only one office or program or a few series of records. Many of these update previously approved schedules, and some include records proposed as permanent.

No Federal records are authorized for destruction without the approval of the Archivist of the United States. This approval is granted only after a thorough consideration of their administrative use by the agency of origin, the rights of the Government and of private persons directly affected by the Government's activities, and whether or not they have historical or other value.

Besides identifying the Federal agencies and any subdivisions requesting disposition authority, this public notice lists the organizational unit(s) accumulating the records or indicates agency-wide applicability in the case of schedules that cover records that may be accumulated throughout an agency. This notice provides the control number assigned to each schedule, the total number of schedule items, and the number of temporary items (the records

proposed for destruction). It also includes a brief description of the temporary records.

The records schedule itself contains a full description of the records at the file unit level as well as their disposition. If NARA staff has prepared an appraisal memorandum for the schedule, it too includes information about the records. Further information about the disposition process is available on request.

Schedules Pending

1. Department of the Air Force, Agency-wide (N1–AFU–00–5, 2 items, 2 temporary items). Records relating to the payment of survivor benefits to spouses and former spouses of members. Included are such records as election forms, cost and annuity estimates, and electronic copies of records created using electronic mail and word processing.

2. Department of the Air Force, Agency-wide (N1–AFU–00–6, 2 items, 2 temporary items). Records relating to tests and inspections of facility grounds and lightning protection systems. Files include sketches of grounding and lightning protection systems, inspection and test reports, and deficiency and repair reports. Also included are electronic copies of records created using electronic mail and word processing.

3. Department of the Army, Agency-wide (N1–AU–00–21, 3 items, 3 temporary items). Records relating to the airworthiness of Army aircraft. Included are such records as technical data, logs, test reports, airworthiness qualification statements, and electronic copies of documents created using electronic mail and word processing.

4. Department of the Army, Agency-wide (N1–AU–01–1, 1 item, 1 temporary item). Master file of the Military Personnel Transition Point Processing System II, an electronic information system used to support and facilitate the transition of soldiers from active duty status to retirement, discharge, or release from active duty. The system includes such information as rank, pay grade, command, service record, type and reason for separation, and related data.

5. Department of the Army, U.S. Criminal Investigation Command (N1–AU–01–2, 2 items, 2 temporary items). Electronic copies of documents created using electronic mail and word processing that relate to reports accumulated by criminal investigation laboratories pertaining to tests of material which may be used as evidence or exhibits in investigations. This schedule also increases the retention period for recordkeeping copies of these files, which were previously approved for disposal.

6. Department of the Army, Agency-wide (N1–AU–01–5, 2 items, 2 temporary items). Master file and outputs of the In-Processing System, an electronic information system used to support and facilitate the in-processing of soldiers and family members to an installation. The system includes such information as readiness status, installation clearances, checklists, and related data.

7. Department of the Army, Agency-wide (N1–AU–01–6, 2 items, 2 temporary items). Master file and outputs of the Out-Processing System, an electronic information system used to support and facilitate the out-processing of soldiers and family members from an installation. The system includes such information as readiness status, installation clearance certificates, checklists, and related data.

8. Department of Defense, National Imagery and Mapping Agency (N1–537–01–1, 211 items, 211 temporary items). Paper and electronic records relating to logistics, supply, maintenance, and transportation, including electronic copies of documents created using electronic mail and word processing. Records relate to such matters as procurement, solid waste management, supply accounting and stock control, maintenance of equipment, warehousing and storage, travel and transportation, property disposal, motor vehicles, and the agency small business program.

9. Department of Energy, Agency-wide (N1–434–00–7, 6 items, 6 temporary items). Records relating to administrative and operational activities that involve environmental matters. Records pertain to such subjects as safety analyses, community environmental surveillance programs, and environmental program support. Also included are electronic copies of documents created using electronic mail and word processing. These records were initially included in Disposition Job N1–434–98–28, but were withdrawn for additional review.

10. Department of the Interior, Office of the Secretary (N1–48–01–1, 3 items, 1 temporary item). Tax returns and related documents filed by the Trans-Alaska Pipeline Liability Fund, a non-profit corporation responsible for settling claims from damages resulting from oil spills occurring before August 18,1990. Annual reports and minutes of the Fund's Board of Trustees are proposed for permanent retention.

11. Department of Justice, Bureau of Prisons (N1–129–00–36, 2 items, 1 temporary item). Electronic copies of documents created using electronic mail and word processing that are associated with the chronological files of the Assistant Director, Community Corrections and Detention Division. Recordkeeping copies of these files are proposed for permanent retention.

12. Department of Justice, Bureau of Prisons (N1–129–00–37, 5 items, 5 temporary items). Records of the National Office on Citizen Participation, including central office volunteer files, inactive program files, institutional files, subject files, and electronic copies of documents created using electronic mail and word processing.

13. Department of Justice, Bureau of Prisons (N1–129–00–38, 5 items, 5 temporary items). Records of the Detention Branch, including chronological files, files relating to facilities operated under contract with private firms or local governments, files relating to detained Mariel Cubans, and subject files relating to such matters as crimes committed by aliens, relations with other agencies regarding detained aliens, and inspections of jails. Also included are electronic copies of documents created using electronic mail and word processing.

14. Department of Justice, Bureau of Prisons (N1–129–00–39, 5 items, 3 temporary items). Records of the Privatization and Special Projects Branch, including privatization master files, privatization project files, and electronic copies of documents created using electronic mail and word processing. Recordkeeping copies of files relating to the transfer of inmates from the District of Columbia Department of Corrections to Federal custody are proposed for permanent retention.

15. Department of Justice, Bureau of Prisons (N1–129–00–40, 16 items, 14 temporary items). Records of the Community Corrections Branch. Included are such records as statement of work files, past performance files, community corrections subject files, correspondence, escape reports, incident reports, untimely release reports, population reports, program review files, program statement and operations memorandum files, training files and videotapes, juvenile subject files, and electronic copies of documents created using electronic mail and word processing. Recordkeeping copies of quarterly reports of community corrections center utilization rates and quarterly field reports are proposed for permanent retention.

16. Department of the Treasury, Bureau of the Public Debt (N1–53–00–

12, 3 items, 2 temporary items). Security-related records consisting of forms used to report offenses and incidents that take place at entrances to agency facilities as well as forms used in connection with issuing identification badges for employees. Also included are records relating to certain Government investment loans, which are proposed for permanent retention.

17. Department of the Treasury, Bureau of the Public Debt (N1–53–00–5, 3 items, 1 temporary item) Video masters and duplicates of public service announcements used by the Savings Bond Marketing Office to promote the sale of Savings Bonds. Original film, film transfers, and a video copy of each announcement are proposed for permanent retention.

18. Department of the Treasury, Bureau of the Public Debt (N1–53–01–2, 12 items, 11 temporary items). Government Account Series (GAS) system and related records, including such records as the GAS master file, systems documentation, and hardcopy inputs and outputs used to initiate transactions, confirm requests, summarize daily or monthly activities, detect and correct accounting errors, and reconcile account balances. The GAS Daily Principal Outstanding Report—End of Year is proposed for permanent retention in hard copy. Data from GAS is imported into the agency's Public Debt Accounting and Reporting System, which was previously approved for permanent retention.

19. Department of the Treasury, Under Secretary (Domestic Finance) (N1–56–00–3, 19 items, 15 temporary). Records relating to the Office of the Assistant Secretary for Financial Institutions, Office of Government Sponsored Enterprise Policy, and Office of Financial Institutions Policy. The records include chronological files, administrative files, schedules of daily activities, and news clips and periodicals. Also included are electronic copies of records created using electronic mail and word processing. Recordkeeping copies of office subject files and schedules of daily activities of the Under Secretary and the Assistant Secretary are proposed for permanent retention.

20. Department of the Treasury, Under Secretary (Domestic Finance) (N1–56–01–1, 7 items, 7 temporary items). Records of the Office of Market Finance relating to the processing of requests from the Bureau of the Public Debt for securities pricing information, including the electronic master file, inputs, outputs, and system documentation. Also included are the Noon Investment Package, which consists of information exchanged with the Bureau of the Public Debt, as well as electronic copies of documents created using electronic mail and word processing.

21. Department of the Treasury, Financial Management Service (N1–425–01–1, 20 items, 19 temporary items). Electronic systems with related inputs, outputs, and system documentation relating to Government-wide accounting, including summary financial and budgetary operations of the Government and the collection of data on the Government's assets, liabilities, and the cost of Government operations. Also included are office chronological files and electronic copies of documents created using electronic mail and word processing. Recordkeeping copies of the annual report of the Central Accounting System are proposed for permanent retention.

22. Department of the Treasury, Financial Management Service (N1–425–01–2, 8 items, 8 temporary items). Records of the Office of the Assistant Commissioner for Federal Finance relating to the management of the Government's cash and credit programs, including bank master and bank operating records concerning the management and operation of financial services provided by banks for the Government and bank operating records for accounts pertaining to Individual Indian Monies. Also included are electronic copies of documents created using electronic mail and word processing.

23. Department of the Treasury, Financial Management Service (N1–425–01–3, 22 items, 22 temporary items). Electronic systems with related inputs, outputs, and system documentation relating to the disbursement of Federal payments, including social security payments and tax refunds, and the collection of debt owed the Federal Government. Also included are paper copies of returned checks, office chronological files, and electronic copies of documents created using electronic mail and word processing.

24. Department of the Treasury, Financial Management Service (N1–425–01–4, 67 items, 67 temporary items). Electronic systems with related inputs, outputs, and system documentation pertaining to Federal payments, claims, collections, and financial transactions, including check payment and reconciliation, debt recovery and accounting, collecting Government funds, and managing Individual Indian Money checks. Also included are electronic copies of documents created using electronic mail and word processing, copies of checks in all media, and paper records relating to check disbursement.

25. Inter-American Foundation, Office of Programs (N1–454–00–1, 7 items, 5 temporary items). Working papers, monitoring reports, and audits relating to grants. Also included are electronic copies of documents created using electronic mail and word processing. Recordkeeping copies of grant project files, including rejected proposals, are proposed for permanent retention.

26. Tennessee Valley Authority, Chief Operating Officer (N1–142–00–7, 4 items, 4 temporary items). Records relating to the operation of fuel plants, including temperature charts, pressure charts, and turbine supervisory charts. Also included are electronic copies of records created using electronic mail and word processing.

Dated: October 25, 2000.

Michael J. Kurtz,

Assistant Archivist for Record Services—Washington, DC.

[FR Doc. 00–28245 Filed 11–2–00; 8:45 am]

BILLING CODE 7515–01–P

NUCLEAR REGULATORY COMMISSION

[Docket No. 50–390]

Tennessee Valley Authority; 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 No. NPF–90, issued to the Tennessee Valley Authority (TVA, the licensee), for operation of the Watts Bar Nuclear Plant (WBN), Unit 1, located in Rhea County, Tennessee.

The proposed amendment would modify the WBN Technical Specifications (TS) to allow a one-time-only increase in the diesel generator Action Completion Time from 72 hours to 10 days. This allowance would facilitate potential repairs to an emergency diesel generator to improve reliability.

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:

(A) The proposed amendment does not involve a significant increase in the probability or consequences of an accident previously evaluated.

The diesel generators are designed as backup AC power sources in the event of loss of offsite power. The probability of occurrence of an accident is not increased as the diesel generators perform a function of accident mitigation only and cannot cause an accident. Similarly, the diesel generator itself would be out of service and could not cause other equipment to malfunction.

The technical specifications currently would allow two emergency diesel generators of one train to be out of service for up to three days followed consecutively by two diesel generators of the opposite train to be out of service for three more days. Thus, the current specifications would allow two diesels to be unavailable for six days total. This proposed change would allow a single diesel generator to be out of service for ten days. This is not considered to be a significant departure from the current requirement. Further, the consequences of postulated accident with one diesel generator unavailable is enveloped by the current allowance for both trained generators unavailable.

The cumulative consequences of an accident are not significantly increased as the increase in core damage frequency as a result of the additional Action Completion Time extension is non-risk significant. Therefore, the proposed amendment does not involve a significant increase in the probability or consequences of an accident previously evaluated.

(B) The proposed amendment does not create the possibility of a new or different kind of accident from any accident previously evaluated.

The possibility for a new or different kind of accident from any accident previously evaluated does not exist as a result of the increase in Action Completion Time for the diesel generator, as the diesel generator performs a function of accident mitigation only and cannot result in the malfunction of other equipment while undergoing repairs.

(C) The proposed amendment does not involve a significant reduction in a margin of safety.

The calculated increase in the Action Completion Time for one diesel generator out of service shows a non-risk significant increase in the predicted core damage frequency (CDF). TVA concludes that the margin of safety has not been reduced.

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. Documents may be examined, and/or copied for a fee, at the NRC's Public Document Room, located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland.

The filing of requests for hearing and petitions for leave to intervene is discussed below.

By December 4, 2000, 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, located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland, and accessible electronically through the ADAMS Public Electronic Reading Room link at the NRC Web site (http://www.nrc.gov). 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, located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland, 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 General Counsel, Tennessee Valley Authority, ET 10H, 400 East Summit Hill Drive, Knoxville, Tennessee 37902, 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 October 30, 2000, which is available for public inspection at the Commission's Public Document Room, located at One White Flint North, 11555 Rockville Pike (first floor), Rockville, Maryland, and accessible electronically through the ADAMS Public Electronic Reading Room link at the NRC Web site (http://www.nrc.gov).

Dated at Rockville, Maryland, this 30th day of October 2000.

For the Nuclear Regulatory Commission.

Robert E. Martin,

Senior Project Manager, Section 2, Project Directorate II, Division of Licensing Project Management, Office of Nuclear Reactor Regulation.

[FR Doc. 00–28248 Filed 11–02–00; 8:45 am]

BILLING CODE 7590–01–P

POSTAL SERVICE

Sunshine Act Meeting

TIMES AND DATES: 1 p.m., Monday, November 13, 2000; 8:30 a.m., Tuesday, November 14, 2000; 10 a.m., Tuesday, November 14, 2000.

PLACE: Washington, DC, at U.S. Postal Service Headquarters, 475 L'Enfant Plaza, SW., in the Benjamin Franklin Room.

STATUS: November 13 (Closed); November 14—8:30 a.m. (Open); 10 a.m. (Closed).

MATTERS TO BE CONSIDERED:

Monday, November 13—1 p.m. (Closed)

1. Financial Performance.
2. Fiscal Year 2001 Integrated Financial Plan.
3. Enhanced Security Capability.
4. International Mail Rates.
5. Quarterly eCommerce Update.
6. Personal Matters.
7. Compensation Issues.
8. Postal Rate Commission Opinion and Recommended Decision in Docket No. R2000–1, Omnibus Rate case.

Tuesday, November 14—8:30 a.m. (Open)

1. Minutes of the Previous Meetings, September 22, and October 2–3, 2000.
2. Remarks of the Postmaster General/Chief Executive Officer.
3. Quarterly Report on Service Performance.
4. Fiscal Year 2001 Operating Budget.
5. Capital Investment Plan.
6. Fiscal Year 2001 Financing Plan.
7. Tentative Agenda for the December 4–5, 2000, meeting in Washington, DC.

Tuesday, November 14—10 a.m. (Closed)

1. Continuation of Monday's closed agenda.

CONTACT PERSON FOR MORE INFORMATION: David G. Hunter, Secretary of the Board, U.S. Postal Service, 475 L'Enfant Plaza, SW., Washington, DC 20260–1000. Telephone (202) 268–4800.

David G. Hunter,

Secretary.

[FR Doc. 00–28413 Filed 11–1–00; 1:42 pm]

BILLING CODE 7710–12–M

SECURITIES AND EXCHANGE COMMISSION

[Rule 11Ac1–3; SEC File No. 270–382; OMB Control No. 3235–0435]

Submission for OMB Review; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Filings and Information Services, Washington, DC 20549.

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') has submitted to the Office of Management and Budget a request for extension of the previously approved collection of information discussed below.

Rule 11Ac1–3 requires disclosure on each new account and on a yearly basis thereafter, on the annual statement, the firm's policies regarding receipt of payment for order flow from any market makers, exchanges or exchange members to which it routes customers' order in national market system securities for execution; and information regarding the aggregate amount of monetary payments, discounts, rebates or reduction in fees received by the firm over the past year.

It is estimated that there are approximately 7,500 registered broker-

dealers.[1] The staff estimates that the average number of hours necessary for each broker-dealer to comply with Rule 11Ac1–3 is fourteen hours annually. Thus, the total burden is 105,000 hours annually. The average cost per hour is approximately $85. Therefore, the total cost of compliance for broker-dealers is $8,925,000.

Records generated by forms pursuant to this rule must be kept for three years. The records required by this rule are mandatory to assist the Commission in its regulatory role. This rule does not involve the collection of confidential information. Please not that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid control number.

General comments regarding the estimated burden hours should be directed to the following persons: (i) Desk Officer for the Securities and Exchange Commission, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10102, New Executive Office Building, Washington, DC 20503; and (ii) Michael E. Bartell, Associate Executive Director, Office of Information Technology, Securities and Exchange Commission, 450 Fifth Street, NW, Washington, DC 20549. Comments must be submitted to OMB within 30 days of this notice.

Dated: October 24, 2000.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–28220 Filed 11–2–00; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

Submission for OMB Review; Comment Request

Upon Written Request, Copies Available From: Securities and Exchange Commission, Office of Filings and Information Services, Washington, DC 20549.

[Rule 17Ad–11; SEC File No. 270–261; OMB Control No. 3235–0274]

Notice is hereby given that pursuant to the Paperwork Reduction Act of 1995 (44 U.S.C. 3501 *et seq.*), the Securities and Exchange Commission (''Commission'') has submitted to the Office of Management and Budget a request for extension of the previously approved collection of information discussed below.

[1] This estimate is based on FYE 1999 Focus Reports received by the Commission.

• Rule 17Ad–11 Reports Regarding Aged Record Differences, Buy-ins, and Failure to Post Certificate Detail to Master Securityholder Files

Rule 17Ad–11 requires approximately 150 transfer agents to report to issuers and the appropriate regulatory agency in the event that aged record differences exceed certain dollar value thresholds. An aged record difference occurs when an issuer's records do not agree with those of securityowners as indicated, for instance, on certificates presented to the transfer agent for purchase, redemption or transfer. In addition, the rule requires transfer agents to report to the appropriate regulatory agency in the event of a failure to post certificate detail to the master securityholder file within 5 business days of the time required by Rule 17Ad–10. Also, transfer agents must maintain a copy of each report prepared under Rule 17Ad–11 for a period of three years following the date of the report. These recordkeeping requirements assist the Commission and other regulatory agencies with monitoring transfer agents and ensuring compliance with the rule.

Because the information required by Rule 17Ad–11 is already available to transfer agents, any collection burden for small transfer agents is minimal. The staff estimates that the average number of hours necessary to comply with Rule 17Ad–11 is one hour annually. The total burden is 150 hours annually for transfer agents, based upon past submissions.

The retention period for the recordkeeping requirement under Rule 17Ad–11 is three years following the date of a report prepared pursuant to the rule. The recordkeeping requirement under rule 17Ad–11 is mandatory to assist the Commission and other are regulatory agencies with monitoring transfer agents and ensuring compliance with the rule. This rule does not involve the collection of confidential information. Please note that an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid control number.

General comments regarding the estimated burden hours should be directed to the following persons: (i) Desk Officer for the Securities and Exchange Commission, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10102, New Executive Office Building, Washington, DC 20503; and (ii) Michael E. Bartell, Associate Executive Director, Office of Information Technology, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549. Comments must be submitted to OMB within 30 days of this notice.

Dated: October 30, 2000.

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–28263 Filed 11–2–00; 8:45 am]

BILLING CODE 8010–01–M

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 November 6, 2000.

A closed meeting will be held on Wednesday, November 8, 2000 at 11 a.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)(A) and (10), permit consideration for the scheduled matters at the closed meeting.

The subject matters of the close meeting scheduled Wednesday, November 8, 2000 will be:

Institution and settlement of injunctive actions; and

Institution and settlement 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: November 1, 2000.

Jonathan G. Katz,

Secretary.

[FR Doc. 00–28352 Filed 11–1–00; 11:25 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43484; File No. SR–BSE–00–17]

Self-Regulatory Organizations; Notice of Filing and Order Granting Accelerated Approval of Proposed Rule Change by the Boston Stock Exchange, Inc. Relating to Fortune Indexes

October 26, 2000.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 [2] thereunder, notice is hereby given that on October 12, 2000, the Boston Stock Exchange, Inc. (''BSE'' or ''Exchange'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items I and II below, which Items have been prepared by the Exchange. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons and to grant accelerated approval of the proposed rule change.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The BSE intends to trade, via Unlisted Trading Privileges (''UTP''), Index Fund Shares based on the Fortune 500 and Fortune e-50 Indexes pursuant to Rule 19b–4(e) under the Act.[3] Accordingly, the BSE proposes to amend Chapter XXIV–B, *Index Fund Shares,* by adding Section 6, *Fortune Indexes,* to set forth various disclaimers of liability and warranties in connection with these Indexes and trading in Index Fund Shares. The text of the proposed rule change is available at the principal office of the BSE and at the Commission.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the BSE included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item III below. The Exchange has prepared summaries, set forth in Sections A, B. and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

The BSE intends to trade, via UTP, Index Fund Shares based on the Fortune 500 and Fortune e-50 Indexes (''Indexes''), pursuant to rule 19b–4(e) under the Act.[4] Therefore, the BSE proposes to amend Chapter XXIV–B, *Index Fund Shares,* by adding Section 6, *Fortune Indexes,* to set forth various disclaimers of liability and warranties in connection with the Indexes and trading in Index Fund Shares. The proposed rule would state, among other things, that the Indexes are licensed for use by the Exchange in connection with the Index fund Shares; that the Index Fund Shares have not been passed on by Fortune for suitability for a particular use; and that the Index Fund Shares are not sponsored, endorsed, sold, or promoted by Fortune. The proposed rule would also state that Fortune does not warranty the accuracy or completeness of the Indexes or the data included therein, results to be obtained from use of the Indexes or such data, or fitness for a particular use with respect to the Indexes or such data.

2. Statutory Basis

The BSE believes that the proposed rule change is consistent with Section 6(b) of the Act [5] in general, and furthers the objectives of Sections 6(b)(5) [6] in particular, in that it is designed to promote just and equitable principles of trade; to remove impediments to and perfect the mechanism of a free and open market and a national market system; and in general, to protect investors and the public interest. The BSE also states that the proposed rule change is not designed to permit unfair discrimination between customers, issuers, brokers, and dealers.

B. Self-Regulatory Organization's Statement on Burden on Competition

The BSE does not believe that the proposed rule would impose any burden on competition.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were solicited or received.

III. Solicitation of Comments

Interested persons are invited to submit written data, views, and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of U.S.C. 552, will be available for inspection and copying at the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the Exchange. All submissions should refer to File No. SR–BSE–00–17 and should be submitted by November 24, 2000.

IV. Commission's Findings and Order Granting Acceleratred Approval of Proposed Rule Change

A. Generally

The Commission finds that the proposed rule change is consistent with the requirements of the Act and the rules and regulations thereunder applicable to a national securities exchange.[7] Specifically, the Commission believes that the proposal is consistent with section 6(b)(5) of the Act [8] because it will facilitate transactions in securities by setting forth certain disclaimers of liability with respect to Index Fund Shares based on the Fortune 500 and Fortune e-50 Indexes that will trade on the Exchange.[9]

The BSE has requested that the Commission find good cause pursuant to Section 19(b)(2) of the Act [10] for approving the proposed rule change

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] 17 CFR 240.19b–4(e).

[4] 17 CFR 240.19b–4(e).

[5] 15 U.S.C. 78f(b).

[6] 15 U.S.C. 78f(b)(5).

[7] In reviewing the proposed rule change, the Commission considered its potential impact on efficiency, competition, and capital formation. *See* 15 U.S.C. 78c(f).

[8] 15 U.S.C. 78f(b)(5).

[9] The Commission notes that it has previously approved a proposed rule change submitted by the BSE under Exchange Act Rule 19b–4, 17 CFR 240.19b–4(e), that established generic listing standards for Index Fund Shares that would permit the trading of, among other things, shares of the Fortune 500 and FORTUNE e-50 Indexes funds pursuant to UTP. *See* Exchange Act Release No. 34–42988 (June 28, 2000), 65 FR 42021 (July 7, 2000).

[10] 15 U.S.C. 78S(B)(2).

prior to the thirtieth day after publication of the proposal in the **Federal Register**.[11] The Commission does not believe that this proposal raises any new regulatory issues and notes that the proposed rule change is nearly identical to others that have been previously approved by the Commission.[12] Therefore, the Commission finds that there is good cause for approving the proposed rule change prior to the thirtieth day after publication of the proposal in the **Federal Register**.

It Is Therefore Ordered, pursuant to Section 19(b)(2) of the Act,[13] that the proposed rule change (SR–BSE–00–17), is hereby approved on an accelerated basis.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[14]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–28223 Filed 11–2–00; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43483; File No. SR–CHX–00–33]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the Chicago Stock Exchange; Incorporated Relating to the Trading of the street TracksSM Dow Jones Global Titans Index Fund

October 25, 2000.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act''),[1] and Rule 19b–4 thereunder,[2] notice is hereby given that on October 16, 2000, the Chicago Stock Exchange, Incorporated (''Exchange'' or ''CHX'') filed with the Securities and Exchange Commission (''SEC'' or ''Commission'') the proposed rule change as described in Items, I, II, and III below, which Items have been prepared by the CHX. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The CHX proposes to trade, pursuant to unlisted trading privileges, shares of the streetTRACKSSM Dow Jones Global Titans Index™ Fund,[3] using the procedures outlines in Rule 19b–4(e) of the Act.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the CHX included statements concerning the purpose of and basis for the proposed rule change and discussed any comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The CHX has prepared summaries, set forth in sections A, B and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

1. Purpose

On August 21, 1996, the Commission approved a new listing standard, Article XXVIII, Rule 24, which allowed the Exchange to list and trade Investment Company Units.[4] In general, Investment Company Units represent an interest in a registered investment company that holds securities based on, or representing an interest in, an index or portfolio of securities.

Over time, the Commission has approved amendments to Article XXVIII, Rule 24, to permit the trading, pursuant to unlisted trading privileges, of investment company lists based on certain Morgan Stanley Capital International Indices (''WEBSSM,'' now called ''iSharesSM MSCI Index Fund SeriesSM'') and nine series of Select Sector SPDRsSM.[5]

On June 22, 2000, the Commission approved a proposed rule change that added a new interpretation to the CHX's Investment Company Units listing standard.[6] This new provision permits the Exchange to list or trade Investment Company Units udder the expedited procedures described in Rule 19b–4(e) under the Act, so long as those securities meet specific standards. The Exchange has used these procedures to trade, pursuant to unlisted trading privileges, several Investment Company Units, including series of the iShares Trust based on domestic stock indices.

Through this filing, the Exchange proposes to trade, pursuant to unlisted trading privileges, shares of the streetTRACKS (''Shares'') Dow Jones Global Titans Index Fund (the ''Fund''). The Fund is a series of the streetTRACKS Series Trust (the ''Trust''), which is an open-end investment company.[7] As described below, these Investment Company Units are structurally similar to the Investment Company Units already approved for trading on the Exchange.

The Exchange has prepared the following information about the Fund based on the streetTRACKS Trust Prospectus (the ''Prospectus'') and Statement of Additional Information dated September 25, 2000, as well as a submission by the American Stock Exchange, LLC (''Amex''), in which it sought approval to list and trade these securities (the ''Amex Submission'').[8]

a. *The Dow Jones Global Titans Index.* The Dow Jones Global Titans Index (the ''Index'') is composed of 50 common stocks, which are chosen by the Dow Jones and Company (the ''Dow''). As described in the Prospectus, a stock

[11] In its initial submission to the Commission, the BSE inadvertently requested that the Commission grant accelerated *effectiveness* to the proposed rule change. The BSE has indicated that, instead, it requested accelerated *approval* of the proposal. Telephone conversation between Esther Radovsky, Listings Analyst, BSE, and Michael Gaw, Attorney-Adviser, Division of Market Regulation, Commission, on October 24, 2000.

[12] *See, e.g.,* Exchange Act Release No. 34–41664 (July 27, 1999), 64 FR 42424 (August 4, 1999) (approval of BSE rule change to, among other things, adopt certain disclaimers of liability with respect to Nasdaq–100 Index Fund Shares); Exchange Act Release NO. 34–41119 (February 26, 1999), 64 FR 11510 (March 9, 2000) (approval of Amex rule change to, among other things, adopt certain disclaimers of liability with respect to Nasdaq–100 Index Fund Shares); Exchange Act Release No. 34–35534 (March 24, 1995), 60 FR 16686 (March 31, 1995) (approval of Amex rule change to, among other things, adopt certain disclaimers of liability with respect to S&P MidCap 400 Index Fund Shares).

[13] 15 U.S.C. 78s(b)(2).

[14] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] ''streetTRACKS'' is a registered service mark of the State Street Corporation. ''Dow Jones Global Titans Index'' is a trademark of the Dow Jones & Co., Inc.

[4] *See* Securities Exchange Act Release No. 37589 (August 21, 1996), 61 FR 44370 (August 28, 1996) (SR–CHX–96–12).

[5] *See* Securities Exchange Act Release Nos. 39117 (September 22, 1997), 62 FR 50973 (September 29, 1997) (SR–CHX–96–14) (WEBS); and 40950 (January 15, 1999), 64 FR 3730 (January 25, 1999) (SR–CHX–98–31) (Select Sector SPDRs). ''WEBBS'' was a service mark of the Morgan Stanley Group, Inc. ''iShares'' is a service mark of the Barclays Global Investors. ''MSCI Index Fund'' is a trademark of the Morgan Stanley Capital International. ''Select Sector SPDR'' is a service mark of The McGraw-Hill Companies, Inc.

[6] *See* Securities Exchange Act Release No. 42975 (June 22, 2000), 65 FR 40712 (June 30, 2000) (SR–CHX–00–14).

[7] State Street Bank and Trust Company, through its State Street Global Advisors division, (''State Street'') is the adviser to the Trust and responsible for management of the Fund. State Street is also the administrator, custodian and transfer agent for the Fund and may act as a lending agent for the Trust. State Street Capital Markets, LLC is the distributor of the Fund's Shares. The Depository Trust Company (''DTC'') acts an securities depositary for the Shares.

[8] *See* Securities Exchange Act Release No. 43338 (September 25, 2000), 65 FR 59235 (October 4, 2000) (SR–Amex–00–53).

must, in the opinion of the Dow, meet all four of the following criteria to qualify as a candidate for the Index: (1) It must be a well established company with a solid financial situation and a broad client base; (2) it must be well known to global investors for either its long history of success or its widely used products or services; (3) it must be a market leader in its industry with either a dominant position or a competitive advantage; and (4) it must be among the largest of blue-chip companies in the global arena.

According to the Prospectus, in constructing the Global Titans Index, a multi-factor methodology is adopted. First, the 3,000 stocks of the Dow Jones Global Indexes are used as the Initial Pool to ensure that all candidates are investable, liquid and representative of the global markets. Market capitalization is then used as the first screen to create the Final Pool by selecting the top 100 companies. According to the Amex's filing, the Dow's rationale for this step is that market value is a universal measurement across industries, and also that its use is most appropriate for an index built for investment purposes. Every company in the final pool of 100 musts derive some revenue from outside its home country. This screen is instituted to ensure that all stocks in the Index selected are truly global companies.

The Prospectus notes that the next step in Index construction is to combine the Final Pool components' market capitalization rankings with their rankings according to four other indicators of size and leadership. These four indicators, two from the balance sheet and two from the income statement, are assets, book value, sales/revenue, and net profit. The combined rankings of these four fundamental factors determine the fundamental rank of each company. The fundamental rank and the market capitalization rank are used equally as the basis for selecting the Index components.[9]

[9] As described in the Amex Submission, the Index methodology described above is subject to an annual review. A three-month window—March through June—is used for stock evaluation. The steps described above are repeated to build the Final Pool and to calculate the final ranking with respect to the four fundamental measures and weighted average market value. Any non-components that fall into the top 25 of the new final ranking are added to the Index automatically, replacing the lowest ranked components. A 20% buffer zone rule is applied, meaning that any component stocks ranked higher than 20% above the Index's target number of stocks are retained, while those ranked lower than 20% above the target number are replaced by the top ranked non-component stocks.

For purposes of calculation of the Index value, securities for which the primary market is outside of the United States are valued based on the last sale price on the primary market. During periods when the primary market is closed, these securities are valued based on the last sale price, if any, of any corresponding American Depositary Receipt (''ADR'').

b. *The streetTRACKS Dow Jones Global Titans Index Fund.* According to the Prospectus, the Fund's investment objective is to replicate as closely as possible, before expenses, the performance of the Index. The Fund uses a passive management strategy designed to track the performance of the Index. The Fund, using an ''indexing'' investment approach, attempts to replicate, before expenses, the performance of the Index. The Adviser seeks a correlation of 0.95 or better between the Fund's performance and the performance of the Index; a figure of 1.00 would represent perfect correlation. The Fund generally will invest in all of the stocks comprising the Index in proportion to their weighings in the Index. However, under various circumstances, it may not be possible or practicable to purchase all of those stocks in those weighings. In those circumstances, the Fund may purchase a sample of the stocks in the Index in proportions expected by the Adviser to replicate generally the performance of the Index as a whole. There may also be instances in which the Adviser may choose to overweight another stock in the Index, purchase securities not in the Index which the Adviser believes are appropriate to substitute for the Index Securities, or utilize various combination of other available investment techniques, in seeking to track accurately the Index. The Fund may sell stocks that are represented in the Index, or purchase stocks that are not yet represented in the Index, in anticipation of their removal from or addition to the Index. The Fund will normally invest at least 95% of its total assets in common stocks that comprise the Index.

The Prospectus confirms that the Fund will invest in foreign securities, including non-U.S. dollar-denominated securities traded outside of the United States and dollar-denominated securities of foreign issuers traded in the United States. Foreign securities also include investments such as ADRs, which are U.S. dollar-denominated receipts representing shares of foreign-based corporations. ADRs are issued by U.S. banks or trust companies, and entitle the holder to all dividends and capital gains that are paid out on the underlying foreign shares.

As described in the Amex Submission, as of August 31, 2000, the Index included 27 U.S. companies, 20 Western European companies and 3 Japanese companies, representing 68.17%, 27.45% and 4.38% of the Index weight, respectively. Forty-four Index components, representing 94.36% of the Index weight, are listed on the New York Stock Exchange, Inc. (''NYSE'') or on the National Association of Securities Dealers Automated Quotations System (''Nasdaq''). Seventeen of the 23 non-U.S. companies in the Index have ADRs listed and traded on the NYSE. The following five non-U.S. companies in the Index, with a combined Index weight of 5.07%, have ADRs traded in the United States in the over-the-counter ''Pink Sheet'' market: Credit Suisse Group, Lloyds/TSB Group PLC, Nestle S.A., Roche Holding AG, and Siemens AG. ADRs for one non-U.S. company in the Index, Allianz AG Holding, are not currently available.

c. *Creation and Redemption of Fund Shares.* The Fund will issue and redeem Shares only in Creation Unit size aggregations, with 50,000 Shares in each Creation Unit. The Fund will issue and sell Shares through the distributor on a continuous basis at their net asset value. Following issuance, Shares are traded on the Exchange and on other exchanges like other equity securities by professionals, as well as retail and institutional investors.

In order to create (*i.e.,* purchase) Creation Units of the Fund, an investor must generally deposit a designated portfolio of equity securities constituting a substantial replication, or a representation, of the stocks included in the Index (the ''Deposit Securities'') and generally make a small cash payment referred to as the ''Cash Component.'' The list of the names and the number of shares of the Deposit Securities is made available by the custodian through the facilities of the National Securities Clearing Corporation (''NSCC'') immediately prior to the opening of business on the Amex. The Cash Component represents the difference between the net asset value of a Creation Unit and the market value of the Deposit Securities.

Orders must be placed in proper form by or through either (1) a ''Participating Party,'' *i.e.,* a broker-dealer or other participant in the clearing process of the Continuous Net Settlement System of the NSCC; or (2) a DTC Participant, that, in either case, has entered into an agreement with the Trust, the distributor and the transfer agent, with

respect to creations and redemptions of Creation Units. All orders must be placed for one or more whole Creation Units of Shares of the Fund and must be received by the distributor in proper form no later than the close of regular trading on the NYSE (ordinarily 4 p.m., New York time) in order to receive that day's closing net asset value per Share.

Shares may be redeemed only in Creation Units at their net value and only on a day the NYSE is open for business. The custodian makes available immediately prior to the opening of business on the Amex, through the facilities of the NSCC, the list of names and the number of Shares of the Fund's portfolio securities that will be applicable that day to redemption requests in proper form (''Fund Securities''). Fund Securities received on redemption may not be identical to Deposit Securities which are applicable to creations of Creation Units. Unless cash redemptions are available or specified for the Funds, the redemption proceeds consist of the Fund Securities, plus cash in an amount equal to the difference between the net asset value (''NAV'') of the Shares being redeemed as next determined after receipt by the transfer agent of a redemption request in proper form, and the value of the Fund Securities (the ''Cash Redemption Amount''), less the applicable redemption fee.

Shares cannot be redeemed individually but must be redeemed in Creation Units.

d. *Availability of Information Regarding Fund Shares and the Index.* The Exchange understands that Amex, the primary exchange for these products, intends to disseminate, every 15 seconds during regular Amex trading hours, through the facilities of the Consolidated Tape Association (''CTA''), an updated value for Shares on a per Share basis. Amex has represented that this value will be based on last sale price disseminated by United States and applicable foreign exchange markets, the price of foreign issues being converted into U.S. dollars based on current currency exchange rates and/or reported ADR prices in the United States (in U.S. dollars).

The Exchange also understands that additional information will be available to the public, including the Shares outstanding and the Cash Component per Creation Unit size aggregation (which will be made available prior to the opening on the Amex) and the closing prices of the Fund's Deposit Securities (which is available from a variety of market data vendors). Moreover, as described above, the Fund will make available on a daily basis the names and required number of shares of each of the Deposit Securities in a Creation Unit Aggregation, as well as information regarding the cash balancing amount. Finally, the Exchange understands that the NAV for each Fund will be calculated and disseminated daily.

e. *Other Characteristics of the Fund.* Income dividend distributions, if any, are distributed to shareholders quarterly. Net capital gains are distributed at least annually. The Trust may declare and paid dividends more frequently to improve Index tracking or to comply with Internal Revenue Code distribution requirements. Distributions in cash may be invested automatically in additional whole Shares if the broker through which the investor purchased the Shares makes this option available.

Broker-dealers may make available the DTC book-entry Dividend Reinvestment Service for use by beneficial owners of the Fund through DTC participants for reinvestment of their dividend distributions. If this service is available and used, dividend distributions of both income and realized gains will be automatically reinvested in additional whole Shares issued by the Fund based on a payable date NAV.

f. *Trading of Fund Shares on the Exchange.* Fund Shares are subject to the criteria for initial and continued listing of Investment Company Units described in Article XXVIII, Rule 24.

The Exchange will require that a minimum of 100,000 Shares be outstanding when trading begins at the CHX. This number of Shares is comparable to the number of shares outstanding when other Investment Company Units or Portfolio Depositary Receipts began trading on the Exchange. The Exchange believes that the proposed minimum number of Shares required to be outstanding when trading begins on the Exchange is sufficient to provide market liquidity and to further the Fund's objective to seek to provide investment results that correspond generally to the price and yield performance of the Index. The Exchange understands that 150,000 Shares were outstanding when trading began on the Amex on September 29, 2000.

The minimum trading variation for the Fund will be 1/64 of $1.00, until this security is converted to decimal pricing in accordance with the Decimals Implementation Plan for the Equities and Options Market submitted to the Commission in July, 2000.

Fund Shares are considered ''securities'' under the Rules of the Exchange and are subject to all applicable trading rules, including the provisions of Article XX, Rule 40 (''ITS'' 'Trade-Throughs' and 'Locked Markets' ''), which prohibit CHX members from initiating trade-throughs for ITS securities, as well as rules governing priority, parity and precedence of orders, market volatility related trading halt provisions and responsibilities of the assigned specialist firm. Exchange equity margin rules will apply.

Funds Shares are also subject to the Exchange's rules relating to trading halts due to extraordinary market volatility (Article IX, Rule 10A) and the Exchange's rule which allows Exchange officials to halt trading in specific securities, under certain circumstances (Article IX, Rule 10(b)). In exercising the discretion described in Article IX, Rule 10(b), appropriate Exchange officials may consider a variety of factors, including the extent to which trading is not occurring in a stock underlying the index or portfolio and whether other unusual conditions or circumstances detrimental to the maintenance of a fair and orderly market are present.

The Exchange's surveillance procedures for Fund Shares will be similar to the procedures used for other Investment Company Units and will incorporate and rely upon existing CHX surveillance systems.

The Exchange will issue a circular to its members and member organizations, prior to the commencement of trading, alerting them to the characteristics of Fund Shares, including the fact that Shares are not individually redeemable, but are redeemable only in Creation Units. The circular with also confirm that investors purchasing Fund Shares will be required to receive a prospectus prior to or concurrently with the confirmation of a transaction in the Shares; will inform members that the procedures for purchases and redemptions of Shares in Creation Unit size are described in the Trust Prospectus; and will confirm for members that the Fund Shares are subject to existing Exchange rules relating to trading halts. Finally, the circular will inform members that before a member, member organization, or person associated with a member organization undertakes to recommend a transaction in the Fund, the member or member organization should make a determination that the Fund is suitable for the customer and the person making the recommendation should have a reasonable basis for believing, at the time of making the recommendation, that the customer has such knowledge and experience in financial matters that he may reasonably be expected to be capable of evaluating the risks and the

special characteristics of the recommended transaction and is financially able to bear the risks of the recommended transaction.

2. Statutory Basis

The Exchange believes that the proposed rule change is consistent with Section 6(b)(5) [10] of the Act, which requires that an exchange have rules that are designed to prevent fraudulent and manipulative acts and practices, to promote just and equitable principles of trade, to foster cooperation and coordination with persons engaged in regulating, clearing, settling, processing information with respect to, and facilitating transactions in securities, to remove impediments to and perfect the mechanism of a free and open market and a national market system, and, in general, to protect investors and the public interest.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange believes that the proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purpose of the Act. The CHX seeks to trade issues already trading on another exchange and believes that this increased competition among markets can benefit investors.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received From Members, Participants or Others

No written comments were either solicited or received.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the foregoing proposed rule change: (1) Does not significantly affect the protection of investors or the public interest; (2) does not impose any significant burden on competition; and (3) does not become operative for 30 days from the date of filing, or such shorter time as the Commission may designate if consistent with the protection of investors and the public interest; provided that the CHX has given written notice of its intent to file the proposed rule change, along with a brief description and text of the proposed rule change, at least five business days prior to the date of filing the rule change, or such shorter time as designated by the Commission, the proposed rule change has become effective pursuant to Section 19(b)(3)(A) [11] of the Act and Rule 19b–4(f)(6) [12] thereunder.[13]

A proposed rule change filed under Rule 19b–4(f)(6) may not become operative prior to 30 days after the date of filing. However, Rule 19b–4(f)(6)(iii) permits the Commission to designate a shorter time if such action is consistent with the protection of investors and the public interest. The CHX seeks to have the proposed rule change become operative on October 16, 2000, in order to allow the CHX to immediately trade, pursuant to unlisted trading privileges, shares of streetTRACKS Dow Jones Global Titans Index Fund. The Shares are already being traded on the Amex.

The Commission believes that it is consistent with the protection of investors and the public interest that the proposed rule change become operative immediately as of October 16, 2000.[14] At any time within 60 days of the filing of the proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule change is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statement with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal office of the CHX. All submissions should refer to File No. SR–CHX–00–33 and should be submitted by November 24, 2000.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[15]

Margaret H. McFarland,

Deputy Secretary.

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[10] 15 U.S.C. 78f(b)(5).

[11] 15 U.S.C 78s(b)(30(A).

[12] 17 CFR 240.19b–4(f)(6).

[13] As required under Rule 19b–4(f)(6)(iii), the Exchange provided the Commission with written notice of its intent to file the proposed rule change.

[14] For pusposes only of accelerating the operative date of this proposal, the Commission has considered the proposed rule's impact on efficiency, competition, and capital formation. 15 U.S.C. 78c(f).

[15] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43485; File No. SR–ISE–00–08]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Change by the International Securities Exchange LLC, Relating to Fee Changes

October 26, 2000.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (the ''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on September 12, 2000, the International Securities Exchange LLC (the ''Exchange'' or the ''ISE'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule change as described in Items I, II, and III below, which items have been prepared by the ISE. The Commission is publishing this notice to solicit comments on the proposed rule change from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Change

The ISE is proposing various changes to its fee schedule: (i) To provide discounts for multiple ''Click'' terminals; (ii) to establish a fee for ''trade review terminals''; (iii) to clarify the application of execution fee discounts; (iv) to reflect that the ISE collects its ''membership'' or access fee on a monthly, rather than quarterly, basis; and (v) to permit the ISE to collect its regulatory fee on an annual, rather than quarterly, basis. The text of the proposed rule change is available at the ISE and at the Commission.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

In its filing with the Commission, the ISE included statements concerning the purpose of, and basis for, the proposed rule change and discussed any

[1] 15 U.S.C. 73s(b)(1).

[2] 17 CFR 240.19b–4.

comments it received on the proposed rule change. The text of these statements may be examined at the places specified in Item IV below. The ISE has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Change

The purpose of the proposed rule change is to effect the following changes in the ISE's fees:

Discounts: A Click terminal is a device that ISE Electronic Access Members (''EAMs'') can use to enter orders on the ISE. The current ISE fee schedule imposes a flat monthly fee of $500 per terminal and $250 for each application program interface (''API'') associated with a terminal. This structure can act as a disincentive for EAMs to utilize multiple Click terminals. The ISE is adopting a tiered fee schedule with volume discounts for Clicks and APIs that would lower the software fees to half the current charges (from $500 to $250) for the sixth Click terminal and all subsequent terminals, and the API fee (from $250 to $100) for the sixth and subsequent APIs.

Trade review devices: These devices allow a member to ''listen'' to the broadcast of ISE messages confirming executions effected by the member. Members use these devices for analytical, hedging, risk management, back-office processing and similar purposes. The ISE is establishing monthly ''trade review device'' fees, including multiple-terminal discounts, that are the same as the Click fees: $500 for the first five terminals and $250 per terminal thereafter.

Execution Fees: The ISE fee schedule provides for lower execution fees as the Exchange's average daily volume (ADV) increases. There are discounts at ADV of 300,000, 500,000 and 700,000 contracts a day. The amendment to the fee schedule clarifies that the reduced fees apply only to executions above the break-points. For example, at ADV of 550,000 contracts; the $.21 fee will apply for the first 300,000 contracts; the $.17 fee will apply for the next 200,000 contracts; and the $.14 fee will apply for the last 50,000 contracts.

Membership Dues: ISE Rule 205 authorizes the Exchange to charge ''membership dues,'' payable on the first day of a calendar quarter. The fee schedule, however, includes monthly ''access fees,'' rather than specific membership dues. The ISE is amending ISE Rule 205 to reflect this, and is not proposing any changes to the access fees themselves.

Regulatory Fees: The ISE fee schedule contains a provision for an annual $3,500 regulatory fee. ISE Rule 208 currently states that this fee is to be collected on a quarterly basis. The ISE believes that it is an unnecessary administrative burden to bill for and collect this relatively small fee on a quarterly basis. Accordingly, the ISE is eliminating the word ''quarterly'' from this rule so that it can collect the fee on an annual basis. There are no changes to the fee itself.

The basis for this proposed rule change is the requirement under section 6(b)(4) of the Act [3] that an exchange provide for the equitable allocation of reasonable dues, fees and other charges among its members and other persons using its facilities.

B. Self-Regulatory Organization's Statement on Burden on Competition

The ISE believes that the proposed rule change does not impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Change Received from Members, Participants, or Others

The Exchange has not solicited, and does not intend to solicit, comments on this proposed rule change. The Exchange has not received any unsolicited written comments from members or other interested parties.

III. Date of Effectiveness of the Proposed Rule Change and Timing for Commission Action

Because the ISE has designated the foregoing proposed rule change as a fee change pursuant to section 19(b)(3)(A) of the Act [4] and Rule 19b–4(f)(2) thereunder,[5] the proposal has taken effect upon filing with the Commission. At any time within 60 days of the filing of such proposed rule change, the Commission may summarily abrogate such rule change if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

Interested persons are invited to submit written data, views and arguments concerning the foregoing, including whether the proposed rule is consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submission, all subsequent amendments, all written statements with respect to the proposed rule change that are filed with the Commission, and all written communications relating to the proposed rule change between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal offices of the ISE. All submissions should refer to SR–ISE–00–08 and should be submitted by November 24, 2000.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[6]

Margaret H. McFarland,

Deputy Secretary.

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[3] 15 U.S.C. 78f(b)(4).

[4] 15 U.S.C. 78s(b)(3)(A).

[5] 17 CFR 240.19b–4(f)(2).

[6] 17 CFR 200.30–3(a)(12).

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43380; File Nos. SR–PHLX–00–86 and SR–PHLX–00–87]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Changes by the Philadelphia Stock Exchange, Inc. Relating to an Amendment to the Exchange's Payment for Order Flow Fee and a Rebate for Certain Fees Incurred

October 25, 2000.

Pursuant to Section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'') [1] and Rule 19b–4 thereunder,[2] notice is hereby given that on September 11, 2000, the Philadelphia Stock Exchange, Inc. (''Phlx'' of the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') the proposed rule changes as described in Items I, II, and III below, which Items have been prepared by the Phlx. The Commission is publishing this notice to solicit comments on the proposed rule changes from interested persons.

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Changes

In SR–PHLX–00–86, the Phlx proposes to amend its payment for order flow program [3] that imposed a fee, effective, August 1, 2000, of $1.00 per contract on transactions by Phlx specialists and Registered Options Traders (''ROTs'') in the Top 120 Options [4] traded on the Phlx. The effect of the amendment would be to exclude from the program, as of September 1, 2000, any transaction between a Phlx specialist or a Phlx ROT and a Phlx member firm trading in its proprietary account. The proposed amendment is effective as of September 1, 2000.[5]

In SR–PHLX–00–87, the Phlx proposes to rebate the fees that the Phlx ROTs and Phlx specialists incurred during the period from August 1, 2000, through August 31, 2000, when they traded with Phlx member firms that were effecting trades for their proprietary accounts and not on behalf of customers. The text of these proposed rule changes is available at the principal offices of the Phlx.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Changes

In its filing with the Commission, the Phlx included statement concerning the purpose of and basis for the proposed rule changes and discussed any comments it had received on them. The text of these statements may be examined at the places specified in Item IV below. The Phlx has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Changes

The purpose of SR–PHLX–00–86, is to amend the Phlx's payment for order flow fee program such that, effective September 1, 2000, the Phlx will not assess the $1.00 per contract fee on transactions in which a Phlx member firm, trading for its proprietary account, trade with a Phlx specialist or Phlx ROT. In SR–PHLX–00–87, the Phlx proposes to rebate the fees that Phlx specialists and ROTs incurred in executing such transactions with Phlx member firms during the period from August 1, 2000 through August 31, 2000.

The purpose of the Phlx's payment for order flow program is to generate a source of revenue that specialists may use to attract order flow in the Top 120 Options traded on the Phlx. The Phlx's payment for order flow program originally imposed a $1.00 fee on all transactions of specialists and ROTs in the Top 120 Options, other than ROT-to-ROT or specialist-to-ROT transactions. The Phlx believes that it was necessary for it to adopt this type of fee in order to maintain and enhance its competitive position. Effective September 1, 2000, the proposed rule change would exempt from the fee all transactions between a specialist or an ROT and a member firm trading for its proprietary account.[6]

The Phlx believes that it would not promote the goals of its payment for order flow program to collect the $1.00 fee from ROTs and specialists when they engage in transactions with Phlx member firms trading for their proprietary accounts. Any funds collected in connection with those trades would not be used to make payments to member firms for their proprietary order flow, because those are not the kind of transactions that the fee is designed to attract. The Phlx proposes to rebate to specialists and ROTs any fees that were imposed on them for their transactions with respect to the proprietary trading of Phlx member firms during the period from August 1, 2000 through August 31, 2000.

In sum, the Phlx's payment for order flow program, as amended by SR–PHLX–00–86, would impose the $1.00 fee on all transactions by specialists and ROTs in the Top 120 Options, with the exception of: (1) Transactions between ROTs; (2) transactions between a specialist and an ROT; and (3) transactions between a specialist or an ROT and a member firm acting for its proprietary account and not on behalf of a customer. The Exchange envisions that the persons who pay the fees will also participate in the order flow derived from the plan, amended as proposed. The Exchange believes that the plan, amended as proposed, will provide for the equitable allocation of reasonable fees among the Exchange's members because the specialists and ROTs who pay the fee should also receive the benefits of increased order flow. Moreover, the Exchange believes that the fee should promote just and equitable principles of trade, remove impediments to and perfect the mechanism of a free and open market, and protect investors and the public interest by attracting more order flow to the Exchange. In the Exchange's view, this should result in increased liquidity, tighter markets, and more competition among exchange members. Accordingly, the Exchange believes that its proposals are consistent with and further the objectives of the Act, including sections 6(b)(4) [7] and 6(b)(5) [8] thereof.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule changes will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Changes Received From Members, Participants or Others

The Phlx neither solicited nor received any written comments with respect to the proposed rule changes.

III. Date of Effectiveness of the Proposed Rule Changes and Timing for Commission Action

Because the Phlx has designated the foregoing proposed rule changes as fee changes pursuant to section 19(b)(3)(A) of the Act [9] and Rule 19b–4(f)(2) thereunder,[10] the proposals have taken effect upon filing with the Commission. At any time within 60 days of the filing of the proposed rule changes, the Commission may summarily abrogate them if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise

[3] *See* Securities Exchange Act Release No. 43177 (Aug. 18, 2000), 65 FR 51889 (Aug. 25, 2000).

[4] A top 120 Option is defined as one of the 120 most actively traded equity options in terms of the total number of contracts that were traded on all U.S. options markets for the period January 1, 2000 through June 30, 2000, based on volume information provided by The Options Clearing Corporation. The Phlx will determine the Top 120 Options every six months, with the next measuring period commencing June 1, 2000 and ending on November 30, 2000. The proposed fee does not apply to index or currency options.

[5] The $1.00 fee is not eligible for the monthly credit of up to $1,000 to be applied against certain fees, dues, charges, and other amounts that certain members owe to the Exchange. *See* Securities Exchange Act Release No. 42791 (May 16, 2000), 65 FR 33606 (May 24, 2000).

[6] The Phlx has also filed a proposed rule change to amend its payment for order flow program to exclude, effective October 1, 2000, any transactions between Phlx specialists or ROTs and broker-dealer orders. *See* SR–PHLX–00–88 (October 2, 2000). The Phlx also proposed to rebate the fees that were imposed upon specialists and ROTs for transactions of the type that would be excluded by virtue of SR–PHLX–00–88. *See* SR–PHLX–00–89 (October 4, 2000).

[7] 15 U.S.C. 78f(b)(5).

[8] 15 U.S.C. 78f(b)(6).

[9] 15 U.S.C. 78s(b)(3)(A).

[10] 17 CFR 240.19b–4(f)(2).

in furtherance of the purposes of the Act.

IV. Solicitation of Comments

The Commission invites interested persons to submit written data, views, and arguments concerning the foregoing, including whether the proposed rules are consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submissions, all subsequent amendments, all written statements with respect to the proposed rule changes that are filed with the Commission, and all written communications between the Commission and any person relating to the proposed rule changes, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filings will also be available for inspection and copying at the principal offices of the Phlx. All submissions should refer to File Nos. SR–PHLX–00–86 and SR–PHLX–00–87, and should be submitted by November 24, 2000.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[11]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–28224 Filed 11–2–00; 8:45 am]

BILLING CODE 8010–01–M

SECURITIES AND EXCHANGE COMMISSION

[Release No. 34–43481; File Nos. SR–PHLX–00–88 and SR–PHLX–00–89]

Self-Regulatory Organizations; Notice of Filing and Immediate Effectiveness of Proposed Rule Changes by the Philadelphia Stock Exchange, Inc. Relating to an Amendment to the Exchange's Payment for Order Flow Fee and a Rebate for Certain Fees Incurred

October 25, 2000.

Pursuant to section 19(b)(1) of the Securities Exchange Act of 1934 (''Act'')[1] and Rule 19b–4 thereunder,[2] notice is hereby given that the Philadelphia Stock Exchange, Inc. (''Phlx'' or the ''Exchange'') filed with the Securities and Exchange Commission (''Commission'') proposed rule changes SR–PHLX–00–88 and SR–PHLX–00–89 on October 2, 2000 and October 4, 2000, respectively, as described in Items I, II, and III below, which Items the Phlx has prepared. The Commission is publishing this notice to solicit comments on the proposed rule changes from interested persons.

I. Self-Regulatory Organization's Statement of the Terms of Substance of the Proposed Rule Changes

In SR–PHLX–00–88, the Phlx proposes to amend its payment for order flow program[3] that imposed a fee, effective August 1, 2000 of $1.00 per contract on transactions by Phlx specialists and Registered Options Traders (''ROTs'') in the Top 120 Options[4] traded on the Phlx. The effect of the amendment would be to exclude from the program, as of October 1, 2000, any transaction between a Phlx specialist or a Phlx ROT and a broker-dealer order.[5] The proposed amendment is effective as of October 1, 2000.[6]

In SR–PHLX–00–89, the Phlx proposes to rebate the fees that the Phlx ROTs and Phlx specialists incurred during the period from August 1, 2000 through September 30, 2000, when they engaged in a transaction with a broker-dealer order, and not with the order of a customer. The text of these proposed rule changes is available at the principal offices of the Phlx.

II. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Changes

In its filings with the Commission, the Phlx included statements concerning the purpose of and basis for the proposed rule changes and discussed any comments it received on them. The text of these statements may be examined at the places specified in Item IV below. The Phlx has prepared summaries, set forth in sections A, B, and C below, of the most significant aspects of such statements.

A. Self-Regulatory Organization's Statement of the Purpose of, and Statutory Basis for, the Proposed Rule Changes

The purpose of SR-PHLX–00–88 is to amend the Phlx's payment for order flow fee program such that, effective October 1, 2000, the Phlx would not assess the $1.00 per contract fee on transactions in which a Phlx specialist or Phlx ROT trades with a broker-dealer order. Moreover, in connection with SR–PHLX–00–89, the Phlx proposes to rebate the fees that Phlx specialists and ROTs incurred in executing such transactions with broker-dealers during the period from August 1, 2000 through September 30, 2000.

The purpose of the Phlx's payment for order flow program is to generate a source of revenue that specialists may use to attract order flow to the Phlx. The Phlx's payment for order flow program originally imposed a $1.00 fee on all transactions of specialists and ROTs in the Top 120 Options traded on the Phlx, other than ROT-to-ROT or specialist-to-ROT transactions.[7] The Phlx believes that it was necessary for it to adopt this type of fee in order to maintain and enhance its competitive position.

Proposed rule change SR–PHLX–00–88 would now exempt from the fee all transactions between a specialist or an ROT and a broker-dealer order. The Phlx believes that it would not promote the goals of the payment for order flow program to collect the $1.00 fee from an ROT or a specialist that engages in a transaction with a broker-dealer order, and not the order of a customer. Therefore, any funds collected in connection with those trades would not be used to make payments to broker-dealers for their proprietary order flow, because those are not the kind of transactions that the fee is designed to attract. Indeed, because the primary

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[11] 17 CFR 200.30–3(a)(12).

[1] 15 U.S.C. 78s(b)(1).

[2] 17 CFR 240.19b–4.

[3] *See* Securities Exchange Act Release No. 43177 (Aug. 18, 2000), 65 FR 51889 (Aug. 25, 2000).

[4] A Top 120 Option is defined as one of the 120 most actively traded equity options in terms of the total number of contracts that were traded on all U.S. options markets for the period January 1, 2000 through June 30, 2000, based on volume information provided by The Options Clearing Corporation. The Phlx will determine the Top 120 Options every six months, with the next measuring period commencing June 1, 2000 and ending on November 30, 2000. The proposed fee does not apply to index or currency options.

[5] According to the Phlx, a broker-dealer order is an order, entered from other than the floor of the exchange, for any account: (i) In which the holder of a beneficial interest is a member or non-member broker-dealer; or (ii) in which the holder of beneficial interest is a person associated with or employed by a member or non-member broker-dealer. This includes orders for the acount of an ROT entered from off the floor.

[6] The $1.00 fee is not eligible for the monthly credit of up to $1,000 to be applied against certain fees, dues, charges, and other amounts that certain members owe to the Exchange. *See* Securities Exchange Act Release No. 42791 (May 16, 2000), 65 FR 33606 (May 24, 2000).

[7] *See* Securities Exchange Act Release No. 43177 (Aug. 18, 2000), 65 FR 51889 (Aug. 25, 2000). The Phlx later filed a proposed rule change to amend its payment for order flow program in order to exclude from the program, as of September 1, 2000, any transactions between Phlx specialists or ROTs and Phlx member firms trading in their proprietary accounts. *See* SR–PHLX–00–86 (September 11, 2000). The Phlx also proposed to rebate the fees that were imposed upon specialists and ROTs for transactions of the type that would be excluded by virtue of SR–PHLX–00–86. *See* SR–PHLX–00–87 (September 11, 2000).

focus of the program, as amended, is to attract order flow from customers, the $1.00 fee will apply to transactions between specialists or ROTs and customers. In SR–PHLX–00–89, the Phlx proposes to rebate to specialists and ROTs any fees that were imposed on them with respect to such transactions with broker-dealers during the period from August 1, 2000 through September 30, 2000.

In sum, the Phlx's payment for order flow program, as amended, would impose the $1.00 fee on all transactions by specialists and ROTs in the Top 120 Options, with the exception of: (1) Transactions between ROTs, (2) transactions between a specialist and an ROT; (3) transactions between a specialist or ROT and a Phlx member firm acting for its proprietary account and not on behalf of a customer,[8] (4) transactions between a specialist and a broker-dealer order; and (5) transactions between an ROT and a broker-dealer order. The Exchange envisions that the persons who pay the fees will also participate in the order flow derived from the amended program. The Exchange believes that the program, amended as proposed, will provide for the equitable allocation of reasonable fees among the Exchange's members because the specialists and ROTs who pay the fee should also receive the benefits of increased order flow.

Moreover, the Exchange believes that the fee should promote just and equitable principles of trade, remove impediments to and perfect the mechanism of a free and open market, and protect investors and the public interest by attracting more order flow to the Exchange. In the Exchange's view, this should result in increased liquidity, tighter markets, and more competition among exchange members. Accordingly, the Exchange believes that its proposals are consistent with and further the objectives of the Act, including Sections 6(b)(4)[9] and 6(b)(5)[10] thereof.

B. Self-Regulatory Organization's Statement on Burden on Competition

The Exchange does not believe that the proposed rule changes will impose any burden on competition that is not necessary or appropriate in furtherance of the purposes of the Act.

C. Self-Regulatory Organization's Statement on Comments on the Proposed Rule Changes Received From Members, Participants or Others

The Phlx neither solicited nor received written comments with respect to the proposed rule changes.

III. Date of Effectiveness of the Proposed Rule Changes and Timing for Commission Action

Because the Phlx has designated the foregoing proposed rule changes as fee changes pursuant to section 19(b)(3)(A) of the Act[11] and Rule 19b–4(f)(2) thereunder,[12] the proposals have taken effect upon filing with the Commission. At any time within 60 days of the filing of the proposed rule changes, the Commission may summarily abrogate them if it appears to the Commission that such action is necessary or appropriate in the public interest, for the protection of investors, or otherwise in furtherance of the purposes of the Act.

IV. Solicitation of Comments

The Commission invites interested persons to submit written data, views, and arguments concerning the foregoing, including whether the proposed rules are consistent with the Act. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, NW., Washington, DC 20549–0609. Copies of the submissions, all subsequent amendments, all written statements with respect to the proposed rule changes that are filed with the Commission, and all written communications relating to the proposed rule changes between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Room. Copies of such filing will also be available for inspection and copying at the principal offices of the Phlx. All submissions should refer to File Nos. SR–PHLX–00–88 and SR–PHLX–00–89 and should be submitted by November 24, 2000.

For the Commission, by the Division of Market Regulation, pursuant to delegated authority.[13]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 00–28225 Filed 11–2–00; 8:45 am]

BILLING CODE 8010–01–M

[8] *See* footnote 7, *supra.*

[9] 15 U.S.C. 78f(b)(5).

[10] 15 U.S.C. 78f(b)(6).

[11] 15 U.S.C. 78s(b)(3)(A).

[12] 17 CFR 240.19b–4(f)(2).

[13] 17 CFR 200.30–3(a)(12).

SOCIAL SECURITY ADMINISTRATION

Agency Information Collection Activities: Proposed Request and Comment Request

In compliance with Public Law 104–13, the Paperwork Reduction Act of 1995, SSA is providing notice of its information collections that require submission to the Office of Management and Budget (OMB). SSA is soliciting comments on the accuracy of the agency's burden estimate; the need for the information; its practical utility; ways to enhance its quality, utility and clarity; and on ways to minimize burden on respondents, including the use of automated collection techniques or other forms of information technology.

The information collection listed below has been submitted to OMB for clearance. Written comments and recommendations on the information collection would be most useful if received within 30 days from the date of this publication. Comments should be directed to the SSA Reports Clearance Officer and the OMB Desk Officer at the addresses listed after this publication. You can obtain a copy of the OMB clearance package by calling the SSA Reports Clearance Officer on (410) 965–4145, or by writing to him.

Statement for Determining Continuing Eligibility, Supplemental Security Income Payment—0960–0145. SSA uses Form SSA–8202–F6 to conduct low- and middle-error-profile (LEP–MEP) telephone or face-to-face interviews with Supplemental Security Income (SSI) recipients and representative payees. The information collected during the interview is used to determine whether SSI recipients have met and continue to meet all statutory and regulatory requirements for SSI eligibility and whether they have been and are still receiving the correct payment amount. The respondents are recipients of SSI benefits or their representative payees. This notice is being published again to include the burden for Form SSA–8202–OCR–SM.

	SSA–8202–F6	SSA–8202–OCR–SM
Number of Respondents	920,000	800,000
Frequency of Response	1	1
Average Burden Per Response (minute)	17	8
Estimated Annual Burden (hours)	260,667	106,667

(SSA Address), Social Security Administration, DCFAM, Attn: Frederick W. Brickenkamp, 6401 Security Blvd., 1–A–21 Operations Bldg., Baltimore, MD 21235.

(OMB Address), Office of Management and Budget, OIRA, Attn: Desk Officer for SSA, New Executive Office Building, Room 10230, 725 17th St., NW, Washington, D.C. 20503.

Dated: October 30, 2000.

Frederick W. Brickenkamp,

Reports Clearance Officer, Social Security Administration.

[FR Doc. 00–28227 Filed 11–2–00; 8:45 am]

BILLING CODE 4190–29–U

SOCIAL SECURITY ADMINISTRATION

Privacy Act of 1974; Report of New Routine Use

AGENCY: Social Security Administration (SSA).

ACTION: Notification of New Routine Use.

SUMMARY: In accordance with the Privacy Act of 1974 (5 U.S.C. 552a(e)(4) and (11)), we are notifying the public of our intent to establish a new routine use of information maintained in the Privacy Act system of records entitled Master Files of Social Security Number (SSN) Holders and SSN Applications. The proposed new routine use allows SSA to verify SSNs for State bureau of vital statistics (BVS) in the States' Electronic Death Registration (EDR) process. The EDR process will assist SSA in making timely terminations of Social Security benefits in death cases.

DATES: We filed a report of the routine use proposal with the President of the Senate, the Speaker of the House of Representatives, and the Director, Office of Information and Regulatory Affairs, Office of Management and Budget on October 26, 2000. The proposed new routine use will become effective on December 5, 2000, unless we receive comments on or before that date which could result in a contrary determination.

ADDRESSES: Interested individuals may comment on this publication by writing to the SSA Privacy Officer, Social Security Administration, 3–A–6 Operations Building, 6401 Security Boulevard, Baltimore, Maryland 21235. All comments received will be available for public inspection at the above address.

FOR FURTHER INFORMATION CONTACT: Mrs. Patricia Smith, Office of Disclosure Policy, Social Security Administration, 6401 Security Boulevard, Baltimore, Maryland 21235, telephone (410) 965–1552 or E-mail at *patgrimmett@gov.com*.

SUPPLEMENTARY INFORMATION:

I. Discussion of the Proposed New Routine Use

A. General

SSA received funding in fiscal year 1999 to enter into a contract with the National Association for Public Health Statistics and Information Systems (NAPHSIS) to develop standards and guidelines for States to implement an Electronic Death Registration (EDR) Process. EDR will result in significant programmatic and workyear savings for SSA, in that, SSA will receive more accurate and timely death reports from the States.

Under EDR, SSA's requirements are to receive a death report from the State within 24 hours of receipt in the State bureau of vital statistics (BVS) and to verify the Social Security number (SSN) at the beginning of the death registration process. The result of the verification will be that the states will allow SSA to take an immediate termination action on those verified numbers without independently verifying the accuracy of the report.

There are many participants in the death registration process including hospitals, medical examiners, coroners, funeral homes and local and State registrars. The EDR process will require the participant who collects the SSN to transmit the request for verification to the State BVS who will forward the request to SSA. In most states, funeral directors are responsible by State law for certifying the accuracy of that portion of the death certificate. SSA will send a ''yes'' or a code response if the SSN does not verify. The codes are:

- 1—SSN not in file (never issued to anyone)
- 2—Name and date of birth (DOB) match, sex code does not
- 3—Name and sex code match, DOB does not
- 4—Name matches, DOB and sex code do not
- 5—Name does not match, DOB and sex code not checked.

The BVS will, in turn, forward the response to the original requestor. This will allow the funeral director or whoever made the request a chance to obtain better information from the informant in cases where the number does not verify.

Because our records will not have any indication of death at the time the SSN verifications are requested, we must treat the individuals' records as if they are alive. We, therefore, are proposing to establish a new routine use under the Privacy Act to permit the verifications. The proposed routine use is applicable to the Privacy Act system of records entitled Master Files of Social Security Numbers (SSN) and SSN Applications and will appear as routine use number 30 in the notice of the system. The routine use provides for the following disclosure:

> Disclosures will be made to a State bureau of vital statistics (BVS) that is authorized by States to issue electronic death reports when the State BVS requests SSA to verify the Social Security number of an individual on whom an electronic death report will be filed after SSN verification.

B. Compatibility of the Proposed Routine Use

The Privacy Act (5 U.S.C. 552a(a)(7) and (b)(3)) and our disclosure regulation (20 CFR part 401) permits us to disclose information for routine uses; *i.e.,* disclose information about individuals without their consents for purposes compatible with the purpose for which the information is collected. Section 401.150 of the regulation (20 CFR 401.150) allows us to disclose information under a routine use to administer our programs. The SSN verifications that will be made under the proposed routine use would allow SSA to receive timely death information from the States that will result in timely termination of Social Security benefits when Social Security beneficiaries die. Thus, the proposed routine use meets the compatibility criteria of the Privacy Act and our disclosure regulation.

I. Effect of the Proposed Routine Use on the Individuals Rights

Under the proposed routine use SSN verifications will be provided to State BVS for individuals for whom the BVS is preparing an electronic death report. Since the individuals would be dead, there would be no adverse effects on individual rights. In the event that an SSN verification may be inadvertently provided for an individual who is alive, the individual's rights would be protected through an agreement with the State BVS that restricts their use or disclosure of such information.

Kenneth S. Apfel,

Commissioner of Social Security.

[FR Doc. 00–28226 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–29–U

DEPARTMENT OF STATE

[Public Notice No. 3448]

Defense Trade Advisory Group; Notice of Open Meeting

The Defense Trade Advisory Group (DTAG) will meet in open session beginning at 8:30 a.m. on Tuesday, November 21, 2000, in Room F–3420 at the National Foreign Affairs Training Center (NFATC), 4000 Arlington Blvd., Arlington, VA. The membership of this advisory committee consists of private sector defense trade specialists, appointed by the Assistant Secretary of State for Political-Military Affairs, who advise the Department on policies, regulations, and technical issues affecting defense trade.

As the DTAG has not met in plenary session for some time, this meeting is primarily organizational in nature and will focus on establishing future work programs.

Members of the public may attend the open session as seating capacity allows, and will be permitted to participate in the discussion in accordance with the Chairman's instructions.

As access to the Department of State facilities is controlled, persons wishing to attend the meeting must notify the DTAG Executive Secretariat by COB Thursday, November 16, 2000. If notified after this date, the DTAG Secretariat cannot guarantee that State's Bureau of Diplomatic Security can complete the necessary processing required to attend the November 21 plenary.

Each non-member observer wishing to attend should provide his/her name, company or organizational affiliation, date of birth, and social security number to the DTAG Secretariat by fax to (202) 647–4232 (Attention: Mike Slack). A list will be made up for Diplomatic Security and the Reception Desk at the NFATC Visitor Center. Attendees must present a valid photo ID for entry.

FOR FURTHER INFORMATION CONTACT: Mike Slack, DTAG Secretariat, U.S. Department of State, Office of Regional Security and Arms Transfers (PM/RSAT), Room 7424 Main State, Washington, DC 20520–2422. Phone: (202) 647–2882, Fax (202) 647–9779.

Dated: October 30, 2000.

Timothy J. Dunn,

Executive Secretary, Defense Trade Advisory Group.

[FR Doc. 00–28269 Filed 11–2–00; 8:45 am]

BILLING CODE 4710–25–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Agreements Filed; Weekly Receipts: Aviation Proceedings, Agreements Filed During the Week Ending September 15, 2000

The following Agreements were filed with the Department of Transportation under the provisions of 49 U.S.C. 412 and 414. Answers may be filed within 21 days after the filing of the application.

Docket Number: OST–2000–7914.

Date Filed: September 11, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC COMP 0682 dated 12 September 2000, Mail Vote 084—Resolution 010e, TC3/TC31 Special Passenger Amending Resolution from Japan to USA/US Territories, Intended effective date: 15 September 2000.

Docket Number: OST–2000–7915.

Date Filed: September 11, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC2 EUR–AFR 0119 dated 12 September 2000, Mail Vote 085—Resolution 010f, TC2 Europe-Africa Special Passenger Amending Resolution Fares between Durban and points in Europe, Intended effective date: 1 October 2000.

Docket Number: OST–2000–7939.

Date Filed: September 15, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC2 EUR 0333 dated 12 September 2000, Within Europe Expedited Resolutions r1–r13, Minutes—PTC2 EUR 0332 dated 12 September 2000, Tables—None
Intended effective date: 1 October 2000.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28249 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Aviation Proceedings, Agreements Filed During the Week Ending October 6, 2000

The following Agreements were filed with the Department of Transportation under the provisions of 49 U.S.C. 412 and 414. Answers may be filed within 21 days after the filing of the application.

Docket Number: OST–2000–8065.
Date Filed: October 4, 2000.
Parties: Members of the International Air Transport Association.
Subject:
CTC COMP 0285 dated 26 May 2000
Expedited Resolutions 002nn, 015aa
CTC COMP 0305 dated 1 September 2000—technical correction
Intended effective date: 1 August 2000.

Docket Number: OST–2000–8066.
Date Filed: October 4, 2000.
Parties: Members of the International Air Transport Association.
Subject:
CTC COMP 0283 dated 26 May 2000
Expedited Composite Resolutions
Intended effective date: 1 August 2000.

Docket Number: OST–2000–8067.
Date Filed: October 4, 2000.
Parties: Members of the International Air Transport Association.
Subject:
CTC COMP 0288 dated 2 June 2000
Worldwide Area Resolutions (USA/US Territories)
Intended effective date: 1 October 2000.

Docket Number: OST–2000–8075.
Date Filed: October 5, 2000.
Parties: Members of the International Air Transport Association.
Subject:
PTC23/TC123AFR–TC3 0107 dated 3 October 2000
Expedited Africa—TC3 Resolutions r1–r7
Intended effective date 1 November 2000.

Docket Number: OST–2000–8076.
Date Filed: October 5, 2000.
Parties: Members of the International Air Transport Association.
Subject:
PTC23/TC123 EUR–SWP 0046 dated 3 October 2000

PTC23/TC123 EUR–SWP 0047 dated 3 October 2000
Expedited Europe-South West Pacific Resolutions r1–r4
Intended effective date: 15 November 2000 and 1 January 2001.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28251 Filed 11–02–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Aviation Proceedings, Agreements Filed During the Week Ending September 29, 2000

The following Agreements were filed with the Department of Transportation under the provisions of 49 U.S.C. 412 and 414. Answers may be filed within 21 days after the filing of the application.

Docket Number: OST–2000–8019.

Date Filed: September 25, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC3 0449 dated 26 September 2000, Mail Vote 086—Resolution 010g, TC3 Special Passenger Amending Resolution between Korea and South East Asia, Intended effective date: 1 October 2000.

Docket Number: OST–2000–8020.

Date Filed: September 25, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC1 0155 dated 18 August 2000, TC1 Within South America Resolutions r1–r12, PTC1 0153 dated 18 August 2000, TC1 Caribbean Resolutions r1–r12, Minutes—PTC1 0158 dated 12 September 2000, Tables—PTC1 Fares 0045 dated 1 September 2000, TC1 Within South America Specified Fares Tables, PTC1 Fares 0044 dated 1 September 2000, TC1 Caribbean Specified Fares Tables Intended effective date: 1 January 2001.

Docket Number: OST–2000–8021.

Date Filed: September 25, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC1 0152 dated 18 August 2000, TC1 Areawide Resolutions r1–r7, PTC1 0154 dated 18 August 2000, TC1 Longhaul (except between USA and Chile), Resolutions r8–r–56, Minutes—PTC1 0158 dated 12 September 2000, PTC1 0159 dated 19 September 2000, TC1 Longhaul (USA-Chile) Policy Group Report, Tables—PTC1 Fares 0046 dated 1 September 2000, Intended effective date: 1 January 2001.

Docket Number: OST–2000–8022.

Date Filed: September 26, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC2 EUR 0334 dated 19 September 2000, TC2 Within Europe Expedited Resolutions r1–r15, Minutes—PTC2 EUR 0332 dated 12 September 2000, Intended effective date: 15 October 2000.

Docket Number: OST–2000–8023.

Date Filed: September 26, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC2 EUR 0335 dated 19 September 2000, TC2 Within Europe Expedited Resolutions r1–r3, PTC2 EUR 0336 dated 19 September 2000, TC2 Within Europe Expedited Resolution 002LL r–4, PTC2 EUR 0337 dated 19 September 2000, TC2 Within Europe Expedited Resolutions r5–r9, Minutes—PTC2 EUR 0332 dated 12 September 2000, Tables—No Tables, Intended effective dates: 1 November 2000, 1 December 2000, 1 January 2001.

Docket Number: OST–2000–8024.

Date Filed: September 26, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC23 EUR–JK 0057 dated 22 September 2000 and PTC23 EUR–JK 0058 dated 22 September 2000, Expedited Europe-Japan/Korea Resolutions, Intended effective date: 1 November 2000 and 1 January 2001.

Docket Number: OST–2000–8031.

Date Filed: September 28, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC COMP 0692 dated 29 September 2000, Mail Vote 087—TC2/TC23 Special Passenger Amending Resolution to/from Libya, Intended effective date: 15 October 2000.

Docket Number: OST–2000–8035.

Date Filed: September 29, 2000.

Parties: Members of the International Air Transport Association.

Subject: PTC23 ME–TC3 0103 dated 26 September 2000, Expedited Middle East-TC3 Resolutions r1–8, Intended effective date: 1 November 2000.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28252 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart Q During the Week Ending October 13, 2000

The following Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits were filed under Subpart Q of the Department of Transportation's Procedural Regulations (See 14 CFR 302.1701 *et seq.*). The due date for Answers, Conforming Applications, or Motions to Modify Scope are set forth below for each application. Following the Answer period DOT may process the application by expedited procedures. Such procedures may consist of the adoption of a show-cause order, a tentative order, or in appropriate cases a final order without further proceedings.

Docket Number: OST–2000–7559.

Date Filed: October 12, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 26, 2000.

Description: Application of Gemini Air Cargo, Inc. pursuant to Order 2000–9–24, applies for a certificate of public convenience and necessity to operate scheduled foreign air transportation of property and mail between points in the United States, on the one hand, and Manaus, Brasilia, Rio de Janeiro, Sao Paulo, Recife, Porto Alegre, Belem, Belo Horizonte, and Salvador de Bahia, Brazil, on the other; and beyond Brazil to Argentina, Uruguay, Paraguay, and Chile. Gemini also requests designation as the fourth U.S. scheduled all-cargo carrier to Brazil and asks the Department to allocate to Gemini the fourteen all-cargo frequencies that are presently available.

Docket Number: OST–2000–7559.

Date Filed: October 12, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 26, 2000.

Description: Application of Atlas Air, Inc. (''Atlas'') pursuant to 49 U.S.C. 41102 and 14 CFR 302.201 *et seq.*, applies for a certificate of public convenience and necessity authorizing Atlas to engage in scheduled foreign air transportation of property and mail between a point or points in the United States, on the one hand, and Manaus, Brasilia, Rio de Janeiro, Sao Paulo, Recife, Porto Alegre, Belem, Belo Horizonte and Salvador de Bahia, Brazil, on the other, via intermediate points and beyond Brazil to Argentina,

Uruguay, Paraguay and Chile. Atlas requests authorization to integrate this authority with its other all-cargo certificate and exemption authority, and to commingle traffic and services conducted pursuant to such authority, to the extent consistent with applicable agreements between the United States and foreign countries. Additionally, Atlas requests U.S. designation under the 1989 Air Transport Services Agreement between the United States and Brazil, as amended, and an award of seven weekly U.S.-Brazil all-cargo wide-body frequencies.

Docket Number: OST–2000–7559.

Date Filed: October 12, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 26, 2000.

Description: Application of Evergreen International Airlines, Inc. (''Evergreen'') pursuant to Order 2000–9–24 and 14 CFR 302.201, *et seq.*, applies for a certificate of public convenience and necessity to provide scheduled foreign air transportation of property and mail between a point or points in the United States, on the one hand, and Manaus, Brasilia, Rio de Janeiro, Sao Paulo, Recife, Porto Alegre, Belem, Belo Horizonte, and Salvador de Bahia, Brazil, on the other, via intermediate points and beyond Brazil to Argentina, Chile, Uruguay and Paraguay. Evergreen also requests (i) an initial allocation of five weekly frequencies to operate its new Brazil service and (ii) authority to integrate U.S.-Brazil authority with Evergreen's other all-cargo certificate and exemption authority and to commingle traffic on services conducted pursuant to such authority, consistent with applicable agreements between the U.S. and foreign countries.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28250 Filed 11–1–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart Q During the Week Ending September 15, 2000

The following Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits were filed under Subpart Q of the Department of Transportation's Procedural Regulations (See 14 CFR 302.1701 *et seq.*). The due date for Answers, Conforming Applications, or Motions to Modify Scope are set forth below for each application. Following the Answer period DOT may process the application by expedited procedures. Such procedures may consist of the adoption of a show-cause order, a tentative order, or in appropriate cases a final order without further proceedings.

Docket Number: OST–1995–546.

Date Filed: September 13, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 4, 2000.

Description: Application of Bahamasair Holdings Limited (''Bahamasair'') pursuant to 49 U.S.C. Section 41302 and Subpart B, further amends the carrier's pending application for renewal and amendment of its foreign air carrier permit so that it may provide foreign air transportation of persons, property, and mail between a point or points in The Bahamas and the coterminal points: (1) Atlanta, Georgia; (2) Boston, Massachusetts; (3) Charlotte, North Carolina; (4) Chicago, Illinois; (5) Detroit, Michigan; (6) Fort Lauderdale, Florida; (7) Miami, Florida; (8) New Orleans, Louisiana; (9) Newark, New Jersey; (10) New York, New York (LaGuardia); (11) Orlando, Florida; (12) Palm Beach, Florida; (13) Philadelphia, Pennsylvania; (14) Tampa, Florida; and (15) Washington, D.C. (Dulles).

Docket Number: OST–2000–7923.

Date Filed: September 13, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 4, 2000.

Description: Application of Delta Air Lines, Inc. (''Delta''), pursuant to Sections 41102 and 41108 and Subpart B, applies for a certificate of public convenience and necessity, authorizing Delta to provide scheduled foreign air transportation of persons, property and mail between Boston, Massachusetts, and London, England. Delta requests that the certificate issued by the Department include a route integration condition that authorizes Delta to combine service on this route with all other Delta services authorized by existing certificates and exemptions granted by the Department, to the extent permitted by applicable international agreements.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28253 Filed 11–02–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart Q During the Week Ending September 29, 2000

The following Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits were filed under Subpart Q of the Department of Transportation's Procedural Regulations (See 14 CFR 302.1701 *et. seq.*). The due date for Answers, Conforming Applications, or Motions to Modify Scope are set forth below for each application. Following the Answer period DOT may process the application by expedited procedures. Such procedures may consist of the adoption of a show-cause order, a tentative order, or in appropriate cases a final order without further proceedings.

Docket Number: OST–2000–7121.

Date Filed: September 25, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 16, 2000.

Description: Application of AOM-Minerve, S.A. (''AOM'') pursuant to 49 U.S.C. Section 41302 and Subpart B, requests an amendment of its foreign air carrier permit to include New Caledonia in its route description.

Docket Number: OST–2000–8015.

Date Filed: September 25, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 16, 2000.

Description: Application of Sun Air Express, LLC. pursuant to 49 U.S.C. 41738 and Subpart B, requests authority to engage in scheduled commuter passenger operations.

Docket Number: OST–2000–8029.

Date Filed: September 28, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 19, 2000.

Description: Application of Brendan Air, LLC (''Brendan Airways'') pursuant to 49 U.S.C. 41102 and Subpart B, submits this application for a certificate of public convenience and necessity authorizing interstate and overseas charter air transportation of persons, property, and mail.

Docket Number: OST–2000–8030.

Date Filed: September 28, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 19, 2000.

Description: Application of Brendan Air, LLC (''Brendan Airways'') pursuant to 49 U.S.C. Section and Subpart B,

submits this application for a certificate of public convenience and necessity authorizing foreign charter air transportation of persons, property, and mail.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28254 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Notice of Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits Filed Under Subpart Q during the Week Ending September 22, 2000

The following Applications for Certificates of Public Convenience and Necessity and Foreign Air Carrier Permits were filed under Subpart Q of the Department of Transportation's Procedural Regulations (See 14 CFR 302.1701 et. seq.). The due date for Answers, Conforming Applications, or Motions to Modify Scope are set forth below for each application. Following the Answer period DOT may process the application by expedited procedures. Such procedures may consist of the adoption of a show-cause order, a tentative order, or in appropriate cases a final order without further proceedings.

Docket Number: OST–2000–7956.

Date Filed: September 20, 2000.

Due Date for Answers, Conforming Applications, or Motion to Modify Scope: October 11, 2000.

Description: Application of Southeast Airlines, Inc. (''Southeast'') pursuant to 49 U.S.C. 41102 and Subpart Q, applies for a certificate of public convenience and necessity authorizing Southeast to provide chartered foreign air transportation of persons, property and mail between any point or points in the United States, directly and via any intermediate point or points, and any point or points in the countries listed in Appendix A, and beyond to any point or points in third countries. Southeast also requests authority to integrate the service it provides under the certificate with its other authorized services, consistent with all applicable international agreements. Southeast also requests authority to add two additional DC–9 aircraft to its existing fleet of two.

Dorothy Y. Beard,

Federal Register Liaison.

[FR Doc. 00–28255 Filed 11–02–00; 8:45 am]

BILLING CODE 4910–62–P

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Advisory Circular 25.905–1, Minimizing the Hazards From Propeller Blade and Hub Failures

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of issuance of advisory circular.

SUMMARY: This notice announces the issuance of Advisory Circular (AC) 25.905–1, Minimizing the Hazards from Propeller Blade and Hub Failures. The AC describes methods acceptable to the Administrator for showing compliance with the airworthiness standards for propeller installations on transport category airplanes. The guidance provided in the AC supplements the engineering and operational judgment that must form the basis of any compliance findings on design precautions to minimize the hazards to an airplane if a propeller blade fails or is released by a hub failure.

DATES: Advisory Circular 25.905–1 was issued on September 27, 2000, by the Manager of the Transport Airplane Directorate, Aircraft Certification Service, Federal Aviation Administration.

HOW TO OBTAIN COPIES: You can get a paper copy of AC 25.905–1 by writing to U.S. Department of Transportation, Subsequent Distribution Center, SVC–121.23, Ardmore East Business Center, 3341 Q 75th Avenue, Landover, Maryland 20785. You also can find the AC on the Internet at *http://www.faa.gov/avr/air/airhome.htm,* at the link titled ''Advisory Circulars'' under the ''Available Information'' drop-down menu.

FOR FURTHER INFORMATION CONTACT: For technical issues, contact Michael Dostert, FAA, Transport Airplane Directorate, Aircraft Certification Service, Propulsion/Mechanical Systems Branch, ANM–112, 1601 Lind Avenue SW., Renton, Washington 98055–4056; telephone (425) 227–2132; fax (425) 227–1320; e-mail mike.dostert@faa.gov.

For other information contact: Jill DeMarco, FAA, Transport Airplane Directorate, Program Management Branch, ANM–114, 1601 Lind Avenue SW., Renton, Washington 98055–4056; telephone (425) 227–1313; fax (425) 227–1320.

SUPPLEMENTARY INFORMATION:

Discussion of Comments

On March 31, 2000, the FAA issued a notice of the availability of proposed Advisory Circular (AC) 25.905–X, ''Minimizing the Hazards from Propeller Blade and Hub Failures.'' That notice was published in the **Federal Register** on April 11, 2000 (65 FR 19423), and requested public comment on the proposed AC document. Only one commenter filed comments to the proposed AC.

The commenter points out that, in the discussion of the ''Purpose'' of the AC, the FAA stated that the AC does not address hazards associated with unbalance created by blade release or similar failures. However, unbalance vibratory forces could be significant and can interfere with the required corrective actions. The commenter asks why the FAA did not cover this issue in the AC, and if we will address it in another AC.

We agree that imbalance is a critical issue following a propeller or hub failure. Structural issues and the flightcrew's ability to cope with the failure are of concern. We are considering separate action to address these issues. We have asked the Aviation Rulemaking Advisory Committee (ARAC) to review these issues and provide recommendations for further action.

Issued in Renton, Washington, on October 27, 2000.

John J. Hickey,

Manager, Transport Airplane Directorate, Aircraft Certification Service.

[FR Doc. 00–28295 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–U

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Agency Information Collection Activity Under OMB Review

AGENCY: Federal Aviation Administration (FAA), 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 (ICR) abstracted below have been forwarded to the Office of Management and Budget (OMB) for extension of the currently approved collections. 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 collections of information was published on June 30, 2000, (65 FR, page 40716).

DATES: Comments must be submitted on or before December 4, 2000. A comment to OMB is most effective if OMB receives it within 30 days of publication.

ADDRESSES: Send comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, 725—17th Street, NW., Washington, DC 20503, Attention: FAA Desk Officer.

FOR FURTHER INFORMATION CONTACT: Judy Street on (202) 267–9895.

SUPPLEMENTARY INFORMATION:

1. Title: Representatives of the Administrator, 14 CFR part 183.

Type of Request: Extension of a currently approved collection.

OMB Control Number: 2120–0033.

Forms(s) Affected Public: 4,840 respondents.

Abstract: Title 49, U.S.C. 44702, authorizes appointment of properly qualified private persons to be representatives of the Administrator for examining, testing, and certifying airmen for the purpose of issuing those individuals airmen certificates. The information collected is used to determine eligibility of the representatives.

Estimated Annual Burden Hours: 3,974 burden hours annually.

2. Title: Overflight Billing and Collection Customer Information Form.

Type of Request: Extension of a currently approved collection.

OMB Control Number: 2120–0618.

Forms(s): N/A.

Affected Public: 600 respondents.

Abstract: This information is needed to obtain accurate billing information from carriers who fly in U.S. controlled airspace, but who do not take off or land in the U.S. and who will be charged overflight fees.

Estimated Annual Burden Hours: 50 burden hours annually.

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.

Issued in Washington, DC, on October 31, 2000.

Steve Hopkins,

Manager, Standards and Information Division, APF–100.

[FR Doc. 00–28297 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

RTCA; Future Flight Data Collection Committee

Pursuant to section 10(a)(2) of the Federal Advisory Committee Act (Public Law 92–463, 5 U.S.C., appendix 2), notice is hereby given for the Future Flight Data Collection Committee meeting to be held November 7, 2000, starting at 9:00 a.m. This meeting will be held at RTCA, 1140 Connecticut Avenue NW., Suite 1020, Washington, DC 20036.

The agenda will include: (1) Welcome, Introductory and Administrative Remarks; (2) Review of Meeting Agenda; (3) Review Summary of Previous Meeting; (4) Receive report on the deliberations of Working Group 1 (Data Needs); (5) Receive report on the deliberations of Working Group 2 (Technology); (6) Other Business; (7) Establish Agenda for Next Meeting; (8) Date and Location of Next Meeting; (9) Closing.

Attendance is open to the interested public but limited to space availability. With the approval of the chairman, members of the public may present oral statements at the meeting. Persons wishing to present statements, obtain information or pre-register for the committee should contact the RTCA Secretariat, 1140 Connecticut Avenue, NW., Suite 1020, Washington, DC 20036; (202) 833–9339 (phone); (202) 833–9434 (fax). Members of the public may present a written statement to the committee at any time.

Issued in Washington, DC, on October 23, 2000.

Janice L. Peters,

Designated Official.

[FR Doc. 00–28300 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Rule on Application 00–02–C–00–DEN To Impose and Use the Revenue From a Passenger Facility Charge (PFC) at Denver International Airport, Submitted by the City and County of Denver, Denver International Airport, Denver, CO

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of intent to rule on application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose and use PFC revenue at Denver International Airport under the provisions of 49 U.S.C. 40117 and Part 158 of the Federal Aviation Regulations (14 CFR part 158).

DATES: Comments must be received on or before December 4, 2000.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate to the FAA at the following address: Mr. Alan Wiechmann, Manager; Denver Airports District Office, DEN–ADO; Federal Aviation Administration, 26805 E. 58th Avenue, Suite 224, Denver, Colorado 80249–6361.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Mr. Bruce Baumgartner, Manager of Aviation, at the following address: Denver International Airport, Maintenance and Engineering Department, Airport Office Building, 10th Floor, 8500 Pena Boulevard, Denver, Colorado 80249–6340.

Air Carriers and foreign air carriers may submit copies of written comments previously provided to Denver International Airport, under section 158.23 of part 158.

FOR FURTHER INFORMATION CONTACT: Mr. Chris Schaffer, (303) 342–1258, Denver Airports District Office, DEN–ADO; Federal Aviation Administration, 26805 E. 68th Avenue, Suite 224, Denver, Colorado 80249–6361. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application 00–02–C–00–DEN to impose and use PFC revenue at Denver International Airport, under the provisions of 49 U.S.C. 40117 and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On October 20, 2000, the FAA determined that the application to impose and use the revenue from a PFC

submitted by the City and County of Denver, Denver International Airport, Denver, Colorado, was substantially complete with the requirements of section 158.25 of part 158. The FAA will approve or disapproved the application, in whole or in part, no later than January 18, 2001.

The following is a brief overview of the application.

Level of the proposed PFC: $4.50.

Proposed charge-effective date: April 1, 2001.

Proposed charge-expiration date: October 31, 2008.

Total requested for approval: $223,572,000.

Brief description of proposed project: Impose and use: Runway 16R/34L completion; Industrial waste containment facilities; AGTS maintenance facility expansion; Construction of taxiway ''EA''; Terminal mod 3E build-out—Public and non-exclusive systems; Construction of C–2 deicing pad; Impose only: Industrial waste management system—cargo area connection; Taxiway ''L'' (AA–EE) grading, paving, lighting and marking; CTAS center-terminal automated system; Concourse ''A'' east deicing/penalty box; Concourse ''A'' expansion—public areas; Common use terminal equipment; AGTS—new cars; Six additional gates.

Class or classes of air carriers which the public agency has requested not be required to collect PFC's: Dedicated air ambulance services.

Any person may inspect the application in person at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT** and at the FAA Regional Airports Office located at: Federal Aviation Administration, Northwest Mountain Region, Airports Division, ANM–600, 1601 Lind Avenue, SW., Suite 315, Renton, WA 98055–4056.

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at Denver International Airport.

Issued in Renton, Washington on October 20, 2000.

David A. Field,

Manager, Planning, Programming and Capacity Branch, Northwest Mountain Region.

[FR Doc. 00–28298 Filed 11–02–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Rule on Application To Impose and Use the Revenue From a Passenger Facility Charge (PFC) at Fort Lauderdale Hollywood International Airport, Fort Lauderdale, FL

AGENCY: Federal Aviation Administration (FAA), DOT.

ACTION: Notice of intent to rule on application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Fort Lauderdale Hollywood International Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Public Law 101–508) and Part 158 of the Federal Aviation Regulations (14 CFR part 158).

DATES: Comments must be received on or before December 4, 2000.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate to the FAA at the following address: Orlando Airports District Office, 5950 Hazeltine National Drive, Suite 400, Orlando, FL 32822.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Ms. Marjan Mazza, MBA, Assistant to the Aviation Director of the Broward County Aviation Department at the following address: 320 Terminal Drive, 3rd floor, Fort Lauderdale, FL 33315.

Air carriers and foreign air carriers may submit copies of written comments previously provided to the Broward County Aviation Department under section 158.23 of part 158.

FOR FURTHER INFORMATION CONTACT: Jennifer Ganley, P.E., Program Manager, Orlando Airports District Office, 5950 Hazeltine National Drive, Suite 400, Orlando, FL 32822, (407) 812–6331, ext. 25. The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Fort Lauderdale Hollywood International Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Public Law 101–508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On October 26, 2000, the FAA determined that the application to impose and use the revenue from a PFC submitted by Broward County Aviation Department was substantially complete within the requirements of section 158.25 of Part 158. The FAA will approve or disapprove the application, in whole or in part, no later than February 13, 2001.

The following is a brief overview of the application.

PFC Application No.: 01–03–C–00–FLL.

Level of the proposed PFC: $3.00.

Proposed charge effective date: 11/01/07.

Proposed charge expiration date: 03/01/09.

Total estimated net PFC revenue: $27,841,586.

Brief description of proposed project(s):

Construct Concourse B
Construct Concourse B apron

Class or classes of air carriers which the public agency has requested not be required to collect PFCs: Air taxis and commercial operators filing FAA Form 1800–31.

Any person may inspect the application in person at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT.**

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at the Broward County Aviation Department.

Issued in Orlando, Florida on October 26, 2000.

Miguel Martinez,

Acting Manager, Orlando Airports District Office, Southern Region.

[FR Doc. 00–28296 Filed 11–02–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Notice of Intent To Rule on Application To Impose and Use the Revenue From a Passenger Facility Charge (PFC) at Lafayette Regional Airport, Lafayette, LA

AGENCY: Federal Aviation Administration (FAA), DOT

ACTION: Notice of intent to rule on application.

SUMMARY: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Lafayette Regional Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of

1990) (Pub. L. 101–508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

DATES: Comments must be received on or before December 4, 2000.

ADDRESSES: Comments on this application may be mailed or delivered in triplicate copies to the FAA at the following address: Mr. G. Thomas Wade, Federal Aviation Administration, Southwest Region, Airports Division, Planning and Programming Branch, ASW–611, Fort Worth, Texas 76193–0610.

In addition, one copy of any comments submitted to the FAA must be mailed or delivered to Gregory Roberts, Director of Aviation for Lafayette Regional Airport at the following address: Mr. Gregory Roberts, Director of Aviation, Lafayette Airport Commission, 200 Terminal Drive, Lafayette, LA 70508–2159.

Air carriers and foreign air carriers may submit copies of the written comments previously provided to the Airport under section 158.23 of Part 158.

FOR FURTHER INFORMATION CONTACT: Mr. G. Thomas Wade, Federal Aviation Administration, Southwest Region, Airports Division, Planning and Programming Branch, ASW–611, Fort Worth, Texas 76193–0610, (817) 222–5613.

The application may be reviewed in person at this same location.

SUPPLEMENTARY INFORMATION: The FAA proposes to rule and invites public comment on the application to impose and use the revenue from a PFC at Lafayette Regional Airport under the provisions of the Aviation Safety and Capacity Expansion Act of 1990 (Title IX of the Omnibus Budget Reconciliation Act of 1990) (Public Law 101–508) and part 158 of the Federal Aviation Regulations (14 CFR part 158).

On October 5, 2000 the FAA determined that the application to impose and use the revenue from a PFC submitted by the Airport was substantially complete within the requirements of section 158.25 of Part 158. The FAA will approve or disapprove the application, in the whole or in part, no later than January 30, 2001.

The following is a brief overview of the application.

Level of the proposed PFC: $3.00.

Proposed charge effective date: April 1, 2001.

Proposed charge expiration date: February 1, 2004.

Total estimated PFC revenue: $2,323,000.

PFC application number: 01–03–C–00–LFT.

Brief description of proposed project(s):

Projects To Impose and Use PFC's

1. Taxiway L, Widening and Rehabilitation.

2. PFC Application Preparation and Administration.

Proposed class or classes of air carriers to be exempted from collecting PFC's: FAR Part 135 on demand air Taxi/Commercial Operator (ATCO) reporting on FAA Form 1800–31.

Any person may inspect the application in person at the FAA office listed above under **FOR FURTHER INFORMATION CONTACT** and at the FAA regional Airports office located at: Federal Aviation Administration, Southwest Region, Airports Division, Planning and Programming Branch, ASW–610, 2601 Meacham Blvd., Fort Worth, Texas 76137–4298.

In addition, any person may, upon request, inspect the application, notice and other documents germane to the application in person at Lafayette Regional Airport.

Issued in Fort Worth, Texas on October 5, 2000.

William J. Flanagan,

Manager, Airports Division.

[FR Doc. 00–27751 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–13–M

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2000–7918]

Qualification of Drivers; Exemption Applications; Vision

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of applications for exemption from the vision standard; request for comments.

SUMMARY: This notice announces the FMCSA's receipt of applications from 65 individuals for an exemption from the vision requirements in the Federal Motor Carrier Safety Regulations (FMCSRs). If granted, the exemptions will enable these individuals to qualify as drivers of commercial motor vehicles (CMVs) in interstate commerce without meeting the vision standard prescribed in 49 CFR 391.41(b)(10).

DATES: Comments must be received on or before December 4, 2000.

ADDRESSES: Mail or hand deliver comments to the U.S. Department of Transportation, Dockets Management Facility, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590, or submit electronically at *http://dmses.dot.gov/submit.* All comments received will be available for examination and copying at the above address from 9 a.m. to 5 p.m., e.t., Monday through Friday, except Federal holidays. Those desiring notification of receipt of comments must include a self-addressed, stamped postcard or you may print the acknowledgment page that appears after submitting comments electronically.

FOR FURTHER INFORMATION CONTACT: For information about the vision exemptions in this notice, Ms. Sandra Zywokarte, Office of Bus and Truck Standards and Operations, (202) 366–2987; for information about legal issues related to this notice, Mr. Joe Solomey, Office of the Chief Counsel, (202) 366–1374, FMCSA, Department of Transportation, 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:

Electronic Access and Filing

You may submit or retrieve comments online through the Document Management System (DMS) at: *http://dmses.dot.gov/submit.* Acceptable formats include: MS Word (versions 95 to 97), MS Word for Mac (versions 6 to 8), Rich Text File (RTF), American Standard Code Information Interchange (ASCII)(TXT), Portable Document Format (PDF), and WordPerfect (versions 7 to 8). The DMS is available 24 hours each day, 365 days each year. Electronic submission and retrieval help and guidelines are available under the help section of the web site.

An electronic copy of this document may also be downloaded by using a computer, modem and suitable communications software from the Government Printing Office's Electronic Bulletin Board Service at (202) 512–1661. Internet users may also reach the office of the Federal Register's home page at: http://www.nara.gov/fedreg and the Government Printing Office's database at: http://www.access.gpo.gov/nara.

Background

Sixty-five individuals have requested an exemption from the vision requirement in 49 CFR 391.41(b)(10), which applies to drivers of CMVs in interstate commerce. Under 49 U.S.C. 31315 and 31136(e), the FMCSA may grant an exemption for a renewable 2-

year period if it finds ''such exemption would likely achieve a level of safety that is equivalent to, or greater than, the level that would be achieved absent such exemption.'' Accordingly, the agency will evaluate the qualifications of each applicant to determine whether granting the exemptions will achieve the required level of safety.

Qualifications of Applicants

1. Henry Ammons, Jr.

Mr. Ammons, age 52, has had amblyopia in his right eye since childhood. His best corrected visual acuity is 20/20 in his left eye and 20/200 in his right eye. Mr. Ammons was examined in 2000, and his optometrist stated, ''In my opinion, this man has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' In his application, Mr. Ammons reported that he has driven straight trucks for 1 year, accumulating 30,000 miles, and tractor-trailer combination vehicles for 31 years, accumulating 3.1 million miles. He holds a Washington Class A commercial driver's license (CDL). His official driving record for the last 3 years shows no accidents and one speeding violation in a CMV. He exceeded the speed limit by 10 mph.

2. Wayne A. Anderson

Mr. Anderson, 52, has amblyopia in his left eye. His best corrected visual acuity is 20/20 in his right eye and 20/100 in his left eye. Mr. Anderson was examined in 1999, and his ophthalmologist stated, ''I think his level of vision at this stage is sufficient to operate [a] commercial vehicle.'' Mr. Anderson stated that he has driven tractor-trailer combinations for 33 years, accumulating 2.6 million miles. He holds a Manitoba, Canada Class 1 license. His official driving record for the last 3 years shows no accidents and no convictions for moving violations in a CMV.

3. Glenn A. Babcock, Jr.

Mr. Babcock, 64, has a partial thickness hole at the left macula due to injury at age 4 or 5. The visual acuity of his right eye is 20/15–1 best-corrected, and of his left eye, 20/80 not correctable. His optometrist examined him in 1999, and stated, ''I believe that Mr. Glen Babcock, Jr has sufficient vision to perform the tasks required to operate a commercial motor vehicle.'' Mr. Babcock reported that he has driven straight trucks for 15 years and 30,000 miles; tractor-trailer combinations for 35 years and 2.1 million miles; and buses for 5 years and 15,000 miles. He holds a Wisconsin Class ABC CDL, and has no accidents or convictions for moving violations in a CMV on his driving record for the last 3 years.

4. Bobby J. Beall

Mr. Beall, 28, is aphakic in his left eye as a result of treatment for injuries sustained in 1994. His visual acuity is 20/20+ in the right eye, and 20/400 in the left eye. His optometrist examined him in 2000 and stated, ''In my opinion, you have sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Beall reported that he has driven straight trucks for the last 10 years, accumulating 100,000 miles, and tractor-trailer combination vehicles for the last 6 years, accumulating 90,000 miles. He holds a Class A CDL from Missouri and has no accidents or convictions for moving violations in a CMV on his driving record for the past 3 years.

5. Robert D. Bonner

Mr. Bonner, 51, has amblyopia in his right eye. His visual acuity in his left eye is 20/20 and in his right eye 20/200 best-corrected. He was examined in 2000, and his ophthalmologist stated, ''I certify that he has sufficient vision to perform driving tasks and to operate a commercial vehicle.'' Mr. Bonner stated that he has driven tractor-trailer combination vehicles for 19 years, accumulating 790,000 miles. He holds a Washington Class A CDL. His official driving record shows no accidents and no moving violations in a CMV in the last 3 years.

6. James F. Bower

Mr. Bower, 62, has amblyopia in his right eye. His best-corrected visual acuity is 20/20 in the left eye and 20/200 in the right eye. In 2000 his optometrist examined him and affirmed, ''In my medical opinion, Jim Bower has sufficient vision to perform the normal driving tasks required to operate a commercial vehicle.'' Mr. Bower submitted that he has 25 years experience driving tractor-trailer combinations over 3 million miles, and 46 years driving straight trucks over 46,000 miles. He holds a Class A CDL from Wyoming. His driving record for the last 3 years has no accidents or convictions for moving violations in a CMV.

7. Ben T. Brown

Mr. Brown, 50, has congenital esotropia of the left eye. His best-corrected visual acuity is 20/20 in his right eye and 20/200 in his left eye. He was examined in 1999 and his optometrist stated, ''I feel that this patient can perform his duties as a commercial driver without difficulty. He has sufficient vision to be a safe driver.'' Mr. Brown reported that he has driven straight trucks for 5 years, accumulating 35,000 miles, and tractor-trailer combinations for 19 years, accumulating 855,000 miles. He holds a California Class A CDL and has no accidents or citations for moving violations in a CMV on his driving record for the past 3 years.

8. Terry L. Burgess

Mr. Burgess, 51, wears a prosthesis due to enucleation following a motor vehicle accident in the early 1970's. His corrected vision in the right eye is 20/25. An optometrist examined him in 2000 and stated, ''Given the nature of the injury to the left eye I have concluded that Mr. Burgess' visual deficit is quite stable and is not degenerative. Thus, he is able to perform sufficiently while operating a commercial vehicle.'' Mr. Burgess stated that he has 3 years of experience driving tractor-trailers, totaling 63,000 miles. He holds a Michigan Type CA CDL and has had no accidents or moving violations in a CMV for the past 3 years.

9. William A. Burgoyne

Mr. Burgoyne, 61, has amblyopia in his right eye. His visual acuity is 20/15 best-corrected in the left eye and 20/400 in the left eye. Mr. Burgoyne was examined in 1999 and his optometrist stated, ''For the past 19 years we have insisted that Mr. Burgoyne has the visual ability to drive any over the road vehicle. He should be allowed to continue his occupation as a truck driver.'' Mr. Burgoyne stated that he has 20 years of experience driving straight trucks, accumulating 3 million miles, and 10 years of experience driving tractor-trailer combinations, accumulating 1.5 million miles. He holds a Michigan Class A NT CDL, and his driving record for the last 3 years contains no accidents and no convictions for moving violations in a CMV.

10. David S. Carman

Mr. Carman, 37, has a large dense scar in the retina of his left eye due to a childhood infection. His visual acuity is 20/15 in his right eye and 20/200 best-corrected in his left eye. His optometrist examined him in 1999 and stated, ''In my professional opinion, David Carman has vision sufficient to operate a commercial vehicle.'' Mr. Carman reported that he has driven straight trucks for 16 years totaling 320,000 miles. He holds a New Jersey Class B CDL, and his driving record for the last

3 years shows no accidents and one conviction for a moving violation in a CMV for ''Failure to Obey Directional Signal.''

11. Dennis J. Christensen

Mr. Christensen, 59, has had amblyopia resulting from anisometropia since birth. His best corrected vision is 20/20 in his left eye and 20/70 in his right eye. Following a 1999 examination, his optometrist stated, ''It is my impression that Mr. Christensen has the visual performance to safely operate a commercial vehicle. There are no medical conditions that could compromise his visual performance or visual fields.'' Mr. Christensen reported that he has driven tractor-trailer combinations for 3 years, accumulating 300,000 miles. He holds a Minnesota Class A CDL and has had no accidents or convictions for moving violations in a CMV for the past 3 years.

12. David L. Davis

Mr. Davis, 41, has amblyopia in his right eye. His corrected visual acuities are 20/60 in his right eye and 20/20 in his left. Following a 2000 examination, his optometrist commented, ''Because Mr. Davis' vision is 20/20 with both eyes open and his visual fields appear to be very good, it is my opinion, according to the findings in my exam, that Mr. Davis has sufficient vision to perform driving tasks required to operate a commercial vehicle.'' According to Mr. Davis, he has operated straight trucks for 21 years, accumulating 966,000 miles. A holder of a Class AM CDL from Georgia, he has no accidents or citations for moving violations in a CMV for the last 3 years.

13. Darrell B. Dean

Mr. Dean, 35, is blind in his left eye due to congenital cataracts with apparent glaucoma. His best-corrected vision in the right eye is 20/30. An ophthalmologist examined him in 1999 and stated, ''From a visual standpoint, he is able to drive a commercial vehicle.'' Mr. Dean reported that he has driven straight trucks for 2 years and for 4,000 miles, and tractor-trailer combinations 12 years for 1.8 million miles. He holds an Oklahoma Class A CDL and has had no CMV accidents or convictions for moving violations for the past 3 years.

14. Don W. Dotson

Mr. Dotson, 45, has amblyopia in his left eye. His visual acuity is 20/20 best-corrected in the right eye and 20/200 in the left eye. Following a 1999 examination, his ophthalmologist stated, ''I feel that Mr. Dotson is safe to perform commercial driving tasks and to operate a commercial vehicle.'' Mr. Dotson reports that he has operated straight trucks for 5 years, accumulating 157,000 miles, and tractor-trailer combinations for 8 years, accumulating 326,000 miles. He holds a Texas Class A CDL and has no accidents or convictions for moving violations in a CMV on his driving record for the last 3 years.

15. Terrance D. Faust

Mr. Faust, 35, has amblyopia in his right eye. The visual acuity uncorrected in the right eye is 20/60, and in the left eye 20/20. An ophthalmologist examined Mr. Faust in 2000 and affirmed, ''It is my medical opinion that you have sufficient visual ability to perform the driving tasks required to operate a commercial vehicle.'' According to Mr. Faust's application, he has driven 900,000 miles in straight trucks over 17 years, and 65,000 miles in tractor-trailer combination vehicles over 13 years. He holds a Class ABCDM CDL from Wisconsin. In the last 3 years he has had no accidents or convictions for moving violations in a CMV on his driving record.

16. Edgar E. French

Mr. French, 48, lost his right eye due to trauma approximately 15 years ago. The uncorrected visual acuity in his left eye is 20/20. As the result of an examination in 2000, his optometrist concluded, ''As was written in my letter dated 7/17/00, the exam results for the left eye of Mr. Edgar French, in my opinion, do indicate that he can safely operate a commercial vehicle.'' Mr. French reports that he has 15 years and 945,000 miles of experience operating straight trucks. He holds a Class B CDL from Virginia, and there are no accidents or convictions for moving violations in a CMV on his driving record for the last 3 years.

17. Glen T. Garrabrant

Mr. Garrabrant, 38, wears a prosthetic right eye due to ocular trauma in 1989. His visual acuity is 20/20 in his left eye. Following a 1999 examination his ophthalmologist stated, ''In my opinion I feel that this patient has sufficient vision to perform any driving task required to operate a commercial vehicle.'' Mr. Garrabrant reported that he has driven straight trucks for 19 years totaling 1.2 million miles and tractor-trailer combination vehicles for 17 years totaling 1.4 million miles. He holds a New Jersey Class A CDL, and his official driving record shows no CMV accidents or convictions for moving violations during the last 3 years.

18. Doyle G. Gibson

Mr. Gibson, 50, has amblyopia in his right eye. His visual acuity, best-corrected, is 20/70 in the right eye and 20/15 in the left eye. Following a 1999 examination, his ophthalmologist stated, ''I am not an expert on the requirements for operating a commercial vehicle. However, based on Mr. Gibson's successful record of driving with his current vision, I see no contraindication to continuing in his current capacity.'' Mr. Gibson reported that he has driven straight trucks and tractor-trailer combination vehicles for 30 years each, totaling 2.4 million miles driving straight trucks and 1.5 million miles driving tractor-trailer combination vehicles. He holds a Texas Class AM CDL, and his official driving record shows no CMV accidents or moving violations in the last 3 years.

19. Elias Gomez, Jr.

Mr. Gomez, 28, has amblyopia in his right eye. His visual acuity is 20/20 in his left eye and 20/200 best-corrected in his right eye. Following a 1999 examination, his ophthalmologist stated, ''In my medical opinion, he has adequate vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Gomez stated that he has operated tractor-trailer combination vehicles for 3 years and a total of 360,000 miles. He holds a Texas Class A CDL, and his official driving record shows no accidents and one conviction for a moving violation in a CMV for ''Fail to Yield Right-of-Way'' over the last 3 years.

20. Jose E. Gonzalez

Mr. Gonzalez, 36, has amblyopia in his left eye. An eye exam in 1999 showed that the visual acuity in his right eye is 20/20, and in the left eye 20/200. As a result of the examination, his opthalmologist stated, ''It is my opinion that Mr. Gonzalez has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' According to Mr. Gonzalez' application, he has driven straight trucks and tractor-trailer combinations for 15 years, accumulating 75,000 miles in the former and 1.2 million miles in the latter. He holds a Class AM CDL from Texas. In the last 3 years his driving record shows one accident in a CMV and one conviction for speeding in a CMV. The other driver was charged in the accident for ''[f]ailed to control speed.'' He received the ticket on a separate occasion for exceeding the speed limit by 15 mph.

21. Anthony Grant

Mr. Grant, 37, has decreased vision in his left eye due to an accident in 1992. He was examined in 1999, and his optometrist found visual acuity to be 20/20 corrected in the right eye and 20/400 in the left eye. His optometrist stated, ''In my opinion Mr. Grant should be able to drive a commercial vehicle.'' Mr. Grant reported that he has driven straight trucks for 7 years and 400,000 miles; tractor-trailer combination vehicles for 3 years and 78,000 miles; and buses for 2 years and 46,000 miles. He holds an Alabama Class D driver's license and has had no convictions for moving violations or accidents in a CMV during the last 3 years.

22. Joseph M. Graveline

Mr. Graveline, 35, has optic atrophy in his right eye due to an eye injury at age 13. His vision in the left eye is 20/20 and in the right eye 20/60. He was examined in 2000, and his optometrist stated, ''I believe that Mr. Graveline has sufficient vision to perform driving tasks required to operate a commercial vehicle.'' Mr. Graveline reported that he has 4 years and 48,000 miles of experience driving straight trucks. He holds a Connecticut Class A CDL and has had no CMV accidents or convictions for moving violations for the past 3 years.

23. Johnny C. Hall

Mr. Hall, 48, had his left eye enucleated at age 7, after a penetrating injury to the eye. The visual acuity of his right eye is 20/20 without correction. The ophthalmologist who examined him in 2000 stated, ''In my opinion, Mr. Hall has adequate vision to perform the driving tasks required to operate a commercial vehicle.'' According to his application, he has 20 years and 2.5 million miles experience operating tractor-trailer combinations, and 2 years and 250,000 miles experience operating straight trucks. He has a Florida Class A CDL, and there are no accidents or convictions for moving violations in a CMV on his driving record for the last 3 years.

24. William N. Hicks

Mr. Hicks, 56, wears a prosthetic right eye due to an injury at age 2. He sees 20/25 out of his left eye. An ophthalmologist examined him in 2000 and stated, ''I feel that he has sufficient vision in his left eye to meet the conditions for consideration for an exemption under controlling authority to drive a commercial vehicle.'' Mr. Hicks stated that he has 34 years of experience driving tractor-trailer combinations with 3.2 million miles driven. He holds a Texas Class A CDL and has had no accidents and two speeding convictions in a CMV during the past 3 years. Mr. Hicks exceeded the speed limit by 11 mph in one ticket and 8 mph in the other.

25. Robert K. Hodge

Mr. Hodge, 43, has had light perception only in his right eye since age 5 due to an injury. His optometrist examined him in 2000 and stated, ''I certify, in my opinion, that Kent Hodge has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Hodge declared in his application that he has driven straight trucks for 6 years accumulating 72,000 miles, and tractor-trailer combinations for 9 years accumulating 900,000 miles. He holds a Mississippi Class A CDL. During the last 3 years his driving record shows that he has had no accidents or convictions for moving violations in a CMV.

26. William G. Holland

Mr. Holland, 51, has worn a prosthetic left eye for 12 years due to an injury. His visual acuity is 20/15 in his right eye. Following a 2000 examination, his optometrist stated, ''It is my medical opinion that Mr. William Holland has vision sufficient to enable him to operate a commercial vehicle.'' Mr. Holland reported that he has driven tractor-trailer combination vehicles for 30 years and 3 million miles, and straight trucks for 5 years and 175,000 miles. He holds a California Class A CDL, and his official driving record shows no accidents or convictions for moving violations in a CMV for the past 3 years.

27. John R. Hughes

Mr. Hughes, 58, wears a left prosthesis due to an accident in 1956. The corrected visual acuity in his right eye is 20/20. An optometrist examined him in 2000, and stated, ''I certify that in my medical opinion that John Hughes has sufficient vision to operate a commercial vehicle.'' Mr. Hughes reported that he has driven 350,000 miles during 7 years in a tractor-trailer, and 50,000 miles during one year in a straight truck. His Class AM CDL is from New York, and his driving record shows no accidents or convictions for moving violations in a CMV for the last 3 years.

28. Frank Inigarida

Mr. Inigarida, 59, has strabismic amblyopia in his right eye. The best-corrected visual acuity of his left eye is 20/20 and his right eye 20/60. Following a 1999 examination, his ophthalmologist certified, ''In my medical opinion Mr. Inigarida is able to operate a commercial vehicle while wearing his glasses.'' According to Mr. Inigarida's application, he has driven straight trucks for 14 years, accumulating 420,000 miles, and tractor-trailer combination vehicles for 28 years, accumulating 1.4 million miles. He holds a Nevada Class A CDL. His official driving record shows no CMV accidents or convictions for moving violations in the last 3 years.

29. Alan L. Johnston

Mr. Johnston, 27, has occlusional amblyopia in his left eye. His visual acuity is 20/20 in the right eye and 20/400 corrected in the left eye. His optomestrist examined him in 1999, and noted, ''P[atien]t sees well enough to operate a commercial vehicle.'' Mr. Johnston submitted that he has driven 10,000 miles and has 10 years' experience operating a straight truck, and has driven 180,000 miles and has 6 years' experience operating a tractor-trailer combination. He holds a Class A CDL from Illinois, and for the last 3 years his driving record shows that he has had no accidents or convictions for moving violations in a CMV.

30. David O. Kaiser, Sr.

Mr. Kaiser, 44, has anisometropic amblyopia in his right eye. Best-corrected visual acuity in the right eye is 20/400, and the left eye is 20/20 uncorrected. An optometrist examined him in 1999 and stated, ''In my medical opinion, Mr. Kaiser, has a stable condition that is longstanding and will not interfere in his driving ability of a commercial vehicle.'' Mr. Kaiser stated that he has 23 years of experience driving tractor-trailer combinations with 1.1 million miles driven. He holds a Virginia Class B CDL and has had no accidents or convictions for moving violations in a CMV for the past 3 years.

31. Milena Kekerovic

Ms. Kekerovic, 47, has amblyopia in her left eye. The visual acuity of her right eye is 20/20 and of her left eye 20/200 without correction. Following an examination in 1999, her ophthalmologist affirmed, ''Ms. Kekerovic has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Ms. Kekerovic submitted that she has driven tractor-trailer combinations for 16 years accumulating 1.9 million miles; and buses for 5 years accumulating 400,000 miles. A holder of a Class A CDL from Nevada, she has no accidents or convictions for moving violations in a CMV on her driving record for the last 3 years.

32. Mark J. Koscinski

Mr. Koscinski, 49, has a congenital retinal coloboma of the left eye. His visual acuity is 20/20 in the right eye and 20/400 in the left eye. An optometrist who examined him in 2000, stated, ''I certify in my medical opinion that Mark Koscinski has sufficient vision to perform all driving tasks required to operate a commercial vehicle.'' Mr. Koscinski submitted that he has driven 450,000 miles and has 9 years' experience driving tractor-trailer combinations, and has driven 75,000 miles with 5 years' experience driving straight trucks. He holds a Nevada Class A CDL and has no accidents or convictions for moving violations in a CMV on his driving record for the last 3 years.

33. John N. Lanning

Mr. Lanning, 41, has an amblyopic right eye with light perception only. His left eye is correctable to 20/25. An optometrist examined him in 2000 and stated, ''As of his last eye exam in January 2000 his vision has remained stable and has not affected his ability to continue to perform his driving tasks operating a commercial vehicle.'' Mr. Lanning, who stated that he has driven tractor-trailers for 10 years and 1 million miles, has no accidents or convictions on his driving record for moving violations in a CMV during the last 3 years. He holds a California Class A CDL.

34. Robert C. Leathers

Mr. Leathers, 43, has light perception only in his left eye due to a traumatic injury in 1972. The best-corrected vision in his right eye is 20/20. Following a 1999 examination, his optometrist stated, ''In my opinion, Mr. Leathers has been performing driving tasks with the same vision for twenty-seven years. This is evidence that he has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Leathers reported that he has driven tractor-trailer combination vehicles for 24 years and 691,000 miles, and straight trucks for 20 years and 70,000 miles. He holds a Missouri Class A CDL, and his official driving record shows no accidents or convictions for moving violations in a CMV for the past 3 years.

35. Richard L. Leonard

Mr. Leonard, 56, has amblyopia and esotropia in his left eye. In his right eye his vision is 20/20 uncorrected, while in his left his vision is 20/400 corrected. He was examined in 2000, and his optometrist certified by checking a box next to the word ''Yes'' after the question, ''Does patient have sufficient vision to operate a commercial vehicle?'' Mr. Leonard submitted that he has driven tractor-trailer combinations for 15 years and 1.1 million miles, and straight trucks for 10 years and 150,000 miles. He holds a Texas Class A CDL. His driving record shows that he had no convictions for moving violations and one accident in a CMV in the last 3 years. He was not charged in the accident; the other driver was charged with ''Failed to Yield ROW'Stop Intersection.''

36. Calvin E. Lloyd

Mr. Lloyd, 37, has amblyopia as a result of esotropia in his left eye. His best-corrected vision is 20/20 in his right eye and 20/200 in his left. Following a 2000 examination, his ophthalmologist certified, ''Mr. Lloyd has been driving commercially for a number of years without incident. His good eye is corrected to 20/20 and he has very good peripheral vision in his amblyopic eye. These facts lead me to believe that there is no visual reason why he cannot perform as a commercial driver.'' Mr. Lloyd stated that he has driven straight trucks for 11 years and 330,000 miles, and tractor-trailer combination vehicles for 7 years and 420,000 miles. He holds a Tennessee Class AM CDL, and he has had no CMV accidents or convictions for moving violations in the past 3 years.

37. Roy E. Mathews

Mr. Mathews, 43, lost his right eye due to trauma in 1993. The best-corrected visual acuity of his left eye is 20/20. Following a 1999 examination, his ophthalmologist certified, ''Mr. Mathews meets the credentials for a commercial drivers license and currently holds a commercial driver's license. So in my opinion he has sufficient vision to perform the driving task to operate a commercial vehicle.''

Mr. Mathews states that he has driven tractor-trailer combination vehicles for 3 years, accumulating 324,000 miles. He holds a Florida Class A CDL. His official driving record shows no CMV accidents or convictions for moving violations in the last 3 years.

38. Jason B. Mazyck

Mr. Mazyck is a 27-year-old man whose left eye was diagnosed with amblyopia exanopsia, small angle esotropia, posterior staphyloma, and high myopic astigmatism present since birth. His corrected visual acuity is 20/20 in the right eye, and 20/200 in the left eye. An optometrist examined him in 1999 and reported, ''In my opinion, Jason's visual system with the improved horizontal field of vision to the left from the contact lens is excellent for safe driving and operating a commercial vehicle.'' Mr. Mazyck has a Class D South Carolina driver's license. He stated that he has operated straight trucks for 4 years, accumulating 100,000 miles. His official State driving record shows no accidents or citations for moving violations in a CMV for the past 3 years.

39. William F. McCandless, Jr.

Mr. McCandless, 40, has amblyopia in his left eye. His best-corrected vision is 20/20 in his right eye and light perception only in his left. Following a 1999 examination, his optometrist stated, ''His current vision is adequate for semi-tractor trailer driving.'' Mr. McCandless reported that he has accumulated 240,000 miles during 16 years of driving tractor-trailer combination vehicles. He holds a Florida Class A CDL. His official State driving record reveals no accidents or citations for moving violations in a CMV for the past 3 years.

40. James T. McGraw Jr.

Mr. McGraw, 42, has refractive amblyopia of the left eye. His visual acuity is 20/20 in the right eye and 20/200 in the left eye. An optometrist examined him in 1999 and stated, ''It is clear that James T. McGraw, Jr. has sufficient vision to continue to perform the driving tasks required for a commercial vehicle.'' Mr. McGraw stated that he has driven straight trucks 1.1 million miles in 23 years and tractor-trailer combinations 1.1 million miles in 19 years. He holds a Pennsylvania Class A CDL and has had no CMV accidents or convictions for moving violations for the past 3 years.

41. Luther A. McKinney

Mr. McKinney, 44, has amblyopia in his left eye. His vision is 20/20 in the right eye and 20/200 in the left eye. According to a 2000 examination report, Mr. McKinney's optometrist stated, ''With consideration to the results of today's examination, I would conclude that the patient has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. McKinney reported that he has driven tractor-trailer combination vehicles for 21 years and a total of 2.5 million miles. He holds a Virginia Class A CDL. His official driving record shows no accidents or convictions for moving violations in a CMV during the last 3 years.

42. Jose L. Melendez

Mr. Melendez, 57, has a macular scar in his right eye due to an injury at the

age of 16. His visual acuity in his left eye is 20/20 and 20/400 in the right. An ophthalmologist examined him in 1999 and stated, ''He is visually capable of operating a commercial vehicle, and was also found to be within the State of Illinois requirements of vision to legally drive.'' Mr. Melendez reported that he has 5 years of experience driving straight trucks totaling 135,000 miles. He holds an Illinois Class A CDL and has had no CMV accidents or convictions for moving violations for the past 3 years.

43. Carl A. Michel, Sr.

Mr. Michel, 59, has amblyopia in the right eye. His best-corrected visual acuity is 20/20 in his left eye and 20/100 in his right eye. He was examined in 1999, and his ophthalmologist stated, ''In my opinion the above person [Carl A. Michel] has sufficient vision to perform driving tasks required to operate a commercial vehicle.'' Mr. Michel stated that he has accumulated 4.2 million miles driving straight trucks for 42 years; 2.3 million miles driving tractor-trailer combination vehicles for 30 years; and 30,000 miles driving buses for 30 years. He holds a Maryland Class A CDL. For the past 3 years he has had no accidents or moving violations in a CMV.

44. Clarence M. Miles, Jr.

Mr. Miles, 41, has optic nerve atrophy of the right eye due to an accident at 5 years of age. He has no vision in that eye and 20/20 uncorrected in his other eye. The optometrist who examined him in 1999 stated, ''In my medical opinion, this patient has sufficient vision to operate a commercial vehicle.'' Mr. Miles states that he has 8 years and 240,000 miles of experience driving straight trucks, and 3 years and 75,000 miles of experience driving tractor-trailer combinations. He holds an Oklahoma Class A CDL, and his driving record for the last 3 years shows no accidents or citations for moving violations in a CMV.

45. Robert A. Moss

Mr. Moss, 34, has amblyopia exanopsia in the left eye. Corrected visual acuities are 20/20 in the right eye and 20/200 in the left. His optometrist examined him in 2000 and determined, ''There is no indication that Mr. Moss has insufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Moss stated that he has driven tractor-trailers for 12 years, accumulating 1.2 million miles, and straight trucks for one-half year, accumulating 10,000 miles. He has a Missouri Class A CDL and has a driving record free of convictions for moving violations and accidents in a CMV for the last 3 years.

46. Robert A. Murphy

Since 1980, Mr. Murphy, 54, has had scar tissue on his left eye due to an accident. His best-corrected visual acuity is 20/20 in his right eye and 20/70 in his left eye. In a 2000 examination, his ophthalmologist stated, ''In my medical opinion Mr. Murphy has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' According to Mr. Murphy's application, he has operated straight trucks and tractor-trailer combination vehicles for 22 years each, accumulating 160,000 miles and 800,000 miles respectively. He holds a Kentucky Class DA CDL, and his official driving record shows no accidents or convictions for moving violations in a CMV for the last 3 years.

47. Dennis I. Nelson

Mr. Nelson, 48, wears a right prosthesis due to an injury received in childhood. His corrected visual acuity in the left eye is 20/15. An optometrist examined him in 2000 and certified, ''In my opinion, Mr. Nelson does have sufficient vision to perform the driving tasks required to operate a commercial vehicle, particularly evidenced by his completely clean driving record for 30 years within the state of Wisconsin using commercial vehicles.'' Mr. Nelson reports that he has 30 years and 450,000 miles of experience each driving tractor-trailer combinations and straight trucks. He holds a Class ABCD CDL from Wisconsin and has no accidents or convictions for moving violations in a CMV on his driving record for the last 3 years.

48. Martin D. Ortiz

Mr. Ortiz, 43, has anisometropic amblyopia in his right eye. His best corrected visual acuity is 20/100 in the right eye and 20/20 in the left eye. Mr. Ortiz was examined in 1999, and his optometrist certified, ''In my medical opinion, he has sufficient vision to perform the driving tasks to operate a commercial vehicle.'' Mr. Ortiz holds a Class A CDL from California, and reported that he has 20 years of experience driving tractor-trailer combination vehicles totaling 1.7 million miles. His driving record has been clear of accidents and convictions of moving violations in a CMV for the past 3 years.

49. John J. Partenio

For the last 30 years, Mr. Partenio, 71, has had a macular scar in his right eye. His corrected visual acuity is 20/20 in the left eye and 20/200 in the right. As the result of a 2000 examination, his optometrist stated, ''Mr. [Partenio] has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Partenio reported that he has 24 years of experience driving school buses and has driven 100,000 miles. He holds a New Jersey Class B CDL and has had no accidents or convictions for moving violations in a CMV for the past 3 years.

50. Henry C. Patton

Mr. Patton, 63, has amblyopia in his left eye. The corrected visual acuity in his right eye is 20/30++ and in his left, 20/200. Following a 2000 examination, Mr. Patton's optometrist stated, ''I further certify, that Mr. Patton, in my medical opinion, has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Patton stated that he has 45 years of experience driving tractor-trailer combination vehicles for a total of 2.7 million miles. He holds a Colorado Class A CDL, and his official driving record shows no accidents or convictions for moving violations in a CMV during the last 3 years.

51. Rance A. Powell

Mr. Powell, 30, has a large macular scar due to an injury in his left eye at age 6. His uncorrected vision in his right eye is 20/20, while his vision in his left eye is hand-motion only. Following a 2000 examination, his optometrist stated, ''In my medical opinion, the vision deficiency in Mr. Powell's left eye is stable. He has excellent vision in his right eye, therefore I feel he has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Powell reported that he has driven straight trucks for 12 years for a total of 180,000 miles. He holds an Alabama Class AMV CDL, and his official driving record shows no accidents and one speeding conviction in a CMV during the last 3 years. He received the ticket for exceeding the speed limit by 11 mph.

52. John W. Purcell

Mr. Purcell, 47, acquired toxoplasmosis in his left eye at age 12. His visual acuity is 20/15 uncorrected in the right eye and 20/400 corrected in the left eye. Mr. Purcell was examined in 2000, and his ophthalmologist certified, ''In my medical opinion, Mr. Purcell has full peripheral vision and has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Purcell stated that he has 20 years and 320,000 miles of

experience operating straight trucks. He holds an Oregon Class C CDL and has had no accidents or convictions for moving violations in a CMV for the past 3 years.

53. Shannon E. Rasmussen

Mr. Rasmussen, 25, has an anisometropia hyperopia that resulted in amblyopia of the left eye. Best-corrected visual acuities measure 20/15–0 in the right eye and 20/50 in the left eye. As the result of a 2000 examination, his optometrist certified, ''In my medical opinion, Shannon does have sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Rasmussen reported that he has driven straight trucks and tractor-trailer combination vehicles for 7 years each, totaling 182,000 miles in the former and 245,000 miles in the latter. He holds a Class A CDL from the State of Wyoming and has no accidents or citations for moving violations in a CMV during the last 3 years.

54. Merlyn L. Rawson

At least 30 years ago, Mr. Rawson, 56, incurred irreversible damage to his left eye. A 2000 examination revealed that his corrected visual acuity is 20/20 in the right eye and 20/400 in the right eye. His optometrist noted, ''Vision sufficient to perform driving tasks to operate a commercial vehicle.'' Mr. Rawson stated that he has 25 years of experience driving tractor-trailers for a total of 3.7 million miles, and 6 years of experience driving straight trucks for a total of 300,000 miles. He holds an Oregon Class A CDL. During the past 3 years he has had one speeding conviction and one accident in a CMV. He was not charged in the accident and exceeded the speed limit by 12 mph in the speeding ticket.

55. Thomas G. Raymond

Mr. Raymond, 39, has refractive amblyopia in his left eye. His uncorrected visual acuity is 20/20 in the right eye and 20/200 in the left. Following an examination in 2000, his optometrist certified, ''In my opinion, Mr. Raymond is fully capable of operating a commercial vehicle.'' Mr. Raymond has driven tractor-trailer combination vehicles 910,000 miles in 6½ years. He holds a Class A CDL from Florida, and his driving record shows no accidents or convictions for moving violations in a CMV in the last 3 years.

56. James R. Rieck

Mr. Rieck, 29, has amblyopia in his left eye. The visual acuity in his right eye uncorrected is 20/15–, and in his left eye corrected, 20/400. His optometrist examined him in 1999 and certified, ''It is my opinion that Mr. Rieck should have no difficulty performing the driving tasks required to operate a commercial vehicle.'' Mr. Rieck has driven tractor-trailer combinations for 4 years, accumulating 144,000 miles, and straight trucks for 9 months, accumulating 14,000 miles. He holds a Class AM1 CDL from California, and his driving record for the last 3 years shows no accidents or convictions for moving violations in a CMV. Although his license was suspended in 1997 for failure to maintain required liability insurance, the State of California set aside (canceled) the action after his insurance company sent proof that he had maintained his insurance.

57. Daniel J. Schaap

Mr. Schaap, 48, has a central scotoma in his left eye due to a toxoplasmosis scar that he has had since early childhood. A 1999 eye exam revealed that his best-corrected visual acuity is 20/20 in the right eye and 20/400 in the left eye. His optometrist stated, ''Since all other aspects of his vision are normal, and since his driving record has been good, I believe he meets the visual requirements to operate a commercial vehicle.'' Mr. Schaap holds a Michigan Class CA CDL. He reported that he has driven tractor-trailer combinations for 27 years and 749,000 miles. His driving record for the past 3 years reflects no convictions for moving violations and two accidents in a CMV. Mr. Schaap was not found at fault in either accident. The other driver was charged in one accident. The other accident resulted when a retread blew on Mr. Schaap's tractor-trailer and pieces of tread hit another vehicle, breaking its windshield. Mr. Schaap was not charged with a violation in this incident.

58. Dennis J. Smith

Mr. Smith, 25, has refractive amblyopia in his right eye. His uncorrected visual acuity is 20/400 with the right eye and 20/20 with the left eye. In 2000, he underwent an examination by an optometrist who stated, ''It is my professional opinion that Mr. Smith has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' According to Mr. Smith, he has driven straight trucks and tractor-trailer combination vehicles for 6 years each, accumulating 78,000 miles in each. He holds a Class A CDL from Colorado, and his driving record shows no accidents or convictions for moving violations in the last 3 years.

59. Garfield A. Smith

Mr. Smith, 52, has anisometropic amblyopia of the left eye. The best-corrected visual acuity is 20/20 in his right eye, and finger counting at 5 feet in his left eye. An optometrist examined him in 2000 and affirmed, ''He does have sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' According to Mr. Smith's application, he has driven straight trucks for 5 years, accumulating 50,000 miles, and tractor-trailer combinations for 30 years, accumulating 3 million miles. He holds a WV Class A CDL, and his driving record is clear of accidents and convictions for moving violations in a CMV during the last 3 years.

60. Gary L. Spelce

Mr. Spelce, 55, has hyperopia with astigmatism; presbyopia; and amblyopia in his left eye. His corrected visual acuity in the right eye is 20/20 and in the left eye, 20/50. Following a 1999 examination, his optometrist stated, ''It is my optometric opinion that Mr. Spelce has sufficient vision to drive a commercial vehicle.'' Mr. Spelce stated that he has driven straight trucks for 20 years and 624,000 miles, and tractor-trailer combination vehicles for 10 years and 1 million miles. He holds a Texas Class AM CDL, and his official driving record shows no accidents or convictions for moving violations in a CMV for the last 3 years.

61. Frederick E. St. John

Mr. St. John is 42 years old and lost his left eye at age 7 due to an accident. His best-corrected vision in the right eye is 20/20. Following a 1999 examination, his optometrist stated, ''In my opinion and in view of the fact that Fred has been driving a truck for 22 years (according to him) safely, Fred has sufficient vision to drive and operate a commercial vehicle.'' According to Mr. St. John, he has 22 years experience driving tractor-trailer trucks totaling 2.6 million miles. He has a Pennsylvania Class A CDL, and his driving record shows no accidents and one conviction for a moving violation of ''FT Obey Sign/Traffic Control Device'' in a CMV for the past 3 years.

62. Daniel R. Viscaya

Mr. Viscaya, 38, has been completely blind in his left eye since birth secondary to amblyopia and a dense post-subcapsular cataract. His right eye sees 20/20 and requires no correction. Subsequent to an examination in 2000, his optometrist certified, ''It is my medical opinion that Mr. Viscaya's visual function is adequate to operate a

commercial vehicle.'' Mr. Viscaya stated that he has driven tractor-trailer combination vehicles for 4½ years, accumulating 567,000 miles. He holds a Class A CDL from North Carolina and has had no accidents or convictions for moving violations in a CMV for the last 3 years, according to his driving record.

63. Michael P. Walsh

Mr. Walsh, 41, is amblyopic in his right eye. His visual acuity with correction is 20/20 in the left eye and 20/200 in the right. He was examined in 2000, and his optometrist certified, ''In my opinion the patient has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Walsh submitted that he has operated straight trucks for 20 years and 1 million miles, and tractor-trailer combinations for 10 years and 520,000 miles. He holds a Class A XT CDL from Michigan. His driving record for the last 3 years shows no convictions for moving violations and one accident in a CMV. He was not charged in the accident. According to the accident report, the other driver crossed the middle double lines on a curve and struck Mr. Walsh's vehicle.

64. Jerry L. Whitefield

Mr. Whitefield, 49, has amblyopia in his left eye. The best-corrected vision in his right eye is 20/15, and in his left eye, 20/70. Following an examination in 2000, his optometrist stated, ''I will certify that his right eye has sufficient vision to perform the driving tasks required to operate a commercial vehicle.'' Mr. Whitefield submitted that he has operated tractor-trailer combination vehicles for 29 years, accumulating 2.9 million miles, and straight trucks for 4 years, accumulating 200,000 miles. He holds a Class A CDL from Oklahoma, and his driving record for the last 3 years contains no accidents or convictions for moving violations in a CMV.

65. Robert E. Wientjes

Mr. Wientjes, 59, has best-corrected vision in the right eye of 20/20 and the left eye 20/400. His left eye has had a central corneal scar since 1985. Following a 2000 examination, his ophthalmologist stated, ''As Mr. Wientjes'' vision has not changed in a number of years, I feel he has sufficient vision to operate a commercial vehicle, which he has done up until now.'' Mr. Wientjes reported that he has driven tractor-trailer combination vehicles for 30 years and a total of 1.1 million miles. He holds a Kentucky Class DA CDL. His driving record for the last 3 years shows no accidents or convictions for moving violations in a CMV.

Request for Comments

In accordance with 49 U.S.C. 31315 and 31136(e), the FMCSA is requesting public comment from all interested persons on the exemption petitions and the matters discussed in this notice. All comments received before the close of business on the closing date indicated above will be considered and will be available for examination in the docket room at the above address. Comments received after the closing date will be filed in the docket and will be considered to the extent practicable, but the FMCSA may publish in the **Federal Register** a notice of final determination at any time after the close of the comment period. In addition to late comments, the FMCSA will also continue to file in the docket relevant information which becomes available after the closing date. Interested persons should continue to examine the docket for new material.

Authority: 49 U.S.C. 322, 31136 and 31315; and 49 CFR 1.73.

Issued on: October 30, 2000.

Clyde J. Hart, Jr.,

Acting Deputy Administrator, Federal Motor Carrier Safety Administration.

[FR Doc. 00–28204 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Motor Carrier Safety Administration

[Docket No. FMCSA–2000–8203]

Qualification of Drivers; Exemption Applications; Vision

AGENCY: Federal Motor Carrier Safety Administration (FMCSA), DOT.

ACTION: Notice of renewal of exemption; request for comments.

SUMMARY: This notice announces the FMCSA's decision to renew the exemptions from the vision requirement in 49 CFR 391.41(b)(10), for nine individuals.

DATES: This decision is effective November 9, 2000. Comments from interested persons should be submitted by December 4, 2000.

ADDRESSES: Mail or hand deliver comments to the U.S. Department of Transportation, Dockets Management Facility, Room PL–401, 400 Seventh Street, SW., Washington, DC 20590, or submit electronically at *http://dmses.dot.gov/submit.* All comments received will be available for examination and copying at the above address from 9 a.m. to 5 p.m., e.t., Monday through Friday, except Federal holidays. Those desiring notification of receipt of comments must include a self-addressed, stamped postcard or you may print the acknowledgment page that appears after submitting comments electronically.

FOR FURTHER INFORMATION CONTACT: For information about the vision exemptions in this notice, Ms. Sandra Zywokarte, Office of Bus and Truck Standards and Operations, (202) 366–2987; for information about legal issues related to this notice, Mr. Joe Solomey, Office of the Chief Counsel, (202) 366–1374, FMCSA, Department of Transportation, 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:

Electronic Access and Filing

You may submit or retrieve comments online through the Document Management System (DMS) at: *http://dmses.dot.gov/submit.* Acceptable formats include: MS Word (versions 95 to 97), MS Word for Mac (versions 6 to 8), Rich Text File (RTF), American Standard Code Information Interchange (ASCII)(TXT), Portable Document Format (PDF), and WordPerfect (versions 7 to 8). The DMS is available 24 hours each day, 365 days each year. Electronic submission and retrieval help and guidelines are available under the help section of the web site.

An electronic copy of this document may also be downloaded by using a computer, modem and suitable communications software from the Government Printing Office's Electronic Bulletin Board Service at (202) 512–1661. Internet users may also reach the Office of the Federal Register's home page at: *http://www.nara.gov/fedreg* and the Government Printing Office's database at: *http://www.access.gpo.gov/nara.*

Background

Nine individuals have requested renewal of their exemptions from the vision requirement in 49 CFR 391.41(b)(10) which applies to drivers of commercial motor vehicles (CMVs) in interstate commerce. They are Larry A. Dahleen, Earl D. Edland, Dale H. Hellman, Danny E. Hillier, Robert J. Johnson, Michael L. Manning, Gerald R. Rietmann, Jimmy E. Settle, and Hubert Whittenburg. Under 49 U.S.C. 31315 and 31136(e), the FMCSA may grant an exemption for a renewable 2-year period

if it finds ''such exemption would likely achieve a level of safety that is equivalent to, or greater than, the level that would be achieved absent such exemption.'' Accordingly, the FMCSA has evaluated the nine petitions for renewal on their merits and made a determination to extend their exemptions for a renewable 2-year period.

On October 9, 1998, the agency published a notice of final disposition announcing its decision to exempt 12 individuals, including these nine applicants for renewal, from the vision requirement in 49 CFR 391.41(b)(10) (63 FR 54519). The qualifications, experience, and medical condition of each applicant were stated and discussed in detail at 63 FR 30285, June 3, 1998. Three comments were received, and their contents were carefully considered by the agency in reaching its final decision to grant the petitions (63 FR 54519). The agency determined that exempting the individuals from 49 CFR 391.41(b)(10) was likely to achieve a level of safety equal to, or greater than, the level that would be achieved without the exemption as long as the vision in each applicant's better eye continues to meet the standard specified in 391.41(b)(10). As a condition of the exemption, therefore, the agency imposed requirements on the individuals similar to the grandfathering provisions in 49 CFR 391.64(b) applied to drivers who participated in the agency's former vision waiver program.

These requirements are as follows: (1) That each individual be physically examined every year (a) by an ophthalmologist or optometrist who attests that vision in the better eye meets the standard in 49 CFR 391.41(b)(10), and (b) by a medical examiner who attests the individual is otherwise physically qualified under 49 CFR 391.41; (2) that each individual provide a copy of the ophthalmologist's or optometrist's report to the medical examiner at the time of the annual medical examination; and (3) that each individual provide a copy of the annual medical certification to the employer for retention in the driver's qualification file and retains a copy of the certification on his/her person while driving for presentation to a duly authorized Federal, State, or local enforcement official.

Basis for Renewing Exemptions

Under 49 U.S.C. 31315(b)(1), an exemption may be granted for no longer than 2 years from its approval date and may be renewed upon application for an additional 2-year period. In accordance with 49 U.S.C. 31315 and 31136(e), each of the nine applicants has satisfied the entry conditions for obtaining an exemption from the vision requirements (63 FR 30285; 63 FR 54519) and each has requested timely renewal of the exemption. These nine applicants have submitted evidence showing that the vision in their better eye continues to meet the standard specified at 49 CFR 391.41(b)(10), and that the vision impairment is stable. In addition, a review of their records of safety while driving with their respective vision deficiencies over the past 2 years indicates each applicant continues to meet the vision exemption standards. These factors provide an adequate basis for predicting each driver's ability to continue to drive safely in interstate commerce. Therefore, the FMCSA concludes that extending the exemption for a period of 2 years is likely to achieve a level of safety equal to that existing without the exemption for each renewal applicant.

Conclusion

In accordance with 49 U.S.C. 31315 and 31136(e), the FMCSA extends the exemptions from the vision requirement in 49 CFR 391.41(b)(10) granted to Larry A. Dahleen, Earl D. Edland, Dale H. Hellman, Danny E. Hillier, Robert J. Johnson, Michael L. Manning, Gerald R. Rietmann, Jimmy E. Settle, and Hubert Whittenburg, subject to the following conditions: (1) That each individual be physically examined every year (a) by an ophthalmologist or optometrist who attests that the vision in the better eye continues to meet the standard in 49 CFR 391.41(b)(10), and (b) by a medical examiner who attests that the individual is otherwise physically qualified under 49 CFR 391.41; (2) that each individual provide a copy of the ophthalmologist's or optometrist's report to the medical examiner at the time of the annual medical examination; and (3) that each individual provide a copy of the annual medical certification to the employer for retention in the driver's qualification file and retains a copy of the certification on his/her person while driving for presentation to a duly authorized Federal, State, or local enforcement official. Each exemption will be valid for 2 years unless revoked earlier by the FMCSA. The exemption will be revoked if: (1) The person fails to comply with the terms and conditions of the exemption; (2) the exemption has resulted in a lower level of safety than was maintained before it was granted; or (3) continuation of the exemption would not be consistent with the goals and objectives of 49 U.S.C. 31315 and 31136(e).

Request for Comments

The FMCSA has evaluated the qualifications and driving performance of the nine applicants here and extends their exemptions based on the evidence introduced. The agency will review any comments received concerning a particular driver's safety record and determine if the continuation of the exemption is consistent with the requirements at 49 U.S.C. 31315 and 31136(e). While comments of this nature will be entertained at any time, the FMCSA requests that interested parties with information concerning the safety records of these drivers submit comments by December 4, 2000. All comments will be considered and will be available for examination in the docket room at the above address. The FMCSA will also continue to file in the docket relevant information which becomes available. Interested persons should continue to examine the docket for new material.

Authority: 49 U.S.C. 322, 31136 and 31315; and 49 CFR 1.73.

Issued on: October 30, 2000.

Clyde J. Hart, Jr.,

Acting Deputy Administrator, Federal Motor Carrier Safety Administration.

[FR Doc. 00–28205 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–EX–P

DEPARTMENT OF TRANSPORTATION

Federal Railroad Administration

Proposed Agency Information Collection Activities; Comment Request

AGENCY: Federal Railroad Administration, DOT.

ACTION: Notice.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995 and its implementing regulations, the Federal Railroad Administration (FRA) hereby announces that it is seeking renewal of the following currently approved information collection activities. Before submitting these information collection requirements for clearance by the Office of Management and Budget (OMB), FRA is soliciting public comment on specific aspects of the activities identified below.

DATES: Comments must be received no later than January 2, 2001.

ADDRESSES: Submit written comments on any or all of the following proposed activities by mail to either: Mr. Robert Brogan, Office of Safety, Planning and Evaluation Division, RRS–21, Federal Railroad Administration, 1120 Vermont

Ave., NW., Mail Stop 17, Washington, DC 20590, or Ms. Dian Deal, Office of Information Technology and Productivity Improvement, RAD–20, Federal Railroad Administration, 1120 Vermont Ave., NW., Mail Stop 35, Washington, DC 20590. Commenters requesting FRA to acknowledge receipt of their respective comments must include a self-addressed stamped postcard stating, ''Comments on OMB control number ___.'' Alternatively, comments may be transmitted via facsimile to (202) 493–6265 or (202) 493–6170, or E-mail to Mr. Brogan at robert.brogan@fra.dot.gov, or to Ms. Deal at dian.deal@fra.dot.gov. Please refer to the assigned OMB control number in any correspondence submitted. FRA will summarize comments received in response to this notice in a subsequent notice and include them in its information collection submission to OMB for approval.

FOR FURTHER INFORMATION CONTACT: Mr. Robert Brogan, Office of Planning and Evaluation Division, RRS–21, Federal Railroad Administration, 1120 Vermont Ave., NW., Mail Stop 17, Washington, DC 20590 (telephone: (202) 493–6292) or Dian Deal, Office of Information Technology and Productivity Improvement, RAD–20, Federal Railroad Administration, 1120 Vermont Ave., NW., Mail Stop 35, Washington, DC 20590 (telephone: (202) 493–6133). (These telephone numbers are not toll-free.)

SUPPLEMENTARY INFORMATION: The Paperwork Reduction Act of 1995 (PRA), Pub. L. 104–13, 2, 109 Stat. 163 (1995) (codified as revised at 44 U.S.C. 3501–3520), and its implementing regulations, 5 CFR part 1320, require Federal agencies to provide 60-days notice to the public for comment on information collection activities before seeking approval for reinstatement or renewal by OMB. 44 U.S.C. 3506(c)(2)(A); 5 CFR 1320.8(d)(1), 1320.10(e)(1), 1320.12(a). Specifically, FRA invites interested respondents to comment on the following summary of proposed information collection activities regarding: (i) Whether the information collection activities are necessary for FRA to properly execute its functions, including whether the activities will have practical utility; (ii) the accuracy of FRA's estimates of the burden of the information collection activities, including the validity of the methodology and assumptions used to determine the estimates; (iii) ways for FRA to enhance the quality, utility, and clarity of the information being collected; and (iv) ways for FRA to minimize the burden of information collection activities on the public by automated, electronic, mechanical, or other technological collection techniques or other forms of information technology (*e.g.,* permitting electronic submission of responses). *See* 44 U.S.C. 3506(c)(2)(A)(I)–(iv); 5 CFR 1320.8(d)(1)(I)–(iv). FRA believes that soliciting public comment will promote its efforts to reduce the administrative and paperwork burdens associated with the collection of information mandated by Federal regulations. In summary, FRA reasons that comments received will advance three objectives: (i) reduce reporting burdens; (ii) ensure that it organizes information collection requirements in a ''user friendly'' format to improve the use of such information; and (iii) accurately assess the resources expended to retrieve and produce information requested. *See* 44 U.S.C. 3501.

Below is a brief summary of currently approved information collection activities that FRA will submit for clearance by OMB as required under the PRA:

Title: Special Notice For Repairs.
OMB Control Number: 2130–0504.
Abstract: The collection of information is used by state and Federal inspectors to remove freight cars or locomotives from service until they can be restored to a serviceable condition. It is also used by state and Federal inspectors to reduce the maximum authorized speed on a section of track until repairs can be made. Additionally, the collection of information provides railroads written notice that an inspector has recommended to the FRA Administrator to remove from service a section of track that is not safe to use at any speed. Railroads must return the required form after the necessary repairs have been made.
Form Number(s): FRA F 6180.8 and FRA F 6180.8a.
Affected Public: Businesses.
Respondent Universe: 685 railroads.
Frequency of Submission: On occasion.
Estimated Annual Burden: 7 hours.
Status: Regular Review.
Title: Designation of Qualified Persons.
OMB Control Number: 2130–0511.
Abstract: The collection of information is used to prevent the unsafe movement of defective freight cars. Railroads are required to inspect the freight cars for compliance and to determine restrictions on the movement of defective cars.
Affected Public: Businesses.
Respondent Universe: 685 railroads.
Frequency of Submission: On occasion.
Estimated Annual Burden: 40 hours.
Status: Regular Review.

Pursuant to 44 U.S.C. 3507(a) and 5 CFR 1320.5(b), 1320.8(b)(3)(vi), FRA informs all interested parties that it may not conduct or sponsor, and a respondent is not required to respond to, a collection of information unless it displays a currently valid OMB control number.

Authority: 44 U.S.C. 3501–3520.

Issued in Washington, D.C. on October 31, 2000.

Kathy A. Weiner,

Director, Office of Information Technology and Support Systems, Federal Railroad Administration.

[FR Doc. 00–28290 Filed 11–2–00; 8:45 am]
BILLING CODE 4910–06–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

Environmental Impact Statement on the Northwest Corridor—Carrollton Line Light Rail Transit Project in Dallas, Farmers Branch, and Carrollton, TX

AGENCY: Federal Transit Administration, DOT.

ACTION: Notice of Intent to prepare an environmental impact statement.

SUMMARY: The Federal Transit Administration (FTA) and Dallas Area Rapid Transit (DART) have issued this notice to advise interested agencies and the public of their intent to prepare an Environmental Impact Statement (EIS) on the proposed Northwest Corridor-Carrollton Line Light Rail Transit (LRT) Project in Dallas, Farmers Branch, and Carrollton, Texas. The EIS will be prepared in accordance with the National Environmental Policy Act of 1969 (NEPA), as amended. The Dallas-Fort Worth region is currently designated as a serious non-attainment area for ozone by the Environmental Protection Agency.

The Northwest Corridor-Carrollton Line LRT Project is the product of the Northwest Corridor Major Investment Study (MIS) completed by DART in early 2000. The MIS identified a Locally Preferred Investment Strategy (LPIS), which included a light rail element with two service lines, the Carrollton Line and the DFW Line. The Carrollton Line is being advanced into the EIS phase of project development at this time. The DFW Line will be advanced into the EIS process at a later time when alignment and land use issues are resolved. A separate EIS is also being prepared for

a DART LRT extension in the Southeast Corridor of the Dallas metropolitan area.

DATES: *Comment Due Date:* Written comments on the scope of the alternatives and impacts to be considered should be sent to Kay Shelton, Project Manager by December 20, 2000. See **ADDRESSES** below.

Scoping Meetings: Three public scoping meetings will be held at the following locations and dates. Scoping material will be available at the meeting or in advance of the meeting DART and the cities of Dallas, Farmers Branch, and Carrollton will conduct public scoping meetings on the following dates and at the following locations:

Tuesday, December 5, 2000, 6:30 p.m., Bachman Recreation Center, 2750 Bachman Drive, Dallas, Texas

Thursday, December 7, 6:30 p.m., Farmers Branch Elementary School, 13521 Tom Field Road, Farmers Branch, Texas

Friday, December 8, 10 a.m.–1 p.m., DART Board Room, 1401 Pacific Avenue, Dallas, Texas

Interagency Coordination Meeting: DART will conduct an interagency coordination meeting with appropriate federal, state, and local agencies on the following date and at the following location: Wednesday, December 6, 2000, 1 p.m. to 3 p.m., DART Board Conference Room 1–C, 1401 Pacific Avenue, Dallas, Texas

ADDRESSES: *Written comments* on the project scope should be sent to Kay Shelton, DART Planning, P.O Box 660163, 1401 Pacific Avenue, Dallas, Texas 75266–7213. Telephone (214) 749–2841, Fax (214) 749–3662, E-mail: kshelton@dart.org.

FOR FURTHER INFORMATION CONTACT: Mr. Jesse Balleza, Community Planner, Federal Transit Administration, Region VI; Telephone (817) 978–0550.

SUPPLEMENTARY INFORMATION:

I. Scoping

The FTA and DART invite interested individuals, organizations, and federal, state, and local agencies to participate in refining the Carrollton LRT Line, including alignment and station locations. Comments should focus on identifying any significant social, economic, or environmental issues related to the alignment. Specific suggestions related to additional alternatives to be examined and issues to be addressed are welcome and will be considered in the final scope for the project. Scoping comments may be made at the scoping meetings or in writing no later than December 20, 2000. (see **DATES** and **ADDRESSES** above.)

Scoping comments should focus on identifying specific social, economic, or environmental impacts to be evaluated, and suggesting alternatives that are less costly or less environmentally damaging, which achieve similar transit objectives. Comments should focus on the issues and alternatives for analysis, and not on a preference for a particular alternative. Additional information on the EIS process, alternatives, and impact issues to be addressed will be included in the ''Scoping Information Document''. Copies of the document will be available from DART immediately prior to the scoping meetings (see **DATES** and **ADDRESSES** above.)

II. Description of Study Area and Project Need

The Northwest Corridor Study Area includes a large part of northwest Dallas County. It extends from downtown Dallas on the south, to SH 121 on the west and north, to east of Marsh Lane and IH 35E on the east. The Major Investment Study's Locally Preferred Investment Strategy (LPIS) includes two rail lines, the D/FW Line and the Carrollton Line. Each of the two rail lines has independent utility in meeting transportation needs of the Study Area. The Carrollton Line is being advanced now into the Environmental Impact Statement (EIS) phase. The D/FW Line will be advanced into the EIS phase at a later time when land use and alignment issues are resolved.

The Northwest Corridor Major Investment Study defined and evaluated a range of project alternatives using a 4-step evaluation process. In addition to the No Build Alternative, a Transportation Systems Management (TSM) Alternative, Commuter Rail Alternatives, several variations of Light Rail Transit (LRT) Alternatives, and some alternatives that combined both LRT and Commuter Rail were considered. Based on work group and public input, and based on the technical analysis, the above-described build alternative was selected. While some alignment refinements will continue for the LPIS, the other alternatives considered during the MIS were dropped from further consideration. The EIS will consider the No Build Alternative in addition to Carrollton LRT Line as the Build Alternative (see ALTERNATIVES below).

The proposed project for environmental review consists of a light rail transit (LRT) line of approximately 17 miles. The LRT alignment begins in downtown Dallas and extends north from the existing LRT transitway mall beginning at a point between the West End Station and Union Station. The alignment will utilize a portion of the former Union Pacific Railroad (UPRR) right-of-way, sharing the corridor with Trinity Railway Express (TRE) commuter rail and freight rail operations between downtown Dallas and approximately Wycliff Avenue. The proposed LRT alignment crosses over Market Center Boulevard, continuing in the median of Harry Hines Boulevard. North of Inwood Road the LRT alignment turns east along Bomar Street and north at Denton Drive, then crosses under Mockingbird Lane near Denton Drive. Alignment options to serve Love Field will be considered during the EIS process, including continuing north on the former UPRR ROW, or an alignment that provides more direct access to the Love Field passenger terminal. North of Love Field, the alignment follows the UPRR ROW north through the cities of Farmers Branch and Carrollton, terminating in the vicinity of Frankford Road.

Eleven stations are proposed in the following vicinities: the new American Airlines Center (Victory), Market Center, Medical Center, Mockingbird/Love Field, Northwest Highway/Bachman Lake, Walnut Hill, Royal, Farmers Branch Park-and-Ride, Belt Line/Old Downtown Carrollton, North Carrollton Transit Center, and Frankford Road. The Carrollton Line and its associated stations provides the opportunity to serve several important regional activity centers, including downtown Dallas, American Airlines Center (Victory), the Stemmons (IH 35E)/Market Center business area, Medical Center area, Love Field Airport, and the suburban cities of Farmers Branch and Carrollton. The proposed rail line will provide numerous opportunities to interconnect the region's transit services, including DART's expanding LRT system, the Trinity Railway Express commuter rail operation, and DART's local and express bus service.

The corridor parallels IH 35E, one of the most congested highway corridors in the region. Regional growth has added to this congestion, especially employment growth in Dallas County, and population growth in northern Dallas, northeast Tarrant, and Denton Counties. In 2020, the northwest quadrant of Dallas County will account for 33.6 percent of employment in the entire Dallas-Fort Worth region. While covering only 6.4 percent of the region's land area, the study area is a large net importer of employees. In 1995, employment outnumbered population by over 200,000 jobs. In 2020, the surplus of jobs over population is expected to grow to more than 336,000.

Land use in the corridor consists of a major concentration of employment with residential uses occurring east of IH 35E and in the northern portions of the Study Area. Industrial and commercial land uses are primarily confined to land adjacent to IH 35E. Traffic volumes on IH 35E parallel to the Carrollton LRT Line are expected to be more than 300,000 vehicles per day in 2020, an increase of 30 percent from 1995 levels. The EPA has designated the Dallas-Fort Worth metropolitan area as a ''serious'' non-attainment area for the pollutant ozone.

The proposed LRT project is part of a multi-modal strategy that also incorporates bus service refinements, highway and HOV lane improvements, Transportation System Management/ Travel Demand Management (TSM/ TDM), and bicycle and pedestrian improvements. This strategy was developed during the preparation of the Northwest Corridor MIS completed by DART in early 2000.

III. Alternatives

The transportation alternatives proposed for consideration in this project area include:

No-Build Alternative—The No-Build Alternative involves no change to transportation services or facilities in the corridor beyond already committed projects.

Build Alternative—The Carrollton Line LRT project is approximately 17 miles in length and extends from the downtown Dallas West End area to Frankford Road in Carrollton. The alignment will use the former UPRR ROW, purchased by DART for future transit use in 1990, and surface streets where required to make key connections. The project will connect with the existing LRT system in the West End area of downtown and will operate in a shared use corridor with freight traffic and Trinity Railway Express commuter rail traffic for a distance of approximately two miles. The alignment will use a combination of surface streets and UPRR right-of-way in order to serve the Medical Center area and the Love Field environs (approximately three miles). North of the Love Field area, the alignment remains within the UPRR right-of-way to Frankford Road (12 miles). Where the alignment is within the UPRR right-of-way there will be potential shared use with freight traffic. Eleven (11) LRT Stations have been identified for service access. Two significant design options have been identified for evaluation during the EIS process: (1) Griffin alignment: an alignment between the proposed Victory Station and the Downtown Transit Mall via Griffin Street; and (2) Love Field: an alternative alignment to serve Love Field has been proposed, swinging east of the UPRR right-of-way and entering the Love Field Terminal area east of Cedar Springs Road.

IV. Probable Effects

The FTA and DART will evaluate all significant environmental, social, and economic impacts of the alternatives analyzed in the EIS. Impact areas to be addressed include: land use, zoning, and economic development; secondary development; land acquisition, displacements, and relocation of existing uses; historic, archaeological, and cultural resources; parklands and recreation areas; visual and aesthetic qualities; neighborhoods and communities; environmental justice; air quality; noise and vibration; hazardous materials; ecosystems; water resources; energy; safety and security; utilities; traffic and transportation impacts. Potential impacts will be assessed for the long-term operation of each alternative and the short-term construction period. Measures to avoid, minimize, or mitigate any significant adverse impacts will be identified.

V. FTA Procedures

The EIS process will be performed in accordance with applicable laws and Federal Transit Administration regulations and guidelines for preparing an Environmental Impact Statement. The impacts of the project will be assessed, and, if necessary, the scope of the project will be revised or refined to minimize and mitigate any adverse impacts. After its publication, the draft EIS will be available for public review and comment. One or more public hearings will be held during the draft EIS public comment period. On the basis of the draft EIS and comments received, the project will be revised or further refined as necessary and the final EIS prepared.

Issued on: October 30, 2000.

Robert C. Patrick,

Regional Administrator.

[FR Doc. 00–28302 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–57–P

DEPARTMENT OF TRANSPORTATION

Federal Transit Administration

Environmental Impact Statement on Transportation Improvements Within the Southeast Corridor in Dallas, TX

AGENCY: Federal Transit Administration, DOT.

ACTION: Notice of intent to prepare an Environmental Impact Statement.

SUMMARY: The Federal Transit Administration (FTA) and Dallas Area Rapid Transit (DART) have issued this notice to advise interested agencies and the public of their intent to prepare an Environmental Impact Statement (EIS) on the proposed Southeast Corridor Light Rail Transit (LRT) Project, in Dallas, Texas. The EIS will be prepared in accordance with the National Environmental Policy Act of 1969 (NEPA), as amended. The Dallas-Fort Worth region is currently designated as a serious non-attainment area for ozone by the Environmental Protection Agency.

The Southeast Corridor Light Rail Transit (LRT) Project is the product of the Southeast Corridor Major Investment Study (MIS), completed by DART in early 2000. The MIS identified a Locally Preferred Investment Strategy (LPIS), which included the light rail being advanced into the EIS phase of project development at this time. A separate EIS is also being prepared for a DART LRT extension in the Northwest Corridor of the Dallas metropolitan area.

DATES: *Comment Due Date:* Written comments on the scope of the alternatives and impacts to be considered should be sent to John Hoppie, Project Manager by December 20, 2000. See **ADDRESSES** below.

Scoping Meetings: Three public scoping meetings will be held at the following locations and dates. Scoping material will be available at the meeting or in advance of the meeting. DART will conduct public scoping meetings on the following dates and at the following locations:

Tuesday, November 28, 2000, from 6:30 p.m. to 9 p.m., Baylor—Tom Landry Center, 411 N. Washington Ave., Dallas, Texas

Wednesday, November 29, 2000, from 6:30 p.m. to 9 p.m., Martin Luther King Jr. Senior Center, 2922 Martin Luther King Jr. Blvd., Dallas, Texas

Thursday November 30, 2000, from 6:30 p.m. to 9 p.m., Pleasant Mound UMC, 8301 Bruton Rd., Dallas, Texas

Interagency Coordination Meeting: DART will conduct an interagency coordination meeting with appropriate federal, state, and local agencies on the following date and at the following location:

Wednesday, December 6, 2000, 10 a.m. to 12 p.m., DART Board Conference Room 1–C, 1401 Pacific Avenue, Dallas, Texas

ADDRESSES: *Written comments* on the project scope should be sent to John

Hoppie, Project Manager, DART Planning, P.O. Box 660163, 1401 Pacific Avenue, Dallas, Texas 75266. Telephone (214) 749–2525, Fax (214) 749–3670, E-mail: jhoppie@dart.org.

FOR FURTHER INFORMATION CONTACT: Mr. Jesse Balleza, Community Planner, Federal Transit Administration, Region VI; Telephone (817) 978–0550.

SUPPLEMENTARY INFORMATION:

I. Scoping

The FTA and DART invite interested individuals, organizations, and federal, state, and local agencies to participate in refining the Southeast Corridor LRT Line including alignment and station locations. Comments should focus on identifying any significant social, economic, or environmental issues related to the alignment. Specific suggestions related to additional alternatives to be examined and issues to be addressed are welcome and will be considered in the final scope for the project. Scoping comments may be made at the scoping meetings or in writing no later than December 20, 2000. (see **DATES** and **ADDRESSES** above.)

Scoping comments should focus on identifying specific social, economic, or environmental impacts to be evaluated, and suggesting alternatives that are less costly or less environmentally damaging, which achieve similar transit objectives. Comments should focus on the issues and alternatives for analysis, and not on a preference for a particular alternative. Additional information on the EIS process, alternatives, and impact issues to be addressed will be included in the ''Scoping Information Document''. Copies of the document will be available from DART immediately prior to the scoping meetings (see **DATES** and **ADDRESSES** above.)

II. Description of Study Area and Project Need

The Southeast Corridor Light Rail Transit (LRT) Project includes 10.2 miles of LRT running on new double tracks in existing railroad corridors with some street running along Good Latimer and Parry Avenue. There are 9 LRT stations, including 6 with Park & Ride Lots (totaling just under 2000 parking spaces), and 2 with transfer facilities to other modes.

The Southeast Corridor Major Investment Study defined and evaluated a range of project alternatives using a two-phased evaluation process. In addition to the No Build Alternative, a Transportation Systems Management (TSM) Alternative, and several variations of Light Rail Transit (LRT) Alternatives were considered. Based on work group and public input, and based on the technical analysis, the above-described Build Alternative was selected. While some alignment refinements will continue for the Build Alternative, the other alternatives considered were dropped from further consideration. The EIS will consider the No Build Alternative in addition to Southeast LRT Line as the Build Alternative (see ALTERNATIVES below).

DART's Southeast Corridor contains a dynamic mix of land uses including a burgeoning, eclectic entertainment district; one of the region's most prestigious hospital facilities; a multi-faceted, 277 acre, cultural, historical, museum, and entertainment complex; and large areas of single-family and multi-family housing.

The existing corridor and station area development character in the Southeast Corridor has three distinct subareas:

(1) The Baylor HCS/Deep Ellum/Bryan Place is a redeveloping/revitalizing area of a previously urban core environment of warehouses and commercial uses into multi-family lofts, artists' studios, retail, and service businesses. The area is anchored by Baylor HCS. This area includes pedestrian oriented development. The Deep Ellum area has been designated a historic district. Hundreds of new housing units have been created through new construction or conversion of older buildings. This area is within the City of Dallas Intown Housing Program boundary, which is a local initiative aimed at increasing the vitality of the Central Business District by providing mixed income housing through joint ventures with private developers. (2) The South Dallas/Fair Park area is characterized by commercial/light industrial and loft apartments immediately west of Fair Park; a strip of commercial businesses along R.B. Cullum; and single-family residential with some apartments and duplexes to the south and west of Fair Park. Fair Park is a 277-acre city park, which is listed on the National Register of Historic Places. This area is one of the most transit dependent areas of the city. In the South Dallas/Fair Park area, several community-based organizations have on-going in-fill housing programs. (3) The Pleasant Grove/Buckner Terrace area is primarily composed of residential, industrial, and retail/commercial uses. The commercial activities are concentrated along Buckner Boulevard/Loop 12. This area contains a large amount of vacant land, which is dedicated parkland and/or located in the floodplain. Additionally, development of single-family residential housing in the Pleasant Grove and Buckner Terrace areas is filling the last remaining land for housing developments.

DART's 10.2-mile Southeast Corridor LRT extension, like its original 20-mile starter System, is contained entirely within the Dallas city limits. The University of North Texas Center for Economic Development and Research assessed the impacts of the DART LRT Starter System and estimated over $850 million has been invested in and around DART's new LRT stations. Development currently completed or planned at DART stations varies from a new hotel and mixed-use development downtown, to new residential and municipal facilities in a redevelopment area around the Cedars Station south of downtown Dallas.

Along with the previously mentioned transit supportive land use considerations, some of the other influencing conditions within the Southeast Corridor include:

Environmental Justice and Equity Issues—Within the 47 census tracts covering the Southeast Corridor study area, the majority of tracts have a higher percentage of minority and/or low-income population than the average for the county. Through the extensive public involvement and outreach efforts for the project, equity issues related to the South Dallas neighborhood and the Fair Park area have been identified. It is perceived by the neighborhoods that the needs of the community have been overshadowed or set aside for the economic benefit of Fair Park. Fair Park has expanded several times since its establishment; many times residences were purchased by the city to accommodate the expansion. Additionally, special events at the park's numerous venues can create traffic problems and congestion in the neighborhoods. In the Pleasant Grove area, equity issues related to transit service have been identified. Many residents perceive the Southeast Corridor as the last to receive LRT service it has been promised. However, DART services and the concept of LRT in the corridor are widely supported. The LRT project is seen as providing better transit service and a catalyst for economic development.

Station Area Economic Development Potential—Economic development potential of the terminus station was identified by the DART Board of Directors as one of the primary criteria to be used to compare two vastly different alternative alignments for the final two-mile segment of the LRT line. This further emphasizes the growing

importance that DART is placing on economic development.

Historical Transit Service—The LRT alignment and station along Parry Avenue will be at near the ceremonial entrance to Fair Park. This alignment and station will reestablish similar service to the park that was provided by the Dallas Interurban Trolley system until the 1950's.

III. Alternatives

The transportation alternatives proposed for consideration in this project area include:

No-Build Alternative—The No-Build Alternative involves no change to transportation services or facilities in the corridor beyond already committed projects.

Build Alternative—The Southeast Corridor Project (including line, station locations and support facilities), consists of 10.2 miles of LRT running on new double tracks in existing railroad corridors with some street running in along Good Latimer and Parry Avenue. There are 9 potential LRT stations, including 6 with Park & Ride Lots (totaling just under 2000 parking spaces), and 2 with transfer facilities to other modes.

IV. Probable Effects

The FTA and DART will evaluate all significant environmental, social, and economic impacts of the alternatives analyzed in the EIS. Impact areas to be addressed include: land use, zoning, and economic development; secondary development; land acquisition, displacements, and relocation of existing uses; historic, archaeological, and cultural resources; parklands and recreation areas; visual and aesthetic qualities; neighborhoods and communities; environmental justice; air quality; noise and vibration; hazardous materials; ecosystems; water resources; energy; safety and security; utilities; traffic and transportation impacts. Potential impacts will be assessed for the long-term operation of each alternative and the short-term construction period. Measures to avoid, minimize, or mitigate any significant adverse impacts will be identified.

V. FTA Procedures

The EIS process will be performed in accordance with applicable laws and Federal Transit Administration regulations and guidelines for preparing an Environmental Impact Statement. The impacts of the project will be assessed, and, if necessary, the scope of the project will be revised or refined to minimize and mitigate any adverse impacts. After its publication, the draft EIS will be available for public review and comment. One or more public hearings will be held during the draft EIS public comment period. On the basis of the draft EIS and comments received, the project will be revised or further refined as necessary and the final EIS prepared.

Issued on: October 30, 2000.

Robert C. Patrick,

Regional Administrator.

[FR Doc. 00–28301 Filed 11–2–00; 8:45 am]

BILLING CODE 4910–57–P

DEPARTMENT OF TRANSPORTATION

Surface Transportation Board

[STB Finance Docket No. 33938]

Adrian & Blissfield Rail Road Company—Acquisition Exemption—Michigan Department of Transportation

Adrian & Blissfield Rail Road Company (ADBF), a Class III rail carrier, has filed a notice of exemption under 49 CFR 1150.41 to acquire (by purchase) approximately 19.3 miles of rail lines located in Lenawee County, MI, owned by the Michigan Department of Transportation (MDOT).

The lines to be acquired are as follows: (1) From east of Riga, MI, at the interchange with the Indiana and Ohio Railway, or its successor, north and west through Riga, Blissfield, Palmyra, Lenawee Junction, Grosvenor Junction, and Adrian, MI, to Porter Highway; (2) from Grosvenor Junction southwest approximately 1.7 miles; and (3) from Lenawee Junction north approximately .25 miles. The lines are described more specifically as follows: the Adrian Main Line Extension: (i) Between milepost 315.5 (Interchange with Indiana & Ohio Railway at Riga) and milepost 321.0 (Grosvenor Junction); (ii) between Grosvenor Junction milepost 0.0 and milepost 1.7; (iii) between milepost 321.0 (Grosvenor Junction) and milepost 325.5 (Lenawee Junction); (iv) between Lenawee Junction milepost 0.0 and milepost 0.25; and (v) between milepost 325.5 (Lenawee Junction) and milepost 332.85 (Porter Highway). ADBF certifies that its projected revenues as a result of this transaction will not result in the creation of a Class II or Class I rail carrier, and further certifies that its annual revenues will not exceed $5 million. ADBF currently operates over the lines.

The earliest the transaction could be consummated was October 25, 2000, the effective date of the exemption (7 days after the exemption was filed).

If this notice contains false or misleading information, the exemption is void *ab initio.* Petitions to revoke the exemption under 49 U.S.C. 10502(d) may be filed at any time. The filing of a petition to revoke does not automatically stay the transaction.

An original and 10 copies of all pleadings, referring to STB Finance Docket No. 33938, must be filed with the Surface Transportation Board, Office of the Secretary, Case Control Unit, 1925 K Street, NW., Washington, DC 20423–0001. In addition, a copy of each pleading must be served on Kenneth J. Bisdorf, 2301 West Big Beaver Road, Suite 600, Troy, MI 48084–3329.

Board decisions and notices are available on our website at ''WWW.STB.DOT.GOV.''

Decided: October 25, 2000.

By the Board, David M. Konschnik, Director, Office of Proceedings.

Vernon A. Williams,

Secretary.

[FR Doc. 00–28037 Filed 11–02–00; 8:45 am]

BILLING CODE 4915–00–P

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

September 27, 2000.

The Department of the Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2110, 1425 New York Avenue, NW., Washington, DC 20220.

DATES: Written comments should be received on or before December 4, 2000 to be assured of consideration.

Bureau of the Public Debt (PD)

OMB Number: 1535–0048.

Form Number: PD F 1851.

Type of Review: Extension.

Title: Request for Reissue of United States Savings Bonds/Notes in the Name of Trustee of Personal Trust Estate.

Description: The form is used to request reissue of savings bonds/notes in the Name(s) of the trustee(s) of a personal trust estate.

Respondents: Individuals or households.

Estimated Number of Respondents: 55,000.

Estimated Burden Hours Per Respondent: 15 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden Hours: 13,750 hours.

OMB Number: 1535–0068.

Form Number: None.

Type of Review: Extension.

Title: Regulations Governing Book-Entry Treasury Bonds, Notes and Bills.

Description: The information is requested to establish an investor's Treasury Account; to dispose of securities upon the owner's request; and, to determine entitlement to securities.

Respondents: Individuals or households, Business or other for-profit, Not-for-profit institutions, State, Local or Tribal Government.

Estimated Number of Respondents: 7,500.

Estimated Burden Hours Per Respondent: 7 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden Hours: 8,775 hours.

OMB Number: 1535–0087.

Form Number: None.

Type of Review: Extension.

Title: Payment by Banks and Other Financial Institutions of United States Savings Bonds and Notes (Freedom Shares).

Description: Qualified financial institutions are authorized to redeem eligible savings bonds and notes, and receive settlement through the Federal Reserve check collection System.

Respondents: Business or other for-profit, Not-for-profit institutions.

Estimated Number of Respondents: 40,000.

Estimated Burden Hours Per Respondent: 4 seconds.

Frequency of Response: On occasion.

Estimated Total Reporting Burden Hours: 77,467 hours.

Clearance Officer: Vicki S. Thorpe (304) 480–6553, Bureau of the Public Debt, 200 Third Street, Parkersburg, West VA 26106–1328.

OMB Reviewer: Alexander T. Hunt (202) 395–7860, Office of Management and Budget, Room 10226, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports Management Officer.

[FR Doc. 00–28215 Filed 11–2–00; 8:45 am]

BILLING CODE 4810–40–U

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

October 23, 2000.

The Department of the Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2110, 1425 New York Avenue, NW., Washington, DC 20220.

DATES: Written comments should be received on or before December 4, 2000 to be assured of consideration.

Internal Revenue Service (IRS)

OMB Number: 1545–0236.

Form Number: IRS Form 11–C.

Type of Review: Extension.

Title: Occupational Tax and Registration Return for Wagering.

Description: Form 11–C is used to register persons accepting wagers (IRC section 4412). IRS uses this form to register the respondent, collect the annual stamp tax (IRC section 4411), and to verify that the tax on wagers is reported on Form 730.

Respondents: Business or other for-profit, Individuals or households, Farms.

Estimated Number of Respondents/ Recordkeepers: 11,500.

Estimated Burden Hours Per Respondent/Recordkeeper:

Recordkeeping	7 hr., 24 min.
Learning about the law or the form.	57 min.
Preparing the form	2 hr., 3 min.
Copying, assembling, and sending the form to the IRS.	16 min.

Frequency of Response: Annually.

Estimated Total Reporting/ Recordkeeping Burden: 123,050 hours.

OMB Number: 1545–1093.

Regulation Project Number: IA–56–87 and IA–53–87 Final.

Type of Review: Extension.

Title: Minimum Tax—Tax Benefit Rule.

Description: Section 58(h) of the 1954 Internal Revenue Code provides that the Secretary shall provide for adjusting tax preference items where such items provided no tax benefit for any taxable year. This regulation provides guidance where tax preference items provided no tax benefit because of available credits and describes how to claim a credit or refund of minimum tax paid on such preferences.

Respondents: Business or other for-profit.

Estimated Number of Respondents: 200.

Estimated Burden Hours Per Respondent: 12 minutes.

Frequency of Response: Other (one-time claim for credit or refund).

Estimated Total Reporting Burden: 40 hours.

Clearance Officer: Garrick Shear, Internal Revenue Service, Room 5244, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Alexander T. Hunt, (202) 395–7860, Office of Management and Budget, Room 10202, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports Management Officer.

[FR Doc. 00–28216 Filed 11–2–00; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

October 24, 2000.

The Department of the Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2110, 1425 New York Avenue, NW., Washington, DC 20220.

DATES: Written comments should be received on or before December 4, 2000 to be assured of consideration.

Internal Revenue Service (IRS)

OMB Number: 1545–0794.

Regulations Project Number: LR–311–81 Final (TD 7925).

Type of Review: Extension.

Title: Penalties for Underpayment of Deposits and Overstated Deposit Claims, and Time for Filing Information Returns of Owners, Officers and Directors of Foreign Corporations.

Description: Section 606 requires information returns with respect to certain foreign corporations and the

regulations provide the date by which these returns must be filed. Section 6656 provides penalties with respect to failure to properly satisfy tax deposit obligations and the regulations provide the method for applying for relief from these penalties.

Respondents: Business or other for-profit, individuals or households.

Estimated Number of Respondents: 60,000.

Estimated Burden Hours Per Respondent: 30 minutes.

Frequency of Response: On occasion.

Estimated Total Reporting Burden: 30,000 hours.

OMB Number: 1545–1098.

Regulation Project Number: FI–91–86; FI–90–86; FI–90–91; and FI–1–90 Final (TD 8428).

Type of Review: Extension.

Title: Arbitrage Restrictions on Tax-Exempt Bonds.

Description: This regulation requires state and local governmental issuers of tax-exempt bonds to rebate arbitrage profits earned on non-purpose investments acquired with the bond proceeds. Issuers are required to submit a form with the rebate. The regulations provide for several elections, all of which must be in writing.

Respondents: State, local or Tribal Government; Not-for-profit institutions.

Estimated Number of Respondents: 3,100.

Estimated Burden Hours Per Respondent: 2 hours, 46 minutes.

Frequency of Response: On occasion, Other (at most every 5 years).

Estimated Total Reporting Burden: 8,550 hours.

Clearance Officer: Garrick Shear, Internal Revenue Service, Room 5244, 1111 Constitution Avenue, NW., Washington, DC 20224.

OMB Reviewer: Alexander T. Hunt, (202) 395–7860, Office of Management and Budget, Room 10202, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports Management Officer.

[FR Doc. 00–28217 Filed 11–2–00; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Submission for OMB Review; Comment Request

October 27, 2000.

The Department of the Treasury has submitted the following public information collection requirement(s) to OMB for review and clearance under the Paperwork Reduction Act of 1995, Public Law 104–13. Copies of the submission(s) may be obtained by calling the Treasury Bureau Clearance Officer listed. Comments regarding this information collection should be addressed to the OMB reviewer listed and to the Treasury Department Clearance Officer, Department of the Treasury, Room 2110, 1425 New York Avenue, NW., Washington, DC 20220.

DATES: Written comments should be received on or before December 4, 2000 to be assured of consideration.

Internal Revenue Service (IRS)

OMB Number: 1545–1096.

Form Number: IRS Form 9117.

Type of Review: Extension.

Title: Excise Tax Program Order Blank for Forms and Publications.

Description: Form 9117 allows taxpayers who must file Form 720 returns a systemic way to order additional tax forms and informational publications.

Respondents: Business or other for-profit.

Estimated Number of Respondents: 15,000.

Estimated Burden Hours Per Respondent: 2 minutes.

Frequency of Response: Annually.

Estimated Total Reporting Burden: 500 hours.

Clearance Officer: Garrick Shear, Internal Revenue Service, Room 5244, 1111 Constitution Avenue, NW, Washington, DC 20224.

OMB Reviewer: Alexander T. Hunt, (202) 395–7860, Office of Management and Budget, Room 10202, New Executive Office Building, Washington, DC 20503.

Lois K. Holland,

Departmental Reports Management Officer.

[FR Doc. 00–28218 Filed 11–2–00; 8:45 am]

BILLING CODE 4830–01–U

DEPARTMENT OF THE TREASURY

Fiscal Service

Surety Companies Acceptable on Federal Bonds: Name Change—Michigan Mutual Insurance Company

AGENCY: Financial Management Service, Fiscal Service, Department of the Treasury.

ACTION: Notice.

SUMMARY: This is Supplement No. 3 to the Treasury Department Circular 570; 2000 Revision, published June 30, 2000, at 40868.

FOR FURTHER INFORMATION CONTACT: Surety Bond Branch at (202) 874–7102.

SUPPLEMENTARY INFORMATION: Michigan Mutual Insurance Company, a Michigan corporation, has formally changed its name to Amerisure Mutual Insurance Company, effective June 20, 2000. The Company was last listed as an acceptable surety on Federal bonds at 65 FR 40890, June 30, 2000.

A Certificate of Authority as an acceptable surety on Federal bonds, dated today, is hereby issued under Sections 9304 to 9308 of Title 31 of the United States Code, to Amerisure Mutual Insurance Company, Farmington Hills, Michigan. This new Certificate replaces the Certificate of Authority issued to the Company under its former name. The underwriting limitation of $14,225,000 established for the Company as of July 1, 2000, remains unchanged until June 30, 2001.

Certificates of Authority expire on June 30, each year, unless revoked prior to that date. The Certificates are subject to subsequent annual renewal as long as the Company remains qualified (31 CFR Part 223). A list of qualified companies is published annually as of July 1, in the Department Circular 570, which outlines details as to underwriting limitations, areas in which licensed to transact surety business and other information. Federal bond-approving officers should annotate their reference copies of the Treasury Circular 570, 2000 Revision, at page 40873 to reflect this change.

The Circular may be viewed and downloaded through the Internet at *http://www.fms.treas.gov/c570/index.html.* A hard copy may be purchased from the Government Printing Office (GPO), Subscription Service, Washington, DC, telephone (202) 512–1800. When ordering the Circular from GPO, use the following stock number: 048–000–00536–5.

Questions concerning this notice may be directed to the U.S. Department of the Treasury, Financial Management Service, Financial Accounting and Services Division, Surety Bond Branch, 3700 East-West Highway, Room 6A04, Hyattsville, MD 20782.

Dated: October 27, 2000.

Wanda J. Rogers,

Director, Financial Accounting and Services Division, Financial Management Service.

[FR Doc. 00–28246 Filed 11–2–00; 8:45 am]

BILLING CODE 4810–35–M

Federal Register

Friday,
November 3, 2000

Part II

Department of Health and Human Services

Health Care Financing Administration

42 CFR Parts 412 and 413

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 412 and 413

[HCFA–1069–P]

RIN 0938–AJ55

Medicare Program; Prospective Payment System for Inpatient Rehabilitation Facilities

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would establish a prospective payment system for Medicare payment of inpatient hospital services provided by a rehabilitation hospital or by a rehabilitation unit of a hospital. This proposed rule would implement section 1886(j) of the Social Security Act (the Act), as added by section 4421 of the Balanced Budget Act of 1997 (Public Law 105–33) and as amended by section 125 of the Balanced Budget Refinement Act of 1999 (Public Law 106–113), which authorizes the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units. It also authorizes the Secretary to require rehabilitation hospitals and rehabilitation units to submit such data as the Secretary deems necessary to establish and administer the prospective payment system. The prospective payment system described in this proposed rule would replace the reasonable cost-based payment system under which the rehabilitation hospitals and rehabilitation units are currently paid.

DATES: We will consider comments if we receive them at the appropriate address, as provided below, no later than 5 p.m. on January 2, 2001.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY:

Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1069–P, P.O. Box 8010, Baltimore, MD 21244–8010.

If you prefer, you may deliver your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW, Washington, DC 20201; or Room C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to the delivery addresses may be delayed and could be considered late.

FOR FURTHER INFORMATION CONTACT:

Robert Kuhl, (410) 786–4597 (General information).

Pete Diaz, (410) 786–1235 (Requirements for completing the Minimum Data Set for Post Acute Care (MDS–PAC), and other MDS–PAC issues).

Jacqueline Gordon, (410) 786–4517 (Payment system, the case-mix classification methodology, transition payments, relative weights/case-mix index, update factors, transfer policies, payment adjustments).

Nora Hoban, (410) 786–0675 (Calculation of the payment rates, relative weights/case-mix index, wage index, payment adjustments).

SUPPLEMENTARY INFORMATION:

Comments, Procedures, Availability of Copies, and Electronic Access

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1069–P.

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 443–G of the Department's office 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).

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To assist readers in referencing sections contained in this document, we are providing the following table of contents.

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In addition, because of the many terms to which we refer by acronym in this proposed rule, we are listing these acronyms and their corresponding terms in alphabetical order below:

ADL—Activities of Daily Living
BBA—Balanced Budget Act of 1997, Public Law 105–33
BBRA—Balanced Budget Refinement Act of 1999, Public Law 106–113
CMGs—case-mix groups
CMI—case-mix index
COS—Clinical Outcomes Systems
DRGs—diagnosis-related groups
FIM—functional independence measure
FIM—FRG-functional independence measurement-function related group
FRG—Function Related Group
FY—Federal fiscal year
HCFA—Health Care Financing Administration
HHAs—home health agencies
HMO—health maintenance organization
IRF—inpatient rehabilitation facilities
MDCN—Medicare Data Collection Network
MDS—PAC-Minimum Data Set for Post Acute Care
MedPAC—Medicare Payment Advisory Commission
MEDPAR—Medicare provider analysis and review
MPACT—MDS–PAC Tool—Minimum Data Set for Post Acute Care Tool
OASIS—Outcome and Assessment Information Set
ProPAC—Prospective Payment Assessment Commission
RICs—Rehabilitation Impairment Categories
SNF—skilled nursing facility
TEFRA—Tax Equity and Fiscal Responsibility Act of 1982, Public Law 97–248
UDSmr—Uniform Data Set for medical rehabilitation
Y2K—Year 2000/Millennium

I. Background

When the Medicare statute was originally enacted in 1965, Medicare payment for hospital inpatient services was based on the reasonable costs incurred in furnishing services to Medicare beneficiaries. The statute was later amended by section 101(a) of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97–248) to limit payment by placing a limit on allowable costs per discharge. Section 601 of the Social Security Amendments of 1983 (Public Law 98–21) added a new section 1886(d) to the Social Security Act (the Act) which replaced the reasonable cost-based payment system for most hospital inpatient services. Section 1886(d) of the Act provides for a prospective payment system for the operating costs of hospital inpatient stays effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although most hospital inpatient services became subject to a prospective payment system, certain specialty hospitals were excluded from that system. As discussed in detail in section I.A.1 of this preamble, rehabilitation hospitals and distinct part rehabilitation units in hospitals were among the excluded facilities. Subsequent to the implementation of the hospital inpatient prospective payment system, both the number of excluded rehabilitation facilities, particularly distinct part units, and Medicare payments to these facilities grew rapidly. In order to control escalating costs, the Congress, through enactment of section 4421 of the Balanced Budget Act of 1997 (BBA) (Public Law 105–33) and section 125 of the Balanced Budget Refinement Act of 1999 (BBRA) (Public Law 106–113), provided for the implementation of a prospective payment system for inpatient rehabilitation facilities.

Section 4421 of the BBA amended the Act by adding section 1886(j), which authorizes the implementation of a prospective payment system for inpatient rehabilitation services. This proposed rule would implement a Medicare prospective payment system, as authorized by section 1886(j) of the Act, for inpatient rehabilitation hospitals and units. We refer to these inpatient rehabilitation hospitals and units as ''inpatient rehabilitation facilities'' or ''IRFs'' throughout this proposed rule.

The statute provides for the prospective payment system for IRFs to be implemented for cost reporting periods beginning on or after October 1, 2000. The statute also provides for a new prospective payment system for home health services for cost reporting periods beginning on or after October 1, 2000, along with modifications to the existing prospective payment systems for acute care hospitals and skilled nursing facilities.

Although we are working very hard to implement the extensive changes required by the statute, the demands of simultaneously implementing new prospective payment systems (for example, outpatient hospital and home health) and modifying existing payment systems are significant. The creation of each new payment system or modification to an existing payment system requires an extraordinary amount of lead time to develop and implement the necessary changes to our existing computerized claims processing systems. In addition, it requires additional time after implementation to ensure that these complex changes are properly administered. After an extensive analysis of the changes required to HCFA's systems, we have concluded that it is infeasible to implement the IRF prospective payment system as of October 1, 2000. Therefore, we plan to implement the IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001. We believe that this implementation date is the earliest feasible date given the scope and magnitude of the implementation requirements associated with this and other mandated provisions.

In this proposed rule, we provide a number of discussions useful in understanding the development and implementation of the IRF prospective payment system. These discussions include the following:

- An overview of the current payment system for IRFs.
- A discussion of research on IRF patient classification systems and prospective payment systems, including prior and current research performed by the RAND Corporation.
- A discussion of statutory requirements for developing and implementing an IRF prospective payment system.
- A discussion of the proposed requirement that IRFs complete the Minimum Data Set for Post Acute Care (MDS–PAC) (a patient assessment instrument) as a part of the data collection deemed necessary by the Secretary to implement and administer the IRF prospective payment system.
- A discussion of the IRF patient classification system using case-mix groups (CMGs).
- A detailed discussion of the proposed prospective payment system including the relative weights and payment rates for each CMG, adjustments to the payment system, additional payments, and budget

neutrality requirements mandated by section 1886(j).

• An analysis of the impact of the IRF prospective payment system on the Federal budget and inpatient rehabilitation facilities, including small rural facilities.

Finally, we are proposing conforming changes to existing regulations as well as new regulations that are necessary to implement the proposed IRF prospective payment system.

A. Overview of Current Payment System for Inpatient Rehabilitation Facilities

1. Exclusion of Certain Facilities From the Hospital Inpatient Prospective Payment System

Although payment for operating costs of most hospital inpatient services became subject to a prospective payment system when the hospital inpatient prospective payment system was implemented in October 1983, certain types of specialty hospitals and units were excluded from that payment system. As set forth in section 1886(d)(1)(B) of the Act, the following hospitals were originally excluded from the hospital inpatient prospective payment system: psychiatric, rehabilitation, children's, and long-term care. Effective with cost reporting periods beginning on or after October 1, 1989 cancer hospitals were added to this list by section 6004(a) of the Omnibus Budget Reconciliation Act of 1989 Public Law (101–239). In addition, psychiatric and rehabilitation distinct part units of hospitals are excluded from the hospital inpatient prospective payment system.

These specialty hospitals were excluded by the Congress from the hospital inpatient prospective payment system because they typically treat cases that involve lengths of stay that are, on average, longer or more costly than would be predicted by the diagnosis related group (DRG) system and, therefore, could be systematically underpaid if the DRG system was applied to them. These exclusions were the result of concerns that DRGs—the classification system on which payment under the hospital inpatient prospective payment system is based—might not accurately account for the resource costs for the types of patients treated in those facilities.

The concern that DRGs might not accurately account for costs in excluded hospitals arose because the hospital inpatient prospective payment system was developed from the cost and utilization experience of general hospitals, which typically provide acute care for a variety of medical conditions. The hospital inpatient prospective payment system is a system of average-based payments that assume that some patient stays will consume more resources than the typical stay, while others will demand fewer resources.

Thus, an efficiently operated hospital should be able to deliver care to its Medicare patients for an overall cost that is at or below the amount paid under the hospital inpatient prospective payment system. In a *Report to Congress: Hospital Prospective Payment for Medicare* (1982), the Department of Health and Human Services stated that the ''467 DRGs were not designed to account for these types of treatment'' found in the four special classes of hospitals, and noted that ''including these hospitals will result in criticism * * * (and) their application to these hospitals would be inaccurate and unfair.''

Accordingly, this report to the Congress suggested that a DRG system might not work as well for these treatment classes as they did for other medical specialties. One concern was that the resource needs of patients in these excluded hospitals were not solely correlated with diagnoses. A second concern was that the mix of service intensities provided by these specialty hospitals significantly differed from that of general medical/surgical hospitals. The legislative history of the 1983 amendments to the Act stated that the ''DRG system was developed for short-term acute care general hospitals and as currently constructed does not adequately take into account special circumstances of diagnoses requiring long stays.'' (Report of the Committee on Ways and Means, U.S. House of Representatives, to Accompany HR 1900, H.R. Rep. No. 98–25, at 141 (1983)).

Following enactment in April 1983 of the Social Security Amendments of 1983, we undertook a number of initiatives to ensure implementation of the hospital inpatient prospective payment system by October 1, 1983. Important activities included the publication of the rules and regulations for the hospital inpatient prospective payment system. The interim final rule was published in the September 1, 1983 **Federal Register** (48 FR 39752). We published a final rule in the January 3, 1984, **Federal Register** (49 FR 234) following a public comment period, evaluation of comments received, and formulation of responses to and regulatory revisions to the regulations based upon the comments. Updates and modifications of the regulations are published annually in the **Federal Register**. Together, the initial statutory mandate and the published regulations addressed several important program issues. One program issue was the implementation of the criteria for hospitals that are seeking to be excluded from the hospital inpatient prospective payment system under one of the specialty classes, including IRFs. The regulations concerning exclusion from the hospital inpatient prospective payment system, in part 412, subpart B, are discussed below.

2. Requirements for Inpatient Rehabilitation Facilities To be Excluded From the Hospital Inpatient Prospective Payment System

Under section 1886(d)(1)(B) of the Act, the prospective payment system for hospital inpatient operating costs set forth in section 1886(d) of the Act does not apply to several specified types of entities, including a rehabilitation hospital ''as defined by the Secretary'' or, ''in accordance with regulations of the Secretary,'' a rehabilitation unit of a hospital which is a distinct part of the hospital ''as defined by the Secretary.'' In general, existing regulations in part 412, subpart B provide that to be excluded from the hospital inpatient prospective payment system, an IRF must—(1) Have a provider agreement or be a unit in an institution that has in effect an agreement to participate as a hospital under part 489; and (2) except for newly participating hospitals seeking to be excluded, demonstrate that they serve an inpatient population of whom at least 75 percent require intensive rehabilitative services for the treatment of 1 or more of 10 specified conditions. The specified conditions are stroke, spinal cord injury, congenital deformity, amputation, major multiple trauma, hip fracture, brain injury, polyarthritis including rheumatoid arthritis, neurological disorders, and burns. Patients in IRFs require frequent physician involvement, rehabilitation nursing, and care from a coordinated group of professionals. (All IRFs that meet the requirements in §§ 412.23(b), 412.25, and 412.29 would be paid under the IRF prospective payment system proposed in this rule.)

3. Payment System Requirements Prior to the Balanced Budget Act of 1997

Hospitals that are excluded from the hospital inpatient prospective payment system are paid for inpatient operating costs under the provisions of section 1886(b) of the Act. Until the IRF prospective payment system is implemented, IRFs are paid on the basis of Medicare reasonable costs limited by a facility-specific target amount per discharge. Each facility has a separate

payment limit or target amount that is calculated for that facility based on its cost per discharge in a base year, subject to caps. The target amount is adjusted annually by an update factor called the rate-of-increase percentage. Facilities whose costs are below their target amounts receive bonus payments equal to the lesser of half of the difference between costs and the target amount, up to a maximum of 5 percent of the target amount. For facilities whose costs exceed their target amounts, Medicare provides relief payments equal to half of the amount by which the hospitals costs exceeded the target amount up to 10 percent of the target amount. Facilities that experience a more significant increase in patient acuity can also apply for an additional amount under the regulations for Medicare exception payments.

4. Strengths and Weaknesses of the Current Payment System

Utilization of post-acute care services has grown rapidly in recent years. Since the implementation of the hospital inpatient prospective payment system, average length of stay in acute care hospitals has decreased and patients are increasingly being discharged to post-acute care settings such as IRFs, skilled nursing facilities (SNFs), home health agencies (HHAs), and long-term care hospitals to complete their course of treatment. The increased utilization of post-acute care providers, including excluded facilities, has fueled the rapid growth in payments in recent years. With increased utilization and the incentives associated with the reasonable-cost based payment system, discussed below, the number of IRFs has also increased significantly.

In its March 1999 Report to the Congress the Medicare Payment Advisory Commission (MedPAC) (formerly the Prospective Payment Assessment Commission (ProPAC)) stated, ''Aggregate spending has increased at a fairly rapid pace, reflecting increased patient volume rather than increased payments per discharge. Aggregate Medicare operating payments to rehabilitation facilities rose 18 percent annually between 1990 and 1996, from $1.9 billion to $4.3 billion. Since 1990, payments per discharge have risen less than the rate of inflation, reaching $10,500 in 1996.'' (p. 90.) The MedPAC report explains that the—

> TEFRA system has remained in effect longer than expected partly because of difficulties in accounting for the variation in resource use across patients in exempted facilities. The unintended consequences of sustaining that system have included a steady growth in the number of prospective payment system-exempt facilities and a substantial payment inequity between older and newer facilities. In particular, the payment system encouraged new exempt facilities to maximize their costs in the base year to establish high cost limits. Once subject to its relatively high limit, a recent entrant could reduce its costs below its limit, resulting in reimbursement of its full costs. * * * By contrast, facilities that existed before they became subject to TEFRA could not influence their cost limits. Given the relatively low limits of older facilities, they are more likely to incur costs above their limits and thus receive payments less than their costs. (p. 72)

To address concerns such as the historical growth in payments and disparity in payments to existing and newly excluded hospitals and units, the BBA mandated several changes to the current payment system. These changes are outlined in section I.C.1 of this preamble. In addition, we and other organizations have conducted research since the inception of the hospital inpatient prospective payment system to determine if alternate prospective payment systems are feasible for these excluded hospitals.

B. Research for Alternate Prospective Payment Systems for Inpatient Rehabilitation Facilities Prior to the Balanced Budget Act of 1997

Below is a discussion of research projects and other analyses concerning prospective payment systems that are relevant to the development of the IRF prospective payment system that we are proposing to implement in this rule.

The methods and tasks that must be undertaken in order to develop an IRF prospective payment system include development of a patient classification system that accounts for differences in patient case mix. A patient classification system is developed by classifying patients into mutually exclusive groups based on similar clinical characteristics and similar levels of resource use. A factor to weight differences in patient case mix can be developed by measuring the relative difference in resource intensity among the different groups. We are proposing to implement a payment system that uses case-mix groups and weighting factors that account for the intensity of services delivered to IRF Medicare patients.

1. Early Studies

In October 1984, as mentioned in the 1987 Report to the Congress: Developing a Prospective Payment System for Excluded Hospitals (1987), the Medical College of Wisconsin and the RAND Corporation (RAND) began a joint effort to investigate the feasibility of a prospective payment system for excluded hospitals including IRFs. The RAND Corporation is a nonprofit institution with extensive health care background in improving policy and decision making through research and analysis. This joint effort was under a HCFA cooperative agreement with the RAND Corporation. The Medical College of Wisconsin collected data from a survey of patient records that included standard discharge data, diagnostic condition, functional status and other impairment measures, billing data, and facility information gathered from telephone interviews. RAND assisted in the design and analysis of the survey data and obtained a 20 percent sample of the HCFA patient billing file for FY 1984—the implementation year of the hospital inpatient prospective payment system.

The data were used to analyze the delivery systems of rehabilitation care. The Report to the Congress stated that care in IRFs ''emphasizes the treatment of functional limitations and disability''. Functional limitations could be measured by the patient's ability to perform activities of daily living such as locomotion, dressing, eating, bathing, etc. The patient's level of performing these activities of daily living is referred to as the patient's functional status. The results of this analysis showed that ''diagnostic condition explained little, whereas functional status measures explained substantially more, of the variance in total charges for a rehabilitation stay.'' However, at the time of this analysis, a nationally-accepted set of functional status measures had not been developed for application in a classification system for IRFs.

2. Functional Status Studies

While numerous studies involved developing and assessing functional status, several researchers (for example, Batavia 1988; Johnston 1984) suggested using functional status as the basis for a rehabilitation payment system. Functional status, as measured by a patient's ability to perform activities of daily living and by mobility, can be evaluated at admission and discharge or any time during the stay. In addition, change in functional status (the difference in functional status from admission to discharge) can be measured.

Researchers evaluated several methods of using functional status at different stages of the patient's stay to develop a payment system. For the most part, the use of these methods resulted in payment systems that appeared to be inadequate in creating the proper incentives to care for high resource use

patients and to produce quality outcomes. Basing a payment system on expected improvement in a patient's functional limitations requires a scale that is sensitive to changes in functional status. In addition, precise data describing the functional status of the patient would have to be collected on admission and at periodic intervals until discharge (Hosek et al.; 1986).

The development of a patient classification system for a case-mix adjusted prospective payment system was hindered by the lack of an appropriate and widely accepted functional status measure for inpatient rehabilitation. The functional independence measure (FIM) was developed to fill this need (Hamilton *et al.,* 1987). The functional independence measure addresses a patient's functional status covering six domains—self-care, sphincter control, mobility, locomotion, social cognition, and communication. There are two national sources of functional independence measures. The Uniform Data Set for Medical Rehabilitation (UDSmr) is operated within the Center for Functional Assessment Research, U. B. Foundation Activities, Inc. The UDSmr collects data on patient age, sex, living situation prior to hospitalization, the impairment that is the primary reason for admission to the IRF, and functional status at admission and discharge. It also includes patient admission and discharge information as well as hospital charges. The Clinical Outcomes System (COS) is operated by Caredata.com, Inc. (formerly Medirisk Inc.), located in Atlanta, Georgia. The COS contains the same type of patient information as UDSmr. However, we have been notified that the COS has been discontinued as of July 2000.

3. Studies on Patient Classification Systems

In 1991, Nancy Diane Harada presented a study in her dissertation titled ''The Development of a Resource-Based Patient Classification Scheme for Rehabilitation.'' This study developed a clinically-based, diagnosis-specific patient classification system for rehabilitation hospital services. The final classification system in this study includes 33 patient classification groups. The patient classification groups are referred to as Rehabilitation Functional Related Groups.

Harada believed that, at the facility level, the rehabilitation functional related groups could be viewed as a managerial tool to monitor the quality of care, as well as the resources expended in the treatment of rehabilitation patients. From a policy perspective, use of the rehabilitation functional related groups could minimize the adverse incentives for IRFs to underserve certain groups that may arise from the lack of case-mix index adjusted payments in the current cost limit payment system. The results of this study found that rehabilitation functional related group methodology may provide an appropriate basis for the prospective payment of rehabilitation services.

Using FIM data reported to UDSmr, a team of researchers from the University of Pennsylvania developed a patient classification system, Function Related Groups (FRGs), referred to as the FIM–FRGs (Stineman *et al.,* 1994). The American Rehabilitation Association (currently known as the American Medical Rehabilitation Providers Association) funded the development of a prototype of function related groups. Further work and revisions were funded by the Agency for Health Care Research and Quality, formerly known as the Agency for Health Care Policy and Research and the National Center for Medical Rehabilitation Research at the National Institutes of Health.

As FIM–FRGs were refined, they were reframed using the International Classification of Impairments, Disabilities and Handicaps to ensure a better measure of the consumption of rehabilitation resources, prognosis, and outcome (Stineman, 1997). These classifications were designed to be related to the major categories of the DRGs and indirectly linked to the ICD–9–CM with focus on disabilities and impairment categorization.

This original work on a FIM–FRG patient classification system identified 21 clinically defined rehabilitation impairment categories (RICs) such as stroke, traumatic brain dysfunction, non-traumatic brain dysfunction, and non-traumatic spinal cord injury. The RICs were then subdivided into FIM–FRGs using the FIM motor score, FIM cognitive score, and age. Accordingly, the FIM–FRG patient classification system first sorted patients into a RIC and then used assessments of patient functional and cognitive abilities and age to classify them into a FIM–FRG.

4. HCFA-Sponsored Analysis by RAND

In 1994, we contracted with RAND for analyses designed to: (1) examine the stability of the original FRGs; (2) extend the FRGs to take account of previously unexamined cases (re-admissions), previously unused information (interrupted stays), and newly available data (Medicare data on comorbidities and complications); and (3) evaluate the performance of FRGs when cost rather than length of stay is used to form groups and when only Medicare cases rather than all cases are used to form groups.

RAND's analyses: (1) evaluated the suitability of the FIM–FRG patient classification system; (2) evaluated a prospective payment system for inpatient rehabilitation facilities based on the FIM–FRGs; and (3) prepared final reports describing the evaluation of the UDSmr, FIM, and FIM–FRGs. This analysis used more current data to replicate and update previous work performed by RAND in 1990.

Two data systems—the UDSmr and Medicare program information—were the primary sources for these analyses. UDSmr provided RAND with functional status and demographic information for rehabilitation discharge data on 139,360 cases from 352 IRFs from calendar year 1994. The Medicare program information included Medicare bill and cost report data for 1994.

The first step of the analysis involved matching UDSmr cases with Medicare records using patient and facility identifiers. Because patient and facility identifiers on the UDSmr records were encrypted, it was necessary to use a sophisticated matching probability technique to match Medicare records to a corresponding UDSmr case. In addition, several thousand of the Medicare discharges corresponded to part of an interrupted rehabilitation stay. For the purposes of this analysis, a rehabilitation stay interrupted by a single admission to an acute care hospital is treated as two rehabilitation discharges, one interrupted by two admissions to an acute care hospital is treated as three rehabilitation discharges, and so on. Using this definition of ''interrupted stays'', RAND stated that the 139,360 cases found in the UDSmr data corresponded to 144,719 Medicare discharges. A file with the matched patient data was created.

RAND then subjected this patient data to a rigorous and complex statistical algorithm to test the predictive power of resource use to classify these patients into RICs and corresponding FIM–FRGs. As a result, RAND recommended that the number of FRGs per RIC be limited to a maximum of 5 and proposed a total of 70 FRGs. Facility level data from the hospital cost report information system file was used to test the feasibility of using the resulting FIM–FRGs to develop an IRF prospective payment system.

The results of the RAND study were released in September 1997 and are contained in two reports available through the National Technical

Information Service (NTIS). The reports are—

• Classification System for Inpatient Rehabilitation Patients—A Review and Proposed Revisions to the Function Independence Measure-Function Related Groups, NTIS order number PB98–105992INZ; and

• Prospective Payment System for Inpatient Rehabilitation, NTIS order number PB98–106024INZ. These reports can be ordered by calling the NTIS sales desk at 1–800–553–6847 or by e-mail at *orders@ntis.fedworld.gov*.

RAND found that, with limitations, the FIM–FRGs were effective predictors of resource use based on the proxy measurement: length of stay. FRGs based upon FIM motor scores, cognitive scores, and age remained stable over time (prediction remained consistent between the 1990 and 1994 data). Researchers at RAND developed, examined, and evaluated a model payment system based upon FIM–FRG classifications that explains approximately 50 percent of patient costs and approximately 60 to 65 percent of costs at the facility level. Based on this analysis, RAND concluded that a rehabilitation prospective payment system using this model is feasible. RAND's design of a rehabilitation prospective payment system aimed to achieve the following three important goals:

• To provide hospitals with incentives for efficiency.

• To ensure access to high quality and appropriate care for all Medicare beneficiaries.

• To distribute Medicare payments to hospitals in an equitable way.

RAND needed to account adequately for each hospital's patient mix and for other appropriate factors that affect costs. This aspect of the analysis was based on the notion that Medicare should not pay hospitals more for inefficiency or even for a greater intensity of care than is typically received by patients with similar clinical characteristics and social support levels.

Two technical advisory panels provided advice concerning this research. The first panel reviewed the reliability of the FIM scoring process and the second panel provided guidance on the development of the patient classification system. These panels raised some major concerns about the FIM–FRG research.

First, the UDSmr data represented only 24 percent of IRFs and accounted for 40 percent of all Medicare cases in IRFs. Second, the UDSmr data over-represented free-standing rehabilitation hospitals and under-represented excluded units with a slight over-representation of teaching hospitals. Third, while the FIM–FRG system is a good predictor of length of stay, more work was needed to determine the system's ability to predict the intensity of services furnished during a stay. Fourth, hospital charges might not accurately reflect actual resource use in this context, so relative weights based on hospital charges might be distorted. This problem would be further exacerbated because there is evidence of unexplainable distorted charging patterns among facilities under the current payment limits, which have been in effect for a prolonged period of time.

5. Prospective Payment Assessment Commission Analysis for 1997 Report to Congress

In its 1997 Report to Congress, the Prospective Payment Assessment Commission (ProPAC) recommended that a prospective payment system for IRFs based on patient case mix should be implemented as soon as possible. ProPAC stated that RAND's work on the FIM–FRGs could be an adequate basis for prospective payment, and that implementation of a system in the near future is feasible. (ProPAC's March 1, 1997 report was published as Appendix F to our proposed rule ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates'' published in the June 2, 1997 **Federal Register** (62 FR 29902).)

In response to this recommendation, we cited in our final rule ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates'' published in the August 29, 1997, **Federal Register** (62 FR 45966), the concerns raised by the technical advisory panels and our review of the RAND analysis as issues that needed to be further addressed before implementing a prospective payment system using the FIM–FRG patient classification system. In addition, we stated that our preference is to focus on developing a coordinated payment system for post-acute care across all settings that relies on a core assessment tool. Accordingly, one of our goals in developing a prospective payment system would be that it is based on the characteristics of the patient and their needs rather than the characteristics or type of provider of care.

C. Requirements of the BBA and the BBRA for Inpatient Rehabilitation Facilities

1. Provisions for the Current Payment System

The following BBA provisions relating to the current payment system were explained in detail and implemented in our final rule published in the August 29, 1997 **Federal Register** (62 FR 45966).

Section 4411 describes the update of payments for specific fiscal years (FYs) using the market basket effective for cost reporting periods beginning on or after October 1, 1997.

Section 4412 describes the reduction of capital payments for FYs 1998 through 2002, effective October 1, 1997.

Section 4413 describes the provisions for rebasing a facility's target amount for cost reporting periods beginning during FY 1998.

Section 4414 describes the requirement to cap and update the rate-of-increase limits for cost reporting periods beginning on or after October 1, 1997.

Section 4415 describes the provisions regarding bonus and relief payments effective for cost reporting periods beginning on or after October 1, 1997.

Section 4419 eliminates the exemptions from the target amounts effective for cost reporting periods beginning on or after October 1, 1997.

2. Provisions for a Prospective Payment System

Section 4421(a) of the BBA amended the Act by adding a new section 1886(j) to the Act that provides for the implementation of a Medicare prospective payment system for all IRFs. For cost reporting periods beginning on or after the implementation date and before October 1, 2002, payment to IRFs will be based on a blend of—(1) the amount that would have been paid under Part A with respect to these costs if the prospective payment system were not implemented and (2) the IRF Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, IRFs will be paid under the fully implemented Federal prospective payment system.

Under the prospective payment system, rehabilitation facilities will be paid based on predetermined amounts. These prospective payments will encompass the inpatient operating and capital costs of furnishing covered rehabilitation services (that is, routine, ancillary, and capital costs) but not for costs of approved educational activities, bad debts, and other costs not subject to the provisions of the IRF prospective

payment system. Covered rehabilitation services include services for which benefits are provided under Part A (the hospital insurance program) of the Medicare program.

Section 1886(j)(1)(A) of the Act provides that, notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of payment for inpatient rehabilitation hospital services equals an amount determined under section 1886(j) of the Act. Sections 1886(j)(1)(A)(i) and (ii) of the Act provide for a transition phase covering cost reporting periods that begin during the first two Federal fiscal years under the prospective payment system. During this transition phase, IRFs will receive a payment rate comprised of a blend of the ''TEFRA percentage'' of the amount that would have been paid under Part A with respect to those costs if the prospective payment system had not been implemented, and the ''prospective payment percentage'' of payments using the IRF prospective payment system rate.

Section 1886(j)(1)(B) of the Act sets forth a requirement applicable to all facilities for the payment rates under the fully implemented system. Notwithstanding section 1814(b) of the Act and subject to the provisions of section 1813 of the Act regarding beneficiary deductibles and coinsurance responsibility, the amount of the payment with respect to the operating and capital costs of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, will be equal to the per unit payment rate established under this prospective payment system for the fiscal year in which the payment unit of service occurs.

Sections 1886(j)(1)(C)(i) and (ii) of the Act set forth the applicable TEFRA and prospective payment rate percentages during the transition period. For a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the ''TEFRA percentage'' is 66⅔ percent and ''the prospective payment percentage'' is 33⅓ percent; and on or after October 1, 2001, and before October 1, 2002, the ''TEFRA percentage'' is 33⅓ percent and ''prospective payment percentage'' is 66⅔ percent.

Section 1886(j)(1)(D) of the Act contains the definition of ''payment unit.'' Until the passage of the BBRA, ''payment unit'' was defined by the statute as ''a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary''. However, section 125(a)(1) of the BBRA amended section 1886(j)(1)(D) of the Act by striking ''day of inpatient hospital services, or other unit of payment defined by the Secretary.'' Accordingly, the payment unit utilized in the IRF prospective payment system will be a discharge.

Section 125(a)(3) of the BBRA also amended the Act by adding a new section 1886(j)(1)(E) to the Act that states: ''(E) CONSTRUCTION RELATING TO TRANSFER AUTHORITY.—Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.'' We invite comments on the proposed transfer policy discussed in section V. of this preamble.

Section 1886(j)(2)(A) of the Act, as added by the BBA, directed the Secretary to establish case-mix groups based on the factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient. This section also requires the Secretary to establish a method of classifying specific patients in rehabilitation facilities within these groups. The BBRA amended section 1886(j)(2)(A)(i) of the Act to describe the classification system to read as follows: ''Classes of patient discharges of rehabilitation facilities by functional-related groups (each in this subsection referred to as a 'case mix group'), based on impairment, age, comorbidities, and functional capability of the patient and such other factors as the Secretary deems appropriate to improve the explanatory power of functional independence measure-function related groups.''

Section 1886(j)(2)(B) of the Act provides that the Secretary will assign each case-mix group a weighting factor reflecting the facility resources used for patients within the group as compared to patients classified within other groups.

Section 1886(j)(2)(C)(i) of the Act directs the Secretary to adjust ''from time to time'' the case-mix classifications and weighting factors ''as appropriate to reflect changes in treatment patterns, technology, case-mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources.'' Such periodic adjustments shall be made in a manner so that changes in aggregate payments are a result of real changes in case-mix, not changes in coding that are unrelated to real changes in case-mix. Section 1886(j)(2)(C)(ii) of the Act provides that, if the Secretary determines that adjustments to the case-mix classifications or weighting factors resulted in (or are likely to result in) a change in aggregate payments that does not reflect real changes in case-mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of the coding or classification changes.

Section 1886(j)(2)(D) of the Act authorizes the Secretary to require rehabilitation facilities to submit such data as the Secretary deems necessary to establish and administer the IRF prospective payment system.

Section 1886(j)(3)(A) of the Act describes how the prospective payment rate will be determined. A prospective payment rate will be determined for each payment unit for which an IRF is entitled to payment under the prospective payment system. The payment rate will be based on the average payment per payment unit for inpatient operating and capital costs of IRFs, using the most recently available data, and adjusted by the following factors:

- Updating the per-payment unit amount to the fiscal year involved by the applicable percentage increase (as defined by section 1886(b)(3)(B)(ii) of the Act) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor specified by the Secretary for subsequent fiscal years;
- Reducing the rate by a factor equaling the proportion of Medicare payments under the prospective payment system as estimated by the Secretary based on prospective payment amounts which are additional payments relating to outlier and related payments;
- Accounting for area wage variations among IRFs;
- Applying the case-mix weighting factors; and
- Adjusting for such other factors as determined necessary by the Secretary to properly reflect variations in necessary costs of treatment among IRFs.

Section 1886(j)(3)(B) of the Act directs the Secretary to establish IRF prospective payment system payment rates during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, total payments under the new system will equal 98 percent of the amount that would have been made for operating and capital costs in those years if the IRF prospective payment system had not been implemented. In establishing these payment amounts, the Secretary shall consider the effects of

the prospective payment system on the total number of payment units from IRFs and other factors.

Section 1886(j)(3)(C) of the Act addresses the annual increase factor, to be applied beginning with FY 2001. This factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under section 1886(j) of the Act.

Under section 1886(j)(4)(A) of the Act, the Secretary is authorized but not required to provide for an additional payment to a rehabilitation facility for patients in a case-mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary. The amount of the additional payment must approximate the marginal cost of care above what otherwise would be paid and must be budget neutral. The total amount of the additional payments to IRFs under the prospective payment system for a fiscal year may not be projected to exceed 5 percent of the total payments based on prospective payment rates for payment units in that year.

Section 1886(j)(4)(B) of the Act establishes that the Secretary is authorized but not required to provide for adjustments to the payment amounts under the prospective payment system as the Secretary deems appropriate to take into account the unique circumstances of IRFs located in Alaska and Hawaii.

Section 1886(j)(5) of the Act provides for the Secretary to publish in the **Federal Register**, on or before August 1 of each fiscal year, the classifications and weighting factors for the IRF case-mix groups and a description of the methodology and data used in computing the prospective payment rates for that fiscal year.

Section 1886(j)(6) of the Act provides that the Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of IRFs' costs that are attributable to wages and wage-related costs, of the prospective payment rates for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the IRF compared to the national average wage level for such facilities. Additionally, the Secretary is required to make a budget-neutral update to the area wage adjustment factor no later than October 1, 2001, and at least once every 36 months thereafter. The budget neutral update is based on information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services.

Sections 1886(j)(7)(A), (B), (C) and (D) of the Act establish that there shall be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the establishment of case-mix groups, of the methodology for the classification of patients within these groups, the weighting factors, the prospective payment rates, outlier and special payments and area wage adjustments.

Section 125(b) of the BBRA provides that the Secretary shall conduct a study of the impact on utilization and beneficiary access to services of the implementation of the IRF prospective payment system. A report on the study must be submitted to the Congress not later than 3 years after the date the IRF prospective payment system is first implemented.

D. Policy Objectives in Developing a Prospective Payment System for Inpatient Rehabilitation Facilities

In developing the prospective payment system for IRFs, we identified policy objectives to evaluate the relative merits of the various policy options considered. The objectives we identified include the following:

- The creation of a beneficiary-centered payment system that promotes quality of care, access to care, and continuity of care and is administratively feasible while controlling costs.
- The provision of incentives to furnish services as efficiently as possible without diminishing the quality of the care or limiting access to care.
- The creation of a payment system that is fair and equitable to facilities, beneficiaries, and the Medicare program.
- The IRF prospective payment system must be able to recognize legitimate cost differences among various settings furnishing the same service; and any patient classification system used to group patients and services should be based on clinically coherent categories and, at the same time, reflect similar resource use. This would limit opportunities to ''upcode'' or ''game'' the system.

In its March 1999 Report to the Congress, MedPAC recommended in detail the type of prospective payment system it believed should be implemented for IRFs. As will be discussed further in this proposed rule, MedPAC's recommendations share much with our approach and policy objectives for the development of an IRF prospective payment system. Both HCFA and MedPAC believe the IRF prospective payment system should include the use of a comprehensive patient assessment instrument such as the MDS-PAC. HCFA and MedPAC both seek sufficient data to devise a patient classification system that effectively predicts resource use. HCFA and MedPAC believe the prospective payment system should be based on reliable and valid payment weights using functional and other diagnostic data. We agree with MedPAC's recommendation to use a per discharge unit of payment. Also, there is a shared belief that a discharge-based system provides an inherent incentive to discharge patients prematurely, and that this impetus could be overcome by implementing sound transfer and short-stay policies as part of the prospective payment system. Accordingly, we have taken steps to initiate the appropriate research to meet our immediate needs in developing this proposed rule and in implementing an IRF prospective payment system, as well as to collect data for the future that may reflect actual facility resources used to meet the needs of Medicare beneficiaries.

E. Discussion of Evaluated Options for the Prospective Payment System for Inpatient Rehabilitation Facilities

We used the objectives identified above in section I.D. of the preamble to evaluate policy options under consideration. The IRF prospective payment system we are proposing consists of the following major components: the patient assessment instrument; the patient classification system; the unit of payment; and the data used to construct the payment rates. A brief discussion of the major issues and options considered in preparing this proposed rule follows.

1. Patient Assessment Instrument

Data from a patient assessment instrument will allow us to: (1) Group patients into a CMG for payment under the prospective payment system; and (2) monitor the effects the prospective payment system has on the access and the quality of patient care. We have reviewed the data elements of the UDSmr and COS instruments and the MDS–PAC. We are proposing to use the MDS–PAC because we believe it contains the data elements that will better enable us to implement and administer the IRF prospective payment system required by section 1886(j) of the Act. In section III of this preamble, we will discuss in detail the reasons for our proposal to use the MDS–PAC patient assessment instrument.

2. Patient Classification System

The patient classification system is another important component of the prospective payment system. We initially considered two primary patient classification systems—one similar to the hospital inpatient prospective payment system and the other similar to the one used in the skilled nursing facility prospective payment system. Ideally, we would like to maintain similar classification systems for those entities delivering comparable services. We recognize a unified classification system would have to recognize patient needs and facilitate appropriate compensation across various post-acute care settings. Section 125(a) of the BBRA mandated the use of a per discharge payment unit and established classes of patients by functional-related groups. Therefore, in implementing the IRF prospective payment system we will use CMGs, consistent with section 1886(j)(2) of the Act.

3. Unit of Payment

Under the provisions of section 1886(j)(1)(D) as added by the BBA, we considered using either a per diem or a per discharge unit of payment. The vast majority of rehabilitation episodes begin with an acute event. The goal of inpatient rehabilitation is functional improvement that will allow the patient to return to independent living in the community, and, as evidenced by ongoing research, the majority of cases are, in fact, discharged to a community setting. Further, a discharge is also the current unit of payment under the TEFRA payment system. Finally, as noted above, the BBRA amends the Act to provide that the ''payment unit'' under the IRF prospective payment system is the discharge. Therefore, we propose to use a per discharge payment unit in accordance with section 1886(j)(1)(D) of the Act.

4. Data Used to Construct Payment Rates

We gave careful consideration in deciding which data to use to create the proposed relative weights and payment rates. Two sources of data were considered: (1) Medicare bill and corresponding UDSmr/COS data; and (2) patient level staff time measurements. The methodology we are proposing to use to calculate the relative weights of each CMG attempts to account for the cost variations among rehabilitation facilities and focus on variations among patient types. Further, the payment rates we are proposing are established in a budget neutral manner in accordance with section 1886(j)(3)(B) of the Act. Section V of the preamble describes the methodology that we are proposing to use to develop relative weights and payment rates.

Under the current payment system, payment limits are based on historical costs in a base period. Accordingly, payments to a given facility for a given year might not accurately reflect the facility's actual costs in that year. Creating a new payment system based on costs that are a product of the existing payment methodology raises concerns that these costs may not adequately reflect actual resource use. In order to develop a prospective payment system that is more reflective of the actual costs of delivering care, further work is needed to identify these costs and the services and resources required by patients. The IRF data from calendar years 1996 and 1997 bills and FY 1997 cost reports contain the most recent available data we have to create the new IRF prospective payment system rates.

We will continue to explore other options, including the use of staff time measurements, later Medicare bill and UDSmr/COS data, and other data to improve the explanatory power of the CMGs and to derive payments that more directly reflect the resources used to produce services delivered in the IRFs.

F. Inpatient Rehabilitation Facility Prospective Payment System—General Overview

In accordance with the requirements of section 1886(j) of the Act, we are proposing to implement a prospective payment system for IRFs that will replace the current reasonable cost-based payment system. The new prospective payment system will utilize information from a patient assessment instrument to classify patients into distinct groups based on clinical characteristics and expected resource needs. Separate payments are calculated for each group with additional case and facility level adjustments applied, as described below.

1. Patient Assessment Provisions

We are proposing to require IRFs to complete the MDS–PAC patient assessment instrument for all Medicare patients admitted or discharged on or after April 1, 2001. In accordance with our proposed assessment schedule, the MDS–PAC would be completed on the 4th, 11th, 30th, and 60th day from the admission date of a Medicare patient and upon the discharge of a Medicare patient. In general, a 3-day observation period would be required prior to the completion of the MDS–PAC. Data from the MDS–PAC will be used to—

- Determine the appropriate classification of a Medicare patient into a CMG for payment under the prospective payment system (using data from only the MDS–PAC completed on the fourth day);
- Implement a system to monitor the quality of care furnished to Medicare patients; and
- Ensure that appropriate case-mix and other adjustments can be made to the proposed patient classification system.

A computerized MDS–PAC data collection system will be developed. Facilities will be required to input the MDS–PAC data into the data system. In general, this system consists of a computerized patient grouping software program (grouper software) and data transmission software.

Upon the discharge of the patient, the existing Medicare claim form will be completed with the appropriate CMG indicated on the claim form so that the prospective payment can be made. The operational aspects and instructions for completing and submitting Medicare claims under the IRF prospective payment system will be addressed in a Medicare Program Memorandum once the final system requirements are developed and implemented.

Further details about the MDS–PAC patient assessment instrument and data collection system are discussed in section III of this preamble.

2. Patient Classification Provisions

We are proposing a patient classification system that uses case-mix groups called CMGs. The CMGs classify patient discharges by functional-related groups based on a patient's impairment, age, comorbidities, and functional capability. We began the development of the CMGs by using the FIM–FRG classification system and, with the most recent data available, we identified clinical aspects of the FIM–FRG system that could be improved to increase the ability of the CMGs to predict resource use. Further details of the proposed CMG classification system are discussed in section IV of this preamble.

3. Payment Rate Provisions

The payment unit for the proposed IRF prospective payment system for Medicare patients will be a discharge. The payment rates will encompass inpatient operating and capital costs of furnishing covered inpatient rehabilitation hospital services, including routine, ancillary, and capital costs, but not the costs of bad debts or of approved educational activities.

Beneficiaries may be charged only for deductibles, coinsurance amounts, and

non-covered services (for example, telephone, and television, etc.). They may not be charged for the differences between the hospital's cost of providing covered care and the proposed Medicare prospective payment amount.

The prospective payment rates that we are proposing to implement are determined using relative weights to account for the variation in resource needs among CMGs. We would adjust the payment rates to account for area differences in hospital wages. We would update the per discharge payment amounts annually. During FYs 2001 and 2002, the prospective payment system will be ''budget neutral'', in accordance with the statute. That is, total payments for IRFs during these fiscal years will be projected to equal 98 percent of the amount of payments that would have been paid for operating and capital costs of IRFs had this new payment system not been enacted. This is discussed in detail in section V of this preamble.

Based on our analysis of the data, we are proposing to adjust the payment rates for facilities located in rural areas and for costs associated with treating low income patients.

We are proposing to make additional payments to IRFs for discharges meeting specified criteria as ''outliers.'' For the purposes of this proposed rule, outliers are cases that have unusually high costs when compared to the cases classified in the same CMG. We are proposing outlier payments that are projected to equal 3 percent of total estimated payments.

In conjunction with an outlier policy, we are proposing payment policies regarding short stay cases and for cases that expire. In addition, we are proposing to implement a transfer policy, consistent with section 1886(j)(1)(E) of the Act, as added by the BBRA. (A detailed description of these policies appears in section V of the preamble.)

4. Implementation of the Prospective Payment System

The statute provides for a 2-year transition period. During that time, 2 payment percentages will be used to determine an IRF's total payment under the prospective payment system as follows. For a cost reporting period beginning on or after April 1, 2001 and before October 1, 2001, the total prospective payment will consist of 66⅔ percent of the amount based on the current payment system and 33⅓ percent of the proposed Federal prospective payment. For a cost reporting period beginning during FY 2002, the total prospective payment will consist of 33⅓ percent of the amount based on the current payment system and 66⅔ percent of the proposed Federal prospective payment. For cost reporting periods beginning on or after October 1, 2002, Medicare payment for IRFs will be determined entirely under the proposed Federal prospective payment methodology.

G. Applicability of the Inpatient Rehabilitation Facility Prospective Payment System

This proposed rule would not change the criteria for a hospital or hospital unit to be classified as a rehabilitation hospital or a rehabilitation unit that is excluded from the hospital prospective payment systems under sections 1886(d) and 1886(g) of the Act, nor would it revise the survey and certification procedures applicable to entities seeking this classification. Accordingly, for cost reporting periods beginning on or after April 1, 2001, hospitals or hospital units that are classified as rehabilitation hospitals or rehabilitation units under subpart B of part 412 of the regulations will be paid under the proposed IRF prospective payment system (except for IRFs that are paid under the special payment provisions at § 412.22(c) of the regulations) as described below.

The following rehabilitation hospitals and rehabilitation units, that are currently paid under section 1886(b) of the Act, would be paid under the proposed IRF prospective payment system for cost reporting periods beginning on or after April 1, 2001:

1. Excluded Rehabilitation Hospitals and Rehabilitation Units

We are proposing that the IRF prospective payment system apply to inpatient rehabilitation services furnished by Medicare participating entities that are classified rehabilitation hospitals or rehabilitation units under §§ 412.22, 412.23, 412.25, 412.29 and 412.30.

2. Excluded Rehabilitation Hospitals and Rehabilitation Units Outside the 50 States and the District of Columbia

Excluded rehabilitation hospitals and rehabilitation units located in Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Marianas, and the District of Columbia will be subject to the IRF prospective payment system.

The following hospitals are paid under special payment provisions, as described in § 412.22(c), and, therefore, are *not* subject to the proposed IRF prospective payment system rules:

- Veterans Administration hospitals.
- Hospitals that are reimbursed under State cost control systems approved under 42 CFR part 403.
- Hospitals that are reimbursed in accordance with demonstration projects authorized under section 402(a) of Public Law 90–248 (42 U.S.C. 1395b–1) or section 222(a) of Public Law 92–603 (42 U.S.C. 1395b–1 (note)).

II. Current Research To Support the Establishment of the Inpatient Rehabilitation Prospective Payment System—Update of the RAND Analysis

A. Overview of the Updated Work for the Proposed Rule

In July 1999, we contracted with the RAND Corporation (RAND) to update their previous research discussed in section I of this proposed rule. The update included an analysis of FIM data, the FRGs, and the model rehabilitation prospective payment system using more recent data from a greater number of IRFs. The purpose of updating the previous research is to develop the underlying data necessary to assist us in designing, developing, implementing, monitoring, and refining the proposed Medicare IRF prospective payment system based on case-mix groups. In addition, RAND expanded the scope of their previous research to include the examination of several payment elements, such as comorbidities and facility-level adjustments, as well as focus on implementation issues, including evaluation and monitoring. The update is restricted to Medicare patient data and the payment system is designed for payment of Medicare inpatient operating and capital costs only.

Specifically, for this proposed rule, RAND performed the following tasks:

- Constructed an updated data file, using the most recent data available from UDSmr, COS, HCFA, and other data sources.
- Determined the extent to which the UDSmr and COS data are representative of the Medicare population.
- Identified factors or variables that may be used to help us design and implement the payment system.
- Developed data on the elements of the payment system regarding the patient classification system, relative weights and payment rates for each case-mix group, facility-level adjustments, and patient-level adjustments.
- Developed data to examine the joint performance of all of the payment system elements by simulating facility payments for our analysis of the impact of implementing the payment system.

• Developed data to assist in identifying specific issues in connection with implementing the payment system.

• Presented options regarding the design and development of a system to monitor the effects of the payment system and other changes in the health care market on IRFs and on other post-acute care providers, including home health agencies and skilled nursing facilities, by measuring factors such as access, utilization, quality, and cost of care.

B. Construction of Data File for Analysis

Using the methodology in its previous research, RAND constructed a data file that was used to develop the proposed CMG patient classification system and the resulting payment weights, rates, and payment adjustments using more recent data. The analysis of this data file forms the basis of our discussion on the patient classification methodology and the structure of the payment system proposed in this rule. We expect that further analysis of the data file and review of the comments that we receive in response to this proposed rule may result in refinements to some patient CMGs and corresponding weights and rates.

C. Description of Sources of the Data File

The essential sources of the data file are Medicare program information and patient case-mix data. The Medicare program information includes patient discharge files (patient demographic, clinical, and financial information) and facility-level files (facility characteristics and financial information). Patient case-mix data is collected by IRFs using a patient assessment instrument. We are proposing to require the use of the MDS–PAC patient assessment instrument that includes patient case-mix data similar to the data collected on the UDSmr and COS, as described in section III of this preamble. However, the availability of MDS–PAC data records is limited to the sample of providers that participated in the pilot and field tests during its development. Therefore, to initially establish the IRF prospective payment system, we will be using a larger number of data records (as compared to the 1994 data used in RAND's previous study) from UDSmr and COS to represent more adequately the total number of IRFs.

1. Medicare Program Data

For this proposed rule, RAND used calendar year 1996 and 1997 Medicare Provider Analysis and Review (MEDPAR) files. The MEDPAR file contains the records for all Medicare hospital inpatient discharges (including discharges for rehabilitation facilities). The data in the MEDPAR file include patient demographics (age, gender, race, residence zip code), clinical characteristics (diagnoses and procedures), and hospitalization characteristics (admission date, discharge date, days in intensive-care wards, charges by department, and payment information).

The Medicare cost report data is contained in the Health Care Provider Cost Report Information System (HCRIS). The cost report files contain information on facility characteristics, utilization data, and cost and charge data by cost center. For this proposed rule, RAND used the HCRIS file containing the most current available cost data for cost reporting periods beginning during FYs 1996 and 1997. Supplementary information to this file includes—(1) The wage data for the area in which an IRF is located, (2) data on the number of residents assigned to rehabilitation units and the distribution of resident time across inpatient and outpatient settings, (3) data on the number of Medicare cases at each IRF that represent Supplemental Security Income (SSI) beneficiaries, and (4) information about payments under the current reasonable cost payment system.

The Online Survey, Certification and Reporting System (OSCAR) file retains a list of all IRFs that are currently Medicare certified. For this proposed rule, RAND used the OSCAR file to identify instances in which we may be missing facility-level data.

2. Patient Case-Mix Data

We entered into agreements with the University at Buffalo Foundation Activities, Inc. and Caredata.com, Inc. to retrieve UDSmr and COS data, respectively, for RAND's updated research. For this proposed rule, RAND used both UDSmr and COS data that describe rehabilitation stays in participating hospitals for calendar years 1996 and 1997. The data include demographic descriptions of the patient (birth date, gender, zip code, ethnicity, marital status, living setting), clinical descriptions of the patient (condition requiring rehabilitation, ICD–9–CM diagnoses, functional independence measures at admission and discharge) and the hospitalization data (encrypted hospital identifier, admission date, discharge date, charges, payment source, and an indicator of whether this is the first rehabilitation hospitalization for this condition, a readmission, or a short stay for evaluation).

D. Description of the Methodology Used To Construct the Data File

Under a separate contract, we contracted with RAND in September 1998 to construct a data file that linked the 1996 and 1997 UDSmr and COS patient records with patient records on the respective MEDPAR files that describe the same discharge. Under this contract, RAND determined the Medicare provider number(s) that correspond to each UDSmr/COS facility code. Next, RAND matched the UDSmr/COS and MEDPAR patients within the paired facilities.

Because of the proprietary and sensitive nature of the UDSmr and COS patient records, certain data fields that specifically identify the patient and the servicing IRF were encrypted. Therefore, as in RAND's previous study (see section I of this preamble), it was necessary to subject the UDSmr, COS, and MEDPAR records to a sophisticated and complex matching probability technique. The result produces the most statistically valid match of patient/facility records and a data file that contains the characteristics of each Medicare beneficiary and his or her servicing IRF.

Because of the complex scope and nature of the matching technique used, we have included in Appendix A of this proposed rule a technical discussion of each step taken to create the data file. The tables contained in Appendix A show the actual effects of applying the matching technique on both the patient and facility records.

E. Representativeness of the Data File

It is extremely important to examine the quality of the resulting match, including the extent to which the linked MEDPAR and UDSmr/COS records are representative of the MEDPAR universe. After constructing the data file described in Appendix A, we believe that the file contains the best available data to construct a prospective payment system for all IRFs within the parameters of the statutory requirements. Our analysis of the data file allows us to develop the proposed CMG patient classification and payment system, described below in sections IV and V of this preamble.

F. Analyses To Support Future Adjustments to the Payment System

The principal goal of the analysis described above is to determine the extent to which measurable patient characteristics permit classification of patients into identifiable groups that accurately predict the use of resources in inpatient rehabilitation facilities. The

research to date indicates that CMGs are effective predictors of resource use as measured by proxies such as length of stay and charges. The use of these proxies is necessary because data that measures actual nursing and therapy time spent on patient care, and other resource use data, are not available. The scientifically structured collection of data on patient characteristics and patient-specific resource use may enhance our ability to refine the CMGs in a manner that supports our policy objectives for implementing a IRF prospective payment system. Accordingly, we have contracted with Aspen Systems Corporation to collect actual resource use data in a sample of IRFs. The data collected by Aspen will be submitted to RAND for analysis to determine if it can be used to support future refinements to the CMGs.

III. The Minimum Data Set for Post-Acute Care (MDS–PAC) Patient Assessment Instrument

A. Implementation of the MDS–PAC

Under section 1886(j)(2)(D) of the Act, ''The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.'' The collection of patient data is indispensable for the successful development and implementation of the IRF prospective payment system. A comprehensive, reliable system for collecting standardized patient assessment data is necessary for: (1) The objective assignment of Medicare beneficiaries to appropriate IRF CMGs; (2) the development of a system to monitor the effects of an IRF prospective payment system on patient care and outcomes; (3) the determination of whether future adjustments to the IRF CMGs are warranted; and (4) the development of an integrated system for post-acute care in the future.

The MDS–PAC is the standardized patient assessment instrument we are proposing to use under the IRF prospective payment system. We acknowledge that the nature of the patient data we would collect may evolve over time. We believe that the present structure of independent Medicare post-acute benefits, which includes payment systems, coverage requirements, and quality assessment instruments based primarily on site of care, may provide incentives that result in reduced access and choice for beneficiaries and may contribute to inappropriate care. As a result of this fragmentation in the payment and delivery of post-acute care under Medicare, we are reevaluating the payment and delivery of post-acute services with the objective of developing a more integrated approach focusing on the entire post-acute episode of care and each patient's care needs regardless of setting. We believe the MDS–PAC will help to move Medicare toward our long term objective of creating a more integrated post acute care payment and delivery system that facilitates improved quality, choice and access to care for beneficiaries.

Our goal of ultimately establishing a common system to assess patient characteristics and care needs for post-acute providers was endorsed by MedPAC in its March 1999 report to the Congress. MedPAC recommended that the Secretary collect a core set of patient assessment information across all post-acute settings. (Recommendation 5A). In the narrative supporting this recommendation, MedPAC ''commends HCFA's development of the MDS–PAC and encourages its refinement and use. The instrument will facilitate greatly comparisons of patient characteristics and service use across inpatient post-acute settings. Insights gleaned from these data should inform future prospective payment system policies, as well as longer term policy considerations about post-acute care.'' We share MedPAC's opinion of the utility of a common patient data system across post-acute settings. We believe that future refinements in the design and application of the MDS–PAC will provide us with essential information to inform policy decisions related to post-acute care users and their characteristics, quality, and payment.

The implementation of the per-case prospective payment system based on the ''functional-related group'' methodology requires the use of a standardized data collection instrument that contains the elements required to classify a patient into a distinct CMG. To classify a patient into a distinct CMG the data collection instrument must first assign the patient into one of the various high level categories that are based principally on ICD–9–CM diagnoses plus some additional patient information. These high level categories are called Rehabilitation Impairment Categories. After that initial classification step a patient's comorbidity data (which is also based on the ICD–9–CM codes), the level of the patient's impairment as determined by the patient's motor and cognitive function scores, and the age of the patient are used to classify a patient into a distinct CMG within the higher level Rehabilitation Impairment Group. Additional data elements are required to identify the patient and for monitoring the quality of care furnished to patients in IRFs.

Several approaches to the collection of these data elements are available. These include—(a) the development of a new data collection instrument, the MDS–PAC (as proposed in this rule); (b) adoption of an instrument closely modeled on the Uniform Data Set for Medical Rehabilitation (UDSmr) and the Caredata.com Clinical Outcome Set (COS) that would contain the needed data elements exactly as they have been recorded in the past and as used in the development of the FIM–FRG classification of patients; and (c) the incorporation verbatim into the new instrument (MDS–PAC) of the UDSmr/COS data elements that are relevant to payment. We are proposing the first option, the MDS–PAC, for the reasons outlined in the section below.

1. Use of MDS as Foundation

The basis of the MDS–PAC system is the Minimum Data Set (MDS)/Resident Assessment Instrument (RAI). The MDS/RAI was one of the key provisions of the nursing home reform legislation enacted by the Omnibus Budget Reconciliation Act of 1987 (OBRA), Pub. L. 100–203, and the first standardized assessment instrument that the Congress required to be used in a post-acute care setting. The MDS is a core set of screening and assessment elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment (the RAI). OBRA mandated that we develop the MDS and require its use for all residents of certified long-term care facilities as a condition of participating in Medicare or Medicaid.

We originally implemented the MDS/RAI in 1990 through 1991 in the approximately 17,000 certified long-term care facilities nationwide. The MDS/RAI has been used by long-term care facilities to assess all residents at specific points during their stay, regardless of payer source. Residents are assessed upon admission to the facility, after experiencing a significant change, and at least annually, with a review of key items required every 90 days. Regulations requiring all certified long-term care facilities to encode and transmit MDS data to the State and HCFA became effective June 22, 1998 ((62 FR 67174) ''Resident Assessment In Long Term Care Facilities''). As of March 3, 2000, there were 23,829,196 records for 4,576,748 residents submitted to our national MDS repository.

Long-term care facilities use the assessment system as the basis of developing an individualized plan of care. However, the design of our long-term care facility payment and quality of care systems relies on use of the resident characteristic, health status, and service use information derived from the MDS to support a number of our programs. For example, the SNF prospective payment system implemented in July 1998 relies on MDS data to classify patients into the appropriate case-mix categories. In addition, in July 1999, we began to use MDS data to generate quality indicators for use in the long-term care facility survey process. Also, long-term care facilities may request real-time MDS-based quality indicator reports, from the HCFA-sponsored State-level MDS data system, that compare the facility's performance in key care areas with the performance of other facilities within the State. These reports can be used for internal quality assurance and improvement activities. Our Peer Review Organizations (PROs) are using MDS data to conduct long-term care facility quality improvement activities in a number of areas, including pain management, pressure ulcers, and urinary incontinence.

In keeping with our commitment to the nursing home industry to refine the MDS/RAI system over time to incorporate advances in assessment technology and changes in the nursing home population, we developed a second generation instrument, known as the MDS version 2. The MDS 2 was implemented nationally in 1996. Shortly thereafter, we agreed to begin work on a post-acute version of the MDS, in response to the long-term care industry's concerns that the MDS had not been constructed to address the characteristics and needs of the increasing numbers of short stay patients admitted to SNFs for rehabilitation and medically complex care.

Before we started work on the MDS–PAC, however, we made a policy decision that our goal was to establish a common instrument to assess patients receiving services by all Medicare institutional post-acute providers. This broadened the scope of the instrument to include freestanding rehabilitation hospitals and hospital-based rehabilitation units, as well as long-term care hospitals. Our policy decision was based on a belief that there is considerable overlap among the patient populations and services rendered by post-acute care providers. The March 1999 MedPAC report to Congress indicated that prior distinctions in the types of patients and services provided across settings have become less clear for a number of reasons (p. 82), and that lack of uniform patient-level data across settings severely restricts our ability to identify where differences and overlaps occur.

This hypothesis regarding the overlap of patient populations was tested by collecting MDS 2 data for patients of rehabilitation and long-term care hospitals and comparing that data with MDS records for SNF patients. The SNF database included records for long-stay nursing home residents who had been readmitted after a hospitalization and now qualified for a period of skilled care. There were 1,535 SNF patient records collected from initial MDS assessments in 1996. Of these patient records, 517 (34 percent) of the patients were expected to be discharged within 30 days of admission. An additional 248 (16 percent) were expected to be discharged in 31 to 90 days. For the remaining patient records, discharge status was unknown, not anticipated or (in a limited number of cases) the discharge variable was missing. This activity was also conducted in order to provide us with information about the characteristics, health status, and service utilization of rehabilitation and long-term care hospital patients, as part of our initial activities to inform development of the MDS–PAC.

Staff from participating rehabilitation hospitals, rehabilitation units of acute care hospitals, and long-term care hospitals were trained in the use of the MDS 2.0, and were asked to complete it for a sample of their newly admitted patients during June through October 1998. Data were received for 614 patients in 26 rehabilitation hospitals and units, and for 479 patients in 26 long-term care hospitals. Of the 52 providers participating in the baseline data collection, 38 were recruited using a random sample of Medicare-certified providers.

We found many similarities in the characteristics, health status, medical diagnoses, and service utilization patterns of SNF and rehabilitation hospital patients. We note that our focus groups indicated to us that many rehabilitation hospitals and self-proclaimed ''subacute'' SNFs have as a criteria for admission the patient's potential ability to be discharged from the facility within a certain time period. Thus, for comparative purposes we differentiated between the MDS records of SNF patients expected to be discharged and those of SNF patients not expected to be discharged. As illustrated below by Table 1C, patients in rehabilitation hospitals and SNF patients who were expected to be discharged demonstrated similar levels of activity of daily living (ADL) overall impairment, as measured by the MDS 2, while a greater number of SNF patients who were not expected to be discharged experienced impairment in ''late loss'' ADLs or were fully dependent.

TABLE 1C.—PERCENT OF PATIENTS WITH ADL IMPAIRMENT BY FACILITY TYPE

ADL score (hierarchical)	LTC hospital	Rehab hospital	SNF discharge expected	SNF discharge not expected
0—Independent	3.1	.8	4.2	3.4
1—Supervision	4.4	9.5	6.5	5.6
2—Limited	12.8	25.4	29.3	17.9
3—Early Loss ADL—extensive or dependent	4.2	14.8	8.2	9.8
4—Mid late loss ADL—extensive assistance late loss ADL	8.0	21.1	20.9	15.9
5—Mid late-some late loss ADL dependency	34.8	22.5	27.3	33.8
6—Full dependency	32.9	5.9	3.7	13.5

In addition, fewer SNF patients were reported to have symptoms of delirium as compared to rehabilitation hospital patients. While the number of SNF patients not expected to be discharged who experienced memory problems was higher, the overall cognitive performance score (a composite measure based on several MDS items) for patients across the four populations was remarkably similar, except for the higher number of long-term care hospital patients rated as a ''6'' (that is, very severely cognitively impaired). A comparison of cognitive impairment by facility type can be seen in Table 2C.

TABLE 2C.—PERCENT OF PATIENTS WITH COGNITIVE IMPAIRMENT BY FACILITY TYPE

Condition	LTC hospital	Rehab Hospital	SNF discharge expected	SNF discharge not expected
Delirium Symptoms—New				
Easily Distracted	12.0	15.4	3.1	1.7
Altered Perceptions	9.7	5.9	2.6	2.2
Disorganized Speech	8.8	10.5	2.4	2.2
Restlessness	13.6	8.9	2.0	3.0
Lethargy	14.4	9.2	4.0	4.0
Mental Function Varies	17.2	13.5	5.2	4.0
Cognitive Performance Scale				
0=Intact	40.5	49.3	46.0	17.9
1=Borderline Intact	14.3	13.6	16.7	17.6
2=Mild	7.2	10.2	12.0	11.3
3=Moderate	9.1	13.0	16.3	26.2
4=Moderate Severe	4.0	3.3	4.1	10.5
5=Severe	3.0	5.7	3.3	6.9
6=Very Severe	21.9	4.9	1.6	9.6
Memory				
Memory Problem—short term	32.8	36.2	37.0	61.0
Memory Problem—long-term	29.9	23.0	23.1	46.2
Memory Problem—situational	37.5	12.4		

We did not find significant differences across care settings in many of the disease diagnoses recorded in section I of the MDS, although long-term care hospital patients had more cases of diabetes, cardiac dysrhythmia, post heart surgery, peripheral vascular disease, paraplegia, respiratory conditions, renal failure, and antibiotic-resistant infections (Table 3C).

TABLE 3C.—PERCENT OF PATIENTS WITH SPECIFIC CONDITIONS BY FACILITY TYPE

Condition	LTC hospital	Rehab hospital	SNF discharge expected	SNF discharge not expected
Diseases				
Diabetes	37.0	25.0	27.0	24.2
Hyperthyroidism	0.4	0.7	0.7	0.3
Hypothyroidism	9.0	8.2	8.0	6.8
Arteriosclerotic heart disease	17.3	14.7	15.7	18.3
Cardiac dysrhythmia	21.1	11.3	14.7	17.2
Post heart surgery	24.0	13.0	6.9	6.2
CHF	23.0	8.5	21.6	22.9
Deep vein thrombosis	4.8	3.1	11.4	1.8
Hypertension	37.6	45.8	47.9	46.5
Hypotension	2.8	1.3	1.5	1.0
Peripheral vascular disease	15.0	9.0	8.6	6.0
Other cardiovascular disease	14.8	10.3	19.5	20.8
Arthritis	11.3	20.1	25.4	21.9
Hip fracture	6.7	11.6	14.1	7.4
Missing limb	5.4	4.9	3.0	3.5
Osteoporosis	7.1	3.6	8.0	10.5
Pathological bone fracture	1.3	1.8	1.0	1.5
Alzheimer's	1.5	0.5	4.1	12.3
Aphasia	2.3	6.5	3.8	7.2
CP	0.2	0.7	.....	.....
CVA	23.8	34.6	22.2	27.7
Other dementia	7.9	2.1	13.9	31.5
Hemiplegia/hemiparesis	12.9	27.8	8.8	10.1
MS	2.1	1.1	0.1	0.7
Paraplegia	3.0	2.1	0.3	0.3
Parkinson's	2.5	1.6	3.3	4.0
Quadriplegia	3.3	2.6	0.1	0.2
Seizure disorder	6.5	5.2	4.5	4.5
TIA	1.0	23	4.0	4.0
Traumatic brain injury	4.2	7.0	0.3	0.3
Anxiety disorder	4.6	5.2	7.8	6.8
Depression	10.2	14.4	14.6	13.6
Manic depression	0.8	1.1	0.9	0.7

TABLE 3C.—PERCENT OF PATIENTS WITH SPECIFIC CONDITIONS BY FACILITY TYPE—Continued

Condition	LTC hospital	Rehab hospital	SNF discharge expected	SNF discharge not expected
Schizophrenia	0.8	0.5	1.0	1.5
Asthma	3.5	3.1	2.0	1.5
Emphysema/COPD	29.0	10.1	19.3	17.2
Pulmonary failure	24.0	4.3	.....	.....
Cataracts	2.9	3.3	6.5	5.5
Diabetic retinopathy	1.9	1.8	0.7	0.5
Glaucoma	3.8	2.9	5.9	4.0
Macular degeneration	1.5	0.7	1.2	0.8
Allergies	9.4	15.2	28.2	28.9
Anemia	15.7	11.9	18.2	19.5
Cancer	12.1	7.5	14.4	15.3
Renal failure	14.0	4.7	4.9	5.3
Amputated limb	5.4	5.0	N/A	N/A
Post surgery—elective hip	4.0	13.0	.....	.....
Antibiotic resistant infection	16.7	2.8	1.0	0.5
Pneumonia	19.2	3.1	8.5	6.5
UTI	21.9	19.9	21.1	23.1
Bladder Continence				
Continent, no catheter	28.0	60.9	63.4	45.6
Continent, catheter	52.1	15.2	N/A	N/A
Some incontinence	50.8	31.6	36.6	54.4
Bowel Continence	48.0	75.0	71.3	47.9
Complications				
Inability to lie flat—loss of breath	44.0	6.5	6.9	6.2
Shortness of breath—exertion	52.0	21.7	.....	.....
Shortness of breath—at rest	32.0	0.0	.....	.....
Difficulty coughing/clearing airways	40.0	2.2	N/A	N/A
Recurrent respiratory infection	28.0	2.2	.....	.....
Surgical wound	48.0	56.5	.....	.....
Pain				
None	45.4	25.6	36.0	58.8
Less than daily	17.3	19.5	31.0	22.3
Daily	37.3	55.0	33.0	18.9
Health Complications				
Syncope	2.3	1.0	.07	0
Unsteady Gait	26.2	52.5	48.0	40.1
Limited ROM—Arm	20.7	9.3	6.3	12.5
Limited ROM—Hand	18.0	7.2	3.5	8.8
Limited ROM—Foot	26.4	10.5	5.7	14.7
Pressure Ulcers—Any (stage 1–4)	36.0	17.9	17.7	21.6
Expectations (Rehabilitation Potential)				
Patient believes self could be more independent	53.7	74.5	45.1	16.2
Staff believes patient could be more independent	59.1	76.4	50.9	31.3
Patient able to perform tasks slowly	26.1	33.9	12.7	12.4
Major difference in ADLs AM and PM	8.1	16.7	1.9	3.2
Behavior				
Wander	3.6	4.1	2.8	9.1
Verbally abusive	3.4	3.8	3.0	5.4
Physically abusive	1.8	2.1	1.4	5.9
Socially inappropriate	3.2	4.8	4.2	8.6
Resists care	12.2	8.6	9.8	16.3

The diagnostic profiles of patients in rehabilitation hospitals and SNFs were similar, although rehabilitation hospitals treated a higher percentage of patients with strokes, hemiplegia/hemiparesis, and traumatic brain injury and fewer patients with congestive heart failure and emphysema or chronic obstructive pulmonary disease. Both bladder and bowel continence levels were similar for rehabilitation hospital and SNF patients who were expected to be discharged. Pain levels for rehabilitation hospital and SNF patients were also similar overall, although more

SNF patients were reported to experience pain less frequently than daily and more rehabilitation hospital patients were assessed as having daily pain. Pressure ulcer rates for rehabilitation hospital and SNF patients were comparable, as were the number of patients with unsteady gait and limitations in range of motion. Rehabilitation hospitals reported a higher use of restraints. Rehabilitation hospital and SNF patients who were expected to be discharged had a similar number of behavioral symptoms, which were less overall as compared to the number of behavioral symptoms experienced by SNF patients not expected to be discharged.

These results confirmed anecdotal information reported by rehabilitation hospital and SNF clinicians during our focus groups. While Medicare coverage policies allow payment to SNFs for a wider range of patients than rehabilitation hospitals, both groups reported that their patient populations had changed over the past few years, leading to some convergence in the types of patients treated by rehabilitation hospitals and SNFs. Both reported a large increase in the number of comorbidities and clinical complexities for patients admitted primarily for rehabilitative services, saying that ''uncomplicated'' patients were no longer admitted for inpatient rehabilitation, (instead, for example, ''uncomplicated'' patients requiring rehabilitation after a hip fracture now generally receive therapy in their homes).

It is our view that any system used to classify rehabilitation patients should be based on the same measures of a patient's health status and care needs as are used in other segments of the post-acute care industry. However, for purposes of this proposed rule, we are most concerned that the classification instrument work well with IRF patients. Given our use of the MDS in SNFs, it is logical to extend an MDS-based system to IRFs.

We are developing version 3 of the MDS/RAI, which we envision as containing sections for specific populations (for example, traditional, long stay resident; short-stay patient; those receiving palliative or end of life care; and pediatrics).

2. Other Options

We recognized that many rehabilitation hospitals already use a patient assessment instrument that contains the functional independence measures (FIM). The FIM were developed by researchers who were funded by a consortium of rehabilitation professional associations and the Department of Education, at the State University of New York (SUNY) at Buffalo in the 1980s. The FIM are contained in a patient assessment instrument that is marketed by the Uniform Data System for Medical Rehabilitation (UDSmr) maintained by SUNY/Buffalo. Caredata.com Clinical Outcome System (COS) used to market a patient assessment instrument that contained the FIM, but we have been notified that Caredata.com has discontinued its business related to FIM reporting as of July 2000. The patient assessment instrument marketed by UDSmr is proprietary.

Many rehabilitation providers are clients of UDSmr. Our 1997 data shows that approximately 68 percent of Medicare patients had a UDSmr or COS data file, indicating that these patients were assessed with the FIM. There is extensive experience with the FIM contained in the UDSmr and COS patient assessment instruments and the uses of the FIM data. This is documented by a substantial list of publications produced both in the United States and overseas (for example, Sweden and Japan), by the developers of the system, and by independent investigators.

The developers of the FIM offer a certification course to train assessors in the use of the instruments. This results in very high rates of intra and inter rater reliability, with Cronbach alpha coefficients of more than 0.9 for both the motor and cognitive subscores. The Cronbach alpha coefficient is a statistical measure of inter-rater reliability with perfect reliability equal to 1.0. Therefore, a score of 0.9 indicates a very high level of inter-rater reliability.

The MDS-PAC is a modification of the MDS, the patient assessment instrument developed for use in nursing facilities. The principal objective of the MDS is to facilitate care planning through a description of the needs of the patient for services. In contrast, the principal objective of the FIM is to assess person level disability in the inpatient medical rehabilitation setting.

The strength of the FIM assessment instrument is that it is a well-evolved and extensively tested approach to the assessment of the critical components of care provided by IRFs, the impact on the patient improvement in functional capacity, and the purpose of the care provided by the IRFs. The variations among facilities in the difference between the observed and expected improvement in function are used as indicators of the quality and the effectiveness of the facilities. The organization that analyzes FIM data for providers generates benchmark data that allows IRFs to compare the outcome of their performance on the functional independence measures relative to other providers participating in the system.

One drawback of the FIM assessment instrument is that it is specifically focused on functional performance. Information is collected only on the matters directly related to functional performance and only at admission and discharge, and, when possible, 6 months after discharge. There is, therefore, a lack of detail on the needs of the patient or on the evolution of the condition of the patient during the course of the admission. However, given that the mean length of stay in an IRF is 15.81 days (median length of stay is 14 days), we are specifically soliciting comments on the benefits of mid-stay assessments.

We are not proposing to use the FIM assessment instruments marketed by either the UDSmr or COS as the basis for an IRF prospective payment, because of our desire to have a common measurement instrument across different post-acute provider settings. Our proposal to use an MDS-based approach comes from our conviction that the use of common item labels and definitions across different provider settings would be essential to monitoring patient care across different provider settings. While we recognize that there are differences between the MDS and the MDS–PAC, our intention is, at some point in the future, to reconcile these differences. Structuring the IRF assessment instrument consistent with the MDS would allow for comparison of patients across different institutional settings. The MDS–PAC collects information on many of the same activities or functional measures as the FIM but defines these activities more specifically in some cases. It would also help facilitate continuity of care in that comparable baseline data would accompany the patient's transfer from one setting to the other. Standardized information across provider types would also be extremely useful in comparing patient characteristics and potentially the appropriateness of care in different settings that serve the same populations. This is especially important since analysis by RAND (1997) shows that costs for the same services vary significantly by provider.

When we began to develop the MDS in the 1980s, the possibility of using the FIM ADL scoring schema was considered. However, field experience demonstrated that nursing home staff did not feel comfortable making the level of distinctions required in the FIM.

The FIM serve as a functional-based system designed to capture specific aspects of ADL performance. Therefore, the FIM's ability to measure items that are not functionally related, such as cognition, may be problematic. For example, in order to score communication on the FIM, compromises must be made to blend cognitive and performance ideas into a single construct. The scoring schema used in the MDS–PAC allows the instrument to describe a concept like communication from a functional performance perspective as well as from the cognitive perspective based on how much caregivers have to intervene to help compensate for the patient's communication deficits.

UDSmr requires that users of the FIM (for example, therapists) be trained. An evaluation of the FIM scoring will be performed by RAND before a final rule is published. FIM scoring rules assign the lowest (most dependent) value to missing data which is likely to bias scores downward, especially upon admission when data are more likely to be missing. The payment implications may generally be to place patients in a more service intensive CMG. The MDS–PAC addresses this by having a separate coding entry (8) for activities that do not occur rather than instructing users to code with the most dependent level.

An independent team of technical experts highlighted areas of concern regarding the FIM's accuracy in predicting costs for patient care. Panelists were concerned that the scoring of some items, such as cognitive functioning, gave raters a great deal of discretion in determining what evidence was used in the assessment and how often the behavior had occurred. These technical experts also agreed that a functional status assessment for payment purposes should be based on clinical observation of performance rather than on the rater's assessment of the patient's capacity to perform the task.

The MDS–PAC uses the same FIM constructs as were originally designed by the UDSmr team but rewords them in such a way so that these items better fit into the context of the MDS instrument. In addition, the item language and definitions and instructions are integrated into the instrument. The administration of the MDS–PAC at more than one point in a patient's stay will permit assessment of patient changes during that episode of treatment and may lead to possible refinements to the patient classification system.

We seek public comment on our proposal to use the MDS–PAC as the assessment instrument for the IRF prospective payment system, including: comments and supporting data regarding the additional burden and cost, if any, associated with this instrument; the suitability of the instrument for the rehabilitation setting and as a model for other post-acute care settings; views on whether the instrument has been properly tested and validated for industry-wide use; and the utility and reliability of the quality data items contained in the instrument.

3. Combining the MDS–PAC and the FIM

The MDS–PAC covers several topics, for example, nutrition, swallowing, and pain, that are either not included in the FIM or not covered in sufficient detail in the FIM for clinical assessment purposes, and that are not currently used in classifying patients for payment. An alternative to using the MDS–PAC would be to retain the non-payment items from the MDS–PAC and incorporate the FIM items for patient classification into CMGs. Because of our concerns, as outlined above (for example, compatibility with assessments in other settings), we have rejected this option for purposes of this proposed rule and propose to use payment-related questions that are compatible with the FIM.

However, the FIM assessment system has been under development since the mid 1980s and is currently recognized as a valid and reliable instrument to measure impairments in IRFs. The FIM are in current and increasing use in rehabilitation facilities, the data analysis being performed by UDSmr and by COS, with the data analysis organization depending on which of these two organizations the IRF has selected. Thus, there has been extensive training in and experience with the data elements, particularly the functional components, that enter into the construction of the CMGs. We will be testing whether the MDS–PAC results in patient classifications that are equivalent to the classifications that occurred with the FIMs (that is, the assessment instruments that were used to design the payment system).

If the tests show that patients are classified differently using the MDS–PAC, HCFA will, in the final rule, incorporate the phrasing, definitions, and order of the items required by the payment system, based on the FIM, replacing the proposed equivalent sections of the MDS–PAC. This would meet our objective to field the more extensive instrument to provide a more complete picture of the evolution of condition of the patient and of the care provided in the IRF, but also to retain confidence in the validity of the classification of the patient. Using the phrasing, definitions, and order of the items would minimize the effect on reliability and validity inherent in the design of new data collection instruments.

4. The MDS-PAC Development Process

Under contract, a team led by John N. Morris, Ph.D., at the Hebrew Rehabilitation Center for the Aged, began to develop the MDS-PAC in 1997. This team played a key role in designing the original MDS/RAI system and MDS 2.

The MDS–PAC development process relied on broad-based input from a large and diverse constituency, representing rehabilitation facilities, SNFs, long-term care hospitals, and the viewpoints of individual and corporate providers, clinical disciplines, consumers, States, other Federal agencies, and researchers. Examples of organizations representing rehabilitation providers and clinicians include the American Medical Rehabilitation Providers Association, the American Hospital Association (representing hospital-based rehabilitation units), the Federation of American Health Systems, the Commission on Accreditation of Rehabilitation Facilities, the National Head Injury Foundation, the Uniform Data System for Medical Rehabilitation, the Association of Academic Physiatrists, and the American Academy of Physical Medicine and Rehabilitation.

Representatives and staff of over 40 national organizations and agencies with a stake in the MDS–PAC were brought together in a technical expert panel, which met at the outset of the MDS–PAC development process, and at key intervals thereafter. The purpose of the technical expert panel was to provide us with advice on technical and operational issues associated with assessment of post-acute patients. We requested that technical expert panel representatives disseminate project information to their constituents, coordinate input from their members back to our project team, and assist with identifying facilities to participate in field testing of the instrument. We solicited comments from technical expert members on several drafts of the MDS–PAC, and also conducted a mailing that solicited comments from over 1100 facilities and individuals, identified in part by technical expert panel members. We also posted a project summary and various drafts of the MDS–PAC on our MDS web site. In addition, the project team reviewed the

comments we received on the assessment instrument.

We began development of the MDS–PAC by gathering baseline information through focus groups, a provider survey, and collection of MDS data within rehabilitation hospitals/hospital-based units and long-term care hospitals. We held two focus groups, consisting of physicians, nurses, and therapists who were involved in patient assessment and care planning on a daily basis within rehabilitation hospitals and units, SNFs, and long-term care hospitals. The clinicians who participated in the focus groups were all nominated by the national associations representing rehabilitation hospitals, SNFs, and long-term care hospitals. The purpose of the focus groups was to solicit real-world input regarding current assessment and care planning practices for post-acute patients.

We also conducted a survey of SNF, rehabilitation hospital, and long-term care hospital providers to gather information about their patient populations, assessment and care planning practices, care processes, care delivery models, and the availability of various types of specialized staff. Facility staff were asked to comment on the perceived clinical utility of MDS items and each of the RAPs for their own patient populations. Providers participating in our focus groups were asked to pilot the questionnaire, which was subsequently refined. The questionnaire was then distributed to over 900 SNFs, rehabilitation hospitals and units, and long-term care hospitals that had requested information on the project or whose names we had received from associations participating on the technical expert panel. A total of 416 providers (224 SNFs, 131 rehabilitation hospitals or units, and 61 long-term care hospitals) responded to the survey during January through March 1998. A summary of these responses was presented during our March 1998 meeting with the technical expert panel.

Using the input gathered from our initial activities, we developed an initial draft of the MDS–PAC in September 1997. In developing the initial MDS–PAC draft, it is important to note that we did not start with the current MDS 2. Rather, we used a ''bottom-up'' approach to build the MDS–PAC. This means that we started by listing the various domains and issues that had been identified through our initial focus groups and provider survey as relevant for the post-acute patient. We then selected items to measure those specific issues from the MDS 2 or other HCFA assessment instruments, such as the Outcome and Assessment Information Set (OASIS) or the Uniform Needs Assessment Instrument. New items were developed for those areas in which no item currently existed within our group of assessment tools. In building and refining the MDS–PAC items we relied extensively on the input of clinical experts serving on, or identified by, our technical expert panel. Appendix B contains a summary of the survey items and the responses of the clinical experts.

The original MDS–PAC draft was refined through the production of 10 major draft revisions over a 2-year period. We solicited comments on various drafts through mailings to our technical expert panel, and to over 1100 providers that had been identified by the technical expert panel or otherwise indicated an interest in the project, as well as through posting of various drafts on our web site.

One of the guiding principles of our MDS–PAC development has been that the instrument had to include items that were compatible with the FIM and would result in the same patient classifications generated using the FIM. In nearly all instances, we did not simply insert the functional independence measures items into the MDS–PAC. Generally, the goal was to develop blended items that were consistent with the general MDS model and scales, but were also capable of generating the type and level of detail contained in a specific functional independence measure item. This work was conducted through extensive collaboration with Dr. Carl Granger, who was a member of our MDS–PAC technical expert panel, and his UDSmr team. Prior to our final rule, we will be conducting further research to determine whether the MDS–PAC will classify patients into the same CMGs as they would have been classified into using FIM.

5. Developmental Testing of the MDS–PAC

Drafts of the MDS–PAC were subjected to substantial field testing, to ensure it is both reliable and feasible for use as the patient data collection system needed to implement the IRF prospective payment system. Formal testing consisted of an initial pilot test, as well as two larger rounds of field testing, in rehabilitation hospitals and units, SNFs, and long-term care hospitals. In conducting research, a pilot test allows a preliminary trial of an instrument to discover and rectify any major problems before the main study begins. A pilot test uses a small study sample of facilities, whose results enable researchers to make last minute corrections and adjustments. A field test uses a larger sample and more formally delineated procedures and protocols.

In conducting our tests we worked with a number of providers that volunteered to participate either directly or through their provider associations. However, most of the participants in each of the testing rounds were recruited randomly from our listing of Medicare-certified providers maintained in the Online Survey and Certification Reporting System; we designed our sample to ensure that participating facilities varied in geographic location, size, etc.

Pilot testing of the MDS–PAC was conducted in September through October 1998, with a total of 20 providers (7 rehabilitation hospitals or units, 4 long-term care hospitals, 9 SNFs; 15 sites recruited randomly). A total of 161 assessments were completed as part of the pilot test, with 69 completed by rehabilitation hospitals, 68 by SNFs, and 24 by long-term care hospitals.

MDS–PAC testing consisted of a pilot test and two field tests. A total of 16 assessors participated in the pilot test conducted in IRFs and 96 and 75 assessors participated in the first and second field tests, respectively. The MDS–PAC was used to assess a total of 885 admissions and 345 discharges in these IRFs during this pilot and field testing. The average length of stay for these admissions was 18.9 days with a median of 16 days.

The initial field test occurred in January through April 1999, in 85 providers total (40 rehabilitation hospitals or units, 21 long-term care hospitals, 22 SNFs, and 2 facilities for which the above category was not properly recorded; 51 sites recruited randomly). A total of 1164 patients were assessed using draft 8 of the MDS–PAC, with 599 cases assessed in rehabilitation hospitals or units, 284 in SNFs and 281 in long-term care hospitals.

The second field test was conducted in June through September 1999, in a total of 57 providers (33 rehabilitation hospitals and units, 11 long-term care hospitals, 13 SNFs; 39 sites recruited randomly). A total of 462 cases were completed in the second field test, with 285 patients assessed by rehabilitation hospitals, 80 by SNFs, and 97 by long-term care hospitals.

Testing focused on the inter-rater reliability and clinical validity of MDS–PAC items, as well as the administrative feasibility and burden associated with completion of the assessment tool. Paired assessments were completed for a sample of cases during each of the field trials (N=171 assessments

conducted using the June 30, 1999 version of the MDS–PAC used in field test 2) and reliability coefficients were calculated using a weighted Kappa statistic. Reliability measures whether the instrument would result in the same findings if it were administered at a later date or by a different person. The average reliability for the 315 items on the version of the MDS–PAC tested in the second field test (draft 9) was 0.78. A frequently cited standard in the research community, Fleiss (1975), establishes item reliability of 0.5 as acceptable, with levels of 0.75 or better considered as superior for tools of this nature. Reliability coefficients ranged from 0.51 for ''repetitive health complaints'' to 1.0 for several items.

Facility staff were asked to log the amount of time spent on each MDS–PAC assessment, and also categorize how that time was spent. There was general comparability across provider types in how time was spent. Review of the clinical record consumed the most time and interaction with the patient's physician or family was conducted by only a minority of assessors. Recognizing the learning curve associated with any new process, burden estimates were calculated for both the initial few cases completed by staff and subsequent cases after staff had become more familiar with the process (that is, after completing approximately 10 MDS–PAC assessments).

Rehabilitation hospital staff initially required a median of 105 minutes to complete the intake assessment and 85 minutes after they became familiar with the Version 9 MDS–PAC, as compared to the 85 and 77 minutes respectively, required by SNF staff. The time required to complete follow-up or discharge MDS–PAC assessments was also calculated, as these assessments involve fewer items than the initial MDS–PAC assessment. Rehabilitation hospital staff required a median of 75 minutes to complete the first few cases using this shorter assessment and 48 minutes after they completed approximately 10 cases. SNF staff spent a median of 50 minutes on the first few follow-up assessments they completed, and 45 minutes subsequently.

B. Overview of the MDS–PAC Assessment Process

1. Description of the MDS–PAC

We include, in Appendix BB of this proposed rule, the MDS–PAC Version 1, which we refer to throughout this preamble as the MDS–PAC. Appendix BBB contains the Item-by-Item Guide to the MDS–PAC, which consists of instructions for completing the MDS–PAC. The MDS–PAC that is included in Appendix BB is a modified version of the MDS–PAC that was the product of the previously described pilot and field testing. This modified version MDS–PAC reflects changes we made in order to ensure that the MDS–PAC items used to classify a patient into a CMG cover all of the same subjects as the functional independence measures items that were used to develop the classification system.

Before the final rule, we will conduct field testing of the modified MDS–PAC, Version 1, to establish its validity, reliability, and equivalence for payment. In addition, we will study a sample of facilities that are currently using UDSmr's FIM patient assessment instrument and the COS. These facilities will complete their instruments (either UDSmr's or COS) and the MDS–PAC on the same patient at the same time. Results of this paired assessment will be compared to determine the capability of the MDS–PAC instrument to accurately and consistently assign CMGs and whether the MDS–PAC assigns the same CMGs as the UDSmr/COS instrument would. If the results of this study do not indicate that the MDS–PAC accurately and consistently assigns CMGs as the UDSmr/COS instrument would, then the MDS–PAC will be redesigned to incorporate the phrasing, content, and coding conventions of the UDSmr/COS instruments. This study will be completed this fall by researchers from RAND, and the results will be incorporated into the final rule. The study and any modifications to the assessment instrument will be completed prior to the publication of the IRF prospective payment system final rule.

The MDS–PAC is a patient-centered assessment tool that emphasizes a patient's care needs, rather than the characteristics of the provider. The assessment instrument consists of 15 sections, each collecting different categories of patient information. These categories include identification and demographic information about the patient, as well as the following categories of information: cognition; communication; behavior and mood; functional status; bowel and bladder continence; diagnoses; medical complexities and other health conditions; oral and nutritional information; pain status information; information on procedures and services; functional prognosis; and resources for discharge.

2. Use of the MDS–PAC

We propose to require that IRFs use a standardized patient data collection assessment instrument for Medicare patients in IRFs, the MDS–PAC. We propose to require that IRFs must computerize and electronically report the MDS–PAC data.

Each year tens of thousands of Medicare patients are treated in IRFs. As discussed in more detail in section III.F. of this preamble, we propose that each of these patients would be assessed on the average at least of three times, with the MDS–PAC being used as the patient assessment instrument. Therefore, there will be a very large quantity of data collected and submitted to us each year. As a result, it would be unrealistic for us to perform a meaningful analysis of this large amount of data for payment, medical review, and quality monitoring purposes in the absence of the capability to use automated data collection. An analysis of MDS–PAC data would allow us to use MDS–PAC data in a manner similar to how we use SNF MDS data.

One use of SNF MDS data is to support quality of care monitoring. The SNF MDS data is reliable and effective in supporting early identification of potential quality of care problems. Early identification, in turn, helps to focus the survey process upon these identified problem areas.

Using MDS data we have developed indicators of the quality of care in SNFs. The quality of care indicators are used to support analytical evaluations of the quality of services that SNFs furnish. For example, we use MDS data to provide us with objective and detailed measures of the clinical status and care outcomes of residents in a SNF. In addition, quality of care indicators can be used to analyze the relationship between Medicare policy changes and quality of care.

Computerization of the MDS–PAC data would make it easier and more practical for an IRF to use the MDS–PAC data to classify a patient into a CMG. Electronic transmission of the MDS–PAC data by the IRF makes the creation of an MDS–PAC database feasible. An MDS–PAC database, in turn, permits the data to be accessed easily in various formats for different analytical purposes, which can be used to support the Medicare program's fraud and abuse efforts, for medical review purposes, and for uses similar to how the SNF MDS data is used.

We propose that beginning on April 1, 2001, IRFs must collect MDS–PAC data as part of the IRF's inpatient assessment process for patients who are receiving Medicare-covered Part A services. This MDS–PAC data collection requirement applies to Medicare beneficiaries who are already inpatients as of April 1,

2001, as well as beneficiaries admitted as inpatients on or after April 1, 2001. In addition, we propose that the IRFs must use the MDS–PAC to assess inpatients in accordance with the MDS–PAC assessment schedule specified in section III.F. of this preamble.

The IRFs would encode the MDS–PAC data by entering the MDS–PAC data into a computer software program. MDS–PAC records would be considered ''locked'' when they passed all HCFA-specified edits and were accepted by the MDS–PAC database to which the IRF transmitted its records.

We propose in § 412.610 that IRFs must also maintain all completed MDS–PAC assessments for the previous 5 years, either in a paper format in the patient's clinical record or in an electronic computer file format that can be easily obtained, because the assessments may be needed as part of a retrospective review conducted at the IRF for various purposes, for example, as part of the documentation that the IRF used to determine the medical necessity of the Medicare-covered services the IRF furnished. Also, completed MDS–PAC assessments that are available at the IRF could be beneficial to other entities that appropriately have access to these records (for example, a State or Federal agency conducting an investigation due to a complaint of patient abuse or a suspicion of fraud). In addition, retention of the MDS–PAC assessment by the IRF would provide a backup to the electronic database.

Data from the initial MDS–PAC assessment would be used to classify patients into a CMG. The CMG would correlate with the payment rate that the IRF receives for the Medicare-covered Part A services furnished by the IRF during the Medicare beneficiary's episode of care.

3. Transmission of the MDS–PAC Data

We propose that between February 1 and February 28, 2001, IRFs must complete a successful transmission of test MDS–PAC data to the HCFA MDS–PAC system. A successful transmission by the IRFs of test MDS–PAC data to the HCFA MDS–PAC system is necessary to determine connectivity with the system and to identify any transmission problems. The HCFA MDS–PAC system would transmit a test data feedback report to each IRF indicating that the test data transmission was either completely successful or experienced problems. The problems would be specified in the test data transmission report.

On March 1, 2001, the HCFA MDS–PAC system would begin to purge all test data from the system to allow for acceptance of production data, that is, data that would be associated with the MDS–PAC assessment schedule and CMG payment rates, as specified in sections III. F. and V. of this preamble.

For example:

February 1, 2001, to February 28, 2001—Period for transmission of test MDS–PAC data.

March 1, 2001, to March 7, 2001—The HCFA MDS–PAC system purges test data.

April 1, 2001—Assessments completed on or after this date must be transmitted as production data.

As specified in section III. I. of this preamble, we would provide training and technical support to the IRFs on administering and completing the MDS–PAC, as well as transmitting the MDS–PAC data.

C. The MDS–PAC Assessment and Medical Necessity

The initial MDS–PAC assessment would be used to classify each Medicare patient into a CMG, with the CMG being the basis for IRF payment. One principle governing appropriate Medicare payment and utilization of Medicare inpatient services is that there must be documentation establishing appropriate medical necessity for the inpatient services furnished to a patient.

When the data recorded on the MDS–PAC accurately reflect the patient's clinical status, they form the basis for documenting the medical necessity of the services furnished to the IRF Medicare inpatient. There may be cases in which a medical review (or other type of facility or patient review) questions the accuracy of the recorded MDS–PAC items and, by extension, the associated medical necessity of the services that the IRF furnished. In these cases, other documentation would be examined to verify the information recorded on the MDS–PAC, and the medical necessity for the services as indicated by the MDS–PAC. Other documentation that would support the accuracy of the recorded MDS–PAC information (and the medical necessity for the services furnished to the inpatient) must be recorded in the patient's medical record and could include, but is not limited to: (1) physician's orders; (2) physician's notes; (3) nursing notes; (4) notes from therapists; (5) diagnostic tests and their results; and (6) other associated information, such as social worker or case manager notes.

A patient's clinical status for a given time period, as indicated by a completed MDS–PAC form, must be verifiable and consistent with the clinical information independently or separately recorded in the patient's clinical record. Otherwise, inaccurately completed MDS–PAC assessments might be used to classify patients into CMGs that would, in turn, form the basis for Medicare payment for medically inappropriate or unnecessary services. We will continue to conduct medical review activities to verify and monitor the medical necessity of services furnished in conjunction with our continuing efforts to eliminate Medicare payment errors.

In proposed § 412.614, facilities will transmit each Medicare inpatient's MDS–PAC assessments to the HCFA MDS–PAC system, and submit claims for Medicare payment to the fiscal intermediary, in accordance with the current claims procedures. Payment to the IRF would be made according to the CMG recorded on the claim sent to the fiscal intermediary. We will have the capability to analyze the claim information against the transmitted MDS–PAC data. The results of this analysis may necessitate additional review of a particular claim and the associated MDS–PAC data to determine if payment was made accurately.

D. The MDS–PAC Assessment Reference Date

In § 412.610(c) we propose that each assessment would have a specific assessment reference date. The purpose of the assessment reference date is to establish a common temporal reference point for the care team participating in the patient's assessment. Although staff members may work on completing a patient's MDS–PAC on different days, establishment of the assessment reference date ensures the commonality of the assessment period (that is, ''starting the clock''), so that all assessment items refer to the patient's objective performance and clinical status during the same period of time. The assessment reference date is a specific endpoint in the MDS–PAC assessment observation time period. Almost all MDS–PAC items refer to the patient's status over a continuous three calendar day time period, which is the observation time period.

During the patient's current hospitalization, an IRF must indicate on the MDS–PAC one of the following assessment reference dates—

- For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization the date that is the third calendar day after the patient started being furnished Medicare-covered Part A services.
- For the assessment that covers calendar days 8 through 10 of the

patient's current hospitalization the date that is the 10th calendar day after the patient started being furnished Medicare-covered Part A services.

- For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization the date that is the 30th calendar day after the patient started being furnished Medicare-covered Part A services.
- For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization the date that is the 60th calendar day after the patient started being furnished Medicare-covered Part A services.
- For the assessment that must be completed when the patient stops receiving Medicare-covered Part A services but is not discharged from the IRF, the assessment reference date must be the actual date that the patient stops receiving Medicare-covered Part A services.
- For the assessment that is completed when the patient stops receiving Medicare-covered Part A services and is discharged from the IRF the assessment reference date must be the actual date of discharge from the patient rehabilitation facility.

The general concept is that the assessment reference date sets the designated endpoint of the common 3-day observation period, and the MDS–PAC items will usually refer back in time from this point. The assessment reference date establishes the end of the assessment time period that the clinician(s) will use for the data gathering. As specified in proposed § 412.606(c), these data are obtained through patient observation, patient interview, the clinical record or other means, in order for the clinician(s) to complete an MDS–PAC assessment that covers a given data-gathering time period.

For discharge assessments, the date when the patient either is discharged or stops receiving Medicare-covered Part A services is the assessment reference date. The observation time period includes either the date that the patient is discharged, or the date that the patient stops receiving Medicare-covered Part A services, along with the preceding 2 calendar days. In a situation when the discharge occurs unexpectedly, the clinical record would become a prime source of the data recorded on the MDS–PAC.

E. Performing the MDS–PAC Assessment

In § 412.606, we propose that Medicare beneficiaries who are inpatients of an IRF must be assessed by a professional clinician(s), and that the MDS–PAC must be used to perform the patient assessment. Because the MDS–PAC will be used to obtain a variety of assessment data, we believe that the assessment process should be a collaborative team effort, employing the clinical skills of a variety of professional clinicians.

The data recorded for a specific MDS–PAC item may be more accurate if the information used to record the data for that specific item was obtained by a professional clinician with specialized training related to that specific MDS–PAC item. A professional clinician may be a dietitian, an occupational therapist, a physical therapist, a physician, a practical (vocational) nurse, a registered nurse, a speech-language pathologist or a social worker.

For purposes of this proposed rule, we propose to incorporate the existing definition of a qualified dietitian specified in § 483.35(a)(2). For purposes of this proposed rule, we propose to incorporate the existing standard at § 482.56(a)(2) of who may perform occupational therapy and physical therapy as defining the terms occupational therapist and physical therapist. Section 482.56(a)(2) states that physical therapy and occupational therapy ''must be provided by staff who meet the qualifications specified by the medical staff, consistent with State law.'' Therefore, an occupational therapist and a physical therapist are individuals who meet the qualifications of the provider's medical staff and State law.

A practical (vocational) nurse, a registered nurse, and a speech-language pathologist are individuals who meet the applicable definitions of § 484.4. For purposes of this proposed rule, an individual would be considered a social worker if that person meets either the definition in § 483.15(g)(3) or the one in § 483.430(b)(5)(vi), because these two sections define a social worker in terms of varying levels of education and experience.

For purposes of this proposed rule, we propose to define the term physician as an individual who is a doctor of medicine or osteopathy who is currently legally licensed to practice medicine and surgery by the State in which that function or action is performed.

Performing an MDS–PAC assessment is a process that involves patient interview, patient observation, and, if necessary, obtaining information from other sources, such as the clinical record or the patient's family. The data recorded on the MDS–PAC would be the result of that total assessment process, and the manner in which data is obtained for a specific MDS–PAC item would depend on a combination of the instructions on the MDS–PAC form itself, the Item-by-Item Guide to the MDS–PAC, and provisions set forth via rulemaking. Although different professional clinicians may be involved in the MDS–PAC assessment process, in order to ensure that the MDS–PAC assessment process is properly followed, we propose that only specific clinicians be authorized to sign item AB1a of the MDS–PAC.

In general, we believe that physicians, registered nurses, physical therapists, and occupational therapists are the only disciplines equipped with the education and experience to accurately assess the entire range of an individual's functional/motor performance and medical/clinical status. Additionally, the licensure requirements of some States restrict the human services disciplines that may perform a clinical assessment. Therefore, we propose that only an occupational therapist, a physical therapist, a physician, or a registered nurse be authorized to sign item AB1a of the MDS–PAC and provide the data for items AB1b thru AB1g of the MDS–PAC. Item AB1a is where the clinician who is attesting to the completion of the assessment signs. Items AB1b thru AB1g are the items that identify the clinician who signed item AB1a and the date that item AB1a was signed.

The clinician who signs item AB1a would be responsible for the accuracy and thoroughness of a specific patient's MDS–PAC assessment, and would be responsible for the accuracy of the date inserted in item AB1g. The signatures of other professional clinicians who contributed to the data recorded on the MDS–PAC would be recorded in item AB, lines 2a through item 2f.

The data for the MDS–PAC items that require the collection of data that is not associated with the observation of an activity by the patient can be obtained from the patient, the patient's clinical record, and, if necessary, from the patient's family. If the patient is uncooperative we believe that the data that is not associated with the observation of an activity by the patient can be obtained from the patient's clinical record, or other easily obtained documentation that contains patient information. We believe that the data for the MDS–PAC items related to the observation of a particular activity would always be recorded on the MDS–PAC, because these items allow for the recording of the data in different ways, including recording that the activity did not occur. For the items related to observation of a patient activity we want to emphasize that the clinician assessor should not require a patient to perform

an activity that in the clinician's professional judgment is clinically contraindicated or hazardous. The Item-by-Item Guide to the MDS–PAC in Appendix BBB contains information concerning observational techniques and provides more guidance for clinicians in performing the MDS–PAC assessment.

F. The MDS–PAC Assessment Schedule

1. General Rule

We propose in § 412.610 that an IRF Medicare patient be assessed by a clinician(s) using the MDS–PAC to gather and record the patient assessment data. The length of the patient's hospitalization would determine how many MDS–PAC assessments are required. Table 4C below, entitled ''MDS–PAC Assessment Schedule and Associated Dates,'' illustrates the proposed MDS–PAC assessment schedule for the following ''MDS–PAC Assessment Type'': Day 4, Day 11, Day 30, and Day 60 assessments. The term ''day'' as used in the assessment schedule is a calendar day, and is counted as including the first day of the patient's current IRF hospitalization when the patient started receiving Medicare-covered Part A services, (which is generally the day of admission to the IRF). As specified in proposed § 412.620(a)(3), in general only data from the Day 4 assessment would determine the CMG classification that would in turn determine the payment that the IRF would receive for the entire episode of the patient's hospitalization. If a patient is not hospitalized in the IRF for the time period needed for the Day 4 assessment, then the patient's CMG would be determined as specified in section V.C. of this preamble.

TABLE 4C.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period*	MDS–PAC assessment reference date*	MDS–PAC must be completed by:*	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:*	MDS–PAC must be transmitted by:*
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73

Currently, on the MDS–PAC, item B4 ''Indicators of Delirium—Periodic Disordered Thinking/Awareness,'' requires an assessment time period that is 7 days in length. Item F1 ''Bladder Continence,'' and item F4 ''Bowel Continence'' require an assessment time period that is 7 to 14 days in length. Therefore, the assessment time period and associated coding for these three items affect the dates for the ''Hospitalization Time Period and Observation Time Period,'' the ''MDS–PAC Assessment Reference Date,'' the ''MDS–PAC Must Be Completed by:,'' the ''MDS–PAC Must be Encoded By:,'' and the ''MDS–PAC Must be Transmitted By:''. As stated previously, we will be conducting additional testing of the MDS–PAC. This additional testing will determine if the assessment time period for items B4, F1, and F4 can be changed, or if the instructions on assessing these items should be changed. If our additional testing indicates that the assessment time periods or the instructions for assessing items B4, F1, and F4 should not be changed, then in the final rule we will change the proposed MDS–PAC assessment schedule and associated dates to reflect the current assessment time periods of these three items.

Table 4C represents the generic assessment schedule and other associated MDS–PAC dates. Table 5C.—Example Applying the MDS–PAC Assessment Schedule and Associated Dates, below is an example of how Table 4C would be applied using actual calendar dates. In Table 5C it is assumed that the patient was admitted on April 3, 2001.

TABLE 5C.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	4/5/01	4/6/01	4/12/01	4/18/01
Day 11	Days 8 to 10	4/12/01	4/13/01	4/19/01	4/25/01
Day 30	Days 28 to 30	5/2/01	5/3/01	5/9/01	5/15/01
Day 60	Days 58 to 60	6/1/01	6/2/01	6/8/01	6/14/01

Each patient is assessed by a clinician(s) using an MDS–PAC to perform a comprehensive assessment according to the schedule stated above. More than one clinician can contribute to completion of the MDS–PAC. We believe that MDS–PAC assessment accuracy would be enhanced if the data collected for an MDS–PAC item is collected by a clinician with specialized training and experience in the area of the data being collected. For example, although a registered nurse could fully assess all aspects of a patient and collect all the MDS–PAC data, a physical therapist or an occupational therapist has the specialized training which may contribute to a more accurate assessment of some neuro-muscular items. Our objective is to have data collected that would best reflect the patient's unique circumstances and clinical status during the assessment observation period, considering that an MDS–PAC item may provide for several possible responses and that the accuracy of patient assessment is contingent on the training and experience of the clinician assessor.

In section IV. of this preamble, we specify the MDS–PAC items that would be used to classify a patient into a specific CMG. We propose to require

that data be collected not only for the items that would be used to classify a patient into a CMG, but also for any of the other MDS–PAC items for which data collection is appropriate according to one or more of the following: (1) the instructions on the MDS–PAC; (2) the Item-by-Item Guide to the MDS–PAC; and (3) applicable rulemaking provisions.

The example that follows, with ''day'' referring to a calendar day, illustrates a typical IRF's Medicare beneficiary hospitalization assessment schedule:

- Hospitalization Day 1. Patient admission day and the day that the IRF begins to furnish Medicare-covered Part A services. This is the day that starts the count as ''day 1'' when determining the assessment time periods for the MDS–PAC assessments.
- Hospitalization Day 3. The last day of the 1 through 3 calendar day assessment observation period and, as a general rule, the last day that can be used to set the assessment reference date for the initial (Day 4) MDS–PAC assessment.
- Hospitalization Day 4. The day by which the Day 4 MDS–PAC must be completed.
- Hospitalization Day 10. The last day of the 8 through 10 calendar day assessment observation period and, as a general rule, the last day that can be used to set the assessment reference date for the first re-assessment.
- Hospitalization Day 11. The day by which the Day 11 MDS–PAC must be completed.
- Hospitalization Day 30. The last day of the 28 through 30 calendar day assessment time period and, as a general rule, the last day that can be used to set the assessment reference date for the second re-assessment.
- Hospitalization Day 31. The day by which the Day 30 MDS–PAC must be completed.

In the above example, if the patient is instead discharged on day 22 of the hospitalization, then the discharge day is the assessment reference date.

2. Interrupted Stays

a. *Definition of an Interrupted Stay.*

As specified in proposed § 412.602 an interrupted stay is one in which an IRF patient is discharged from the IRF and returns to the same IRF within 3 calendar days. For purposes of the MDS–PAC assessment process, if a patient has an interrupted stay, then: (1) the initial CMG classification from the ''initial'' (Day 4) MDS–PAC assessment would remain in effect (no new initial MDS–PAC assessment would be performed); and (2) the required scheduled MDS–PAC update assessments must still be performed. A patient who returns to the same IRF more than 3 calendar days after being discharged is considered a ''new'' patient for purposes of the MDS–PAC assessment schedule process. Being considered a ''new'' patient for the MDS–PAC assessment schedule process means that a new Day 4 assessment needs to be performed. That new Day 4 assessment would determine a new CMG. That new CMG may or may not be the same CMG into which the patient classified prior to the interrupted stay.

In counting the 3 calendar day time period to determine the length of the interrupted stay, the first day of the start of the interrupted stay is counted as ''day 1,'' with midnight of that day serving as the end of that calendar day. The 2 calendar days that immediately follow would be days 2 and 3. If the patient returns to the IRF by midnight of the third calendar day, then it would be determined that the patient had an interrupted stay of 3 calendar days or less.

When a patient has an interrupted stay, the interrupted stay must be documented on the MDS–PAC interrupted stay tracking form. The data recorded on the interrupted stay tracking form must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date the patient returns to the IRF.

b. Effect of an Interrupted Stay Upon the Assessment Schedule

When an interruption of a patient's IRF stay occurs it may affect the MDS–PAC—(1) assessment reference dates; (2) completion dates; (3) encoding dates; and (4) transmission dates.

As discussed in section III. D. of this preamble, the assessment reference date generally is the designated endpoint of the common 3-day observation period, and the MDS–PAC items will usually refer back in time from this point. Therefore, in order to set an assessment reference date, the patient must be an inpatient of the IRF during the 3-day observation time period. The 3-day observation time period must be continuous.

In order to facilitate the discussion that follows regarding the effect of an interrupted stay upon the assessment schedule Table 5C has been reproduced below.

TABLE 5C—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	04/05/01	04/06/01	04/12/01	04/18/01
Day 11	Days 8 to 10	04/12/01	04/13/01	04/19/01	04/25/01
Day 30	Days 28 to 30	05/02/01	05/03/01	05/09/01	05/15/01
Day 60	Days 58 to 60	06/01/01	06/02/01	06/08/01	06/14/01

In Table 5C above, if an interruption of 3 calendar days or less occurred for any of the ''MDS–PAC Assessment Type'' assessment observation time periods (for example, the days specified in the ''Hospitalization Time Period and Observational Time Period'' column in the Table), then the associated assessment reference dates, MDS–PAC completion dates, MDS–PAC encoded by dates, and MDS–PAC transmitted by dates for that particular ''MDS–PAC Assessment Type'' would be shifted forward by the number of days that the patient was not an inpatient of the IRF.

We refer to Table 5C to illustrate the shifting forward of dates. With regard to the Day 4 assessment assume that the patient's stay began with admission to the IRF on April 3, 2001, but was interrupted on April 4, 2001, which would be day 2 of the patient's IRF hospitalization. The patient returned to the same IRF prior to midnight of April 6, 2001, and had an interrupted stay of 3 calendar days. The assessment reference date observation time period for the Day 4 assessment would be shifted to April 6, 7, and 8. (Without the interrupted stay, the Day 4 assessment reference date observation time period would have been April 3, 4, and 5, with the assessment reference date being April 5, 2001). Because of the interruption in stay, the MDS–PAC Day 4 assessment reference date would be

reset to April 8, 2001. The Day 4 MDS–PAC completion date would be reset to April 9, 2001. The Day 4 ''MDS–PAC Must Be Encoded By'' date would be reset to April 15, 2001. The Day 4 ''MDS–PAC Must Be Transmitted By'' date would be reset to April 21, 2001.

Before this interrupted stay, the Day 11 assessment reference date was set to be day 10 of the patient's hospitalization, which would be April 12, 2001. Because of the shifting forward of the Day 4 assessment reference date from April 5, 2001, to April 8, 2001, the Day 11 assessment dates, and only the Day 11 assessment dates, would also be shifted forward. The Day 11 assessment reference date would then be April 15, 2001. The Day 11 MDS–PAC completion date would be reset to April 16, 2001. The Day 11 ''MDS–PAC Must Be Encoded By'' date would be reset to April 22, 2001. The Day 11 ''MDS–PAC Must Be Transmitted By'' date would be reset to April 28, 2001. When there is a shifting forward of the Day 4 or Day 11 assessment dates they would not affect the assessment timeframes for the subsequent (for example, Day 30 or Day 60) assessments, because the purpose of shifting forward an assessment due to an interruption in stay is to keep the time periods between assessments to at least 7 calendar days.

Again, we refer to Table 5C to illustrate the shifting forward of dates. Assume that for the Day 11 reassessment the patient, who was admitted to the IRF on April 3, 2001, started an interrupted stay on April 11, 2001, which would be day 9 of the patient's IRF hospitalization. (For this example, do not assume that the patient also had a Day 4 interrupted stay.) The patient returned to the same IRF prior to midnight of April 13, 2001, and had an interrupted stay of 3 calendar days. The assessment reference date observation time period for the Day 11 assessment would be shifted to April 13, 14, and 15. (Before the interrupted stay, the Day 11 assessment reference date observation time period was April 10, 11, and 12, with the assessment reference date being April 12, 2001.) Due to the interruption in stay, the MDS–PAC assessment reference date would be reset to April 15, 2001. The MDS–PAC completion date would be reset to April 16, 2001. The ''MDS–PAC Must Be Encoded By'' date would be reset to April 22, 2001. The ''MDS–PAC Must Be Transmitted By'' date would be reset to April 28, 2001. The various dates, as illustrated in Table 5C, for the Day 30 and Day 60 assessments would not be affected by the shifting forward of the Day 11 assessment associated dates. However, if the patient had an interrupted stay during the time period that is associated with the Day 30 or Day 60 assessment as indicated in the Table 5C column entitled ''Hospitalization Time Period and Observation Time Period'' then the same shifting forward methodology described above for the Day 11 assessment would apply.

3. MDS–PAC Dates Associated with the Discharge Assessment

As specified in proposed § 412.610(c)(5) and (6) the assessment reference date for the discharge assessment is the day when one of two events occurs first: (1) the day the patient is discharged from the IRF or (2) the day the patient ceases receiving Medicare-covered Part A inpatient rehabilitation services. The MDS–PAC assessment is performed only at the first point in time either of these events occur. There may be cases when a patient ceases receiving inpatient rehabilitation Medicare-covered services, but is not discharged from the IRF.

After the assessment reference date for the discharge MDS–PAC assessment is determined the completion date for the discharge MDS–PAC assessment must be set. As specified in proposed § 412.610(e)(2) the completion date for the discharge MDS–PAC assessment is the 5th calendar day in the period beginning with the discharge MDS–PAC assessment reference date. To count the 5 calendar days, count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The method used to determine the completion date for the discharge MDS–PAC assessment is not the same method used to determine the completion date for the Day 4, Day 11, Day 30 or Day 60 MDS–PAC assessments. The reason for using a different method to determine the discharge MDS–PAC completion date is because of the definition of an interrupted stay. Previously we specified that after the patient returns to the IRF after an interrupted stay another Day 4 assessment is not performed, and the CMG into which the patient classified prior to starting the interrupted stay is still in effect. Therefore, in order to ensure that a clinician does not perform a discharge assessment on a patient who meets the criteria of an interrupted stay, it is necessary to make the completion date of the discharge MDS–PAC assessment a date that exceeds the interrupted stay defined time period. This safeguard prevents the performance of unnecessary MDS–PAC discharge assessments by the IRF.

In addition, any discharge MDS–PAC assessment that is transmitted to the HCFA MDS–PAC system is used by the system to indicate that a patient is no longer hospitalized in the IRF. Therefore, if a discharge assessment that is only associated with an interrupted stay is transmitted to the HCFA MDS–PAC system, it would result in the HCFA MDS–PAC system rejecting any subsequent update (either a Day 11, Day 30 or Day 60) assessments that are associated with the patient's continued hospitalization in the same IRF following an interrupted stay.

As specified in proposed § 412.610(e)(3) the discharge MDS–PAC ''must be encoded by'' date is the 7th calendar day in the period beginning with the discharge MDS–PAC completion date. To count the 7 calendar days, count the discharge MDS–PAC assessment completion date as day 1 of the 7 calendar days. For example, if the MDS–PAC assessment completion date is May 5, 2000, then the MDS–PAC must be encoded by date would be May 11, 2000.

As specified in proposed § 412.614(c) the discharge MDS–PAC ''must be transmitted by'' date is the 7th calendar day in the period beginning with the discharge MDS–PAC ''must be encoded by'' date. To count the 7 calendar days, count the discharge MDS–PAC assessment ''must be encoded by'' date as day 1 of the 7 calendar days. For example, if the MDS–PAC assessment must be encoded by date is May 11, 2000, then the MDS–PAC must be transmitted by date would be May 17, 2000.

Table 6C below illustrates the discharge MDS–PAC dates discussed above:

TABLE 6C.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date*	MDS–PAC assessment reference date	MDS–PAC must be completed on:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/1/00	5/1/00	5/5/00	5/11/00	5/17/00

*This is either: (1) the day the patient is discharged from the IRF; or (2) the day the patient ceases receiving Medicare-coverred Part A inpatient rehabilitation services.

Data from recent studies indicate that the vast majority of patients are discharged from IRFs within the first twenty calendar days of their hospitalization. Therefore, we believe that, in most cases, IRFs would only perform three assessments under this proposal: The Day 4, Day 11, and the discharge assessment. Early data indicated that the mean length of stay was 18.9 days, that the median length of stay was 16 days, with a standard deviation of 13. More recent data from the RAND Institute indicates that the mean length of stay is 15.81 days, and that the median length of stay is 14 days. The recent RAND data also indicates that less than 9 percent of patients would require a Day 30 assessment and less than ½ of 1 percent of patients would require a Day 60 assessment. We are especially interested in Day 30 and Day 60 assessments because these cases will be very unusual when compared to the average length of stay; therefore, we want to understand what characteristics make these cases atypical. In addition, Day 30 assessment data may be useful in making any future CMG refinements; for example, providing outlier information after the IRF prospective payment system has been implemented. We are specifically soliciting comments on the benefits of performing interim assessments on days 11, 30, and 60.

4. Assessment Rule to Use If Medicare Beneficiaries Are Receiving IRF Services on the Effective Date of this Regulation

We propose a special MDS–PAC assessment rule for the Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective. For these patients we are proposing that only one MDS–PAC assessment must be performed. The one MDS–PAC assessment would be used to classify a patient into a CMG, and that CMG would determine the payment the IRF would receive for all the Part A services the IRF furnished to the patient during the patient's current hospitalization. For Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective the one MDS–PAC assessment would, as applicable, cover one of the following calendar day time periods and associated conditions: (1) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for at least 3 calendar days, then the data for the MDS–PAC assessment items must be collected according to the instructions on the MDS–PAC form and the Item-by-Item Guide to the MDS–PAC. (2) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for only 2 calendar days, then the data for the MDS–PAC assessment items that must be collected would pertain to only these 2 calendar days, unless the instructions on the MDS–PAC form and the Item-by-Item Guide to the MDS–PAC specify a shorter time period. (3) When this regulation becomes effective if a patient currently hospitalized continues being an IRF patient for only 1 or less than 1 calendar day then the data for the MDS–PAC assessment items that must be collected would pertain to 1 or less than 1 calendar day, unless the instructions on the MDS–PAC form and the Item-by-Item Guide to the MDS–PAC specify a shorter time period.

For this special MDS–PAC assessment we propose that, no later than 30 calendar days from the date this regulation becomes effective, all the following would apply—(1) the data for this special MDS–PAC assessment must be collected; (2) this special MDS–PAC must be completed; (3) the MDS–PAC data for this special assessment must be encoded; and (4) the MDS–PAC data for this special assessment must not only be transmitted to but also be accepted by the HCFA MDS–PAC system. We propose that if the IRF does not, as specified above, collect, complete, encode, and transmit the data for this special MDS–PAC assessment, then the IRF would receive no payment for any of the Part A services furnished to Medicare beneficiaries who already are IRF patients on the date that this regulation becomes effective.

5. What MDS–PAC Items Are Collected On Each Assessment

The MDS–PAC assessments must be performed according to the schedule specified previously. Table 7C's.—MDS–PAC Items Required by Type of Assessment, title indicates the data for each MDS–PAC item that we propose to require collecting for the Day 4, Day 11, Day 30, Day 60, and discharge assessments.

It should be noted that recording data on the MDS–PAC for a particular item may require, according to the instructions for that item on the MDS–PAC form, that the clinician not record data for certain other items. For example, the MDS–PAC instructions state that if data is recorded indicating a patient is comatose in item B1, the clinician assessing the patient must proceed from item B1 to item E1. This means that the data for the items between B1 and E1 are not recorded. (The term ''update'' in Table 7C below refers to the Day 11, Day 30, and Day 60 assessments. An ''X'' indicates that the MDS–PAC item is required for that assessment type.)

TABLE 7C.—MDS–PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT

MDS–PAC Item	Assessment type		
	Admission	Update	Discharge
ITEM AA1 and ITEM A1. Legal Name of Patient	X	X	X
ITEM AA2 and ITEM A2. Admission Date (2a and, if applicable, also 2b)	X	X	X

TABLE 7C.—MDS–PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT—Continued

MDS–PAC Item	Assessment type		
	Admission	Update	Discharge
ITEM AA3 and ITEM A3. Reason for Assessment	X	X	X
ITEM AA4. Assessment Reference Date	X	X	X
ITEM AA5a and AA5b. Discharge Status	.....	.....	X
ITEM AA6a and AA6b. Social Security (6a) and Medicare Numbers (6b)	X	X	X
ITEM AA7. Medical Record Number	X	X	X
ITEM AA8. Facility Provider Number (Both 8a and 8b)	X	X	X
ITEM AA9. Medicaid Number	X	X	X
ITEM AA10. Gender	X	X	X
ITEM AA11. BirthDate	X	X	X
ITEM AA12. Ethnicity/Race	X	X	X
ITEM AA13a and AA13b. Interrupted Stay* (Only appears on the interrupted stay tracking form. Record and submit data if applicable.).			
ITEM AA14a thru AA14f. Clinician Completing Assessment* (Only appears on the interrupted stay tracking form. Record and submit data if Item 13 data is recorded and submitted.).			
Item AB1a thru AB1g. Person Completing Assessment	X	X	X
Item AB2a thru AB2f. Signature of Staff Completing Part of the Assessment	X	X	X
ITEM A4. Admission Status	X	X	X
ITEM A5. Goals for Stay	X	X	X
ITEM A6. Admitted From	X	X	X
ITEM A7. Precipitating Event Prior to Admission	X	X	X
ITEM A8. Primary and Secondary Payment Source For Stay	X	X	X
ITEM A9. Marital Status	X	X	X
ITEM A10. Education	X	.....	.....
ITEM A11a and A11b. Language	X	X	X
ITEM A12. Dominant Hand	X	.....	.....
ITEM A13. Mental Health History	X	.....	.....
ITEM A14. Conditions Related to MR/DD Status	X	.....	.....
ITEM A15a thru A15e. Responsibility/Legal Guardian	X	.....	.....
ITEM A16a thru A16e. Advance Directives	X	.....	.....
ITEM B1. Comatose	X	X	X
ITEM B2a thru B2d. Memory/Recall Ability	X	X	X
ITEM B3a and B3b. Cognitive Skills for Daily Decision Making	X	X	X
ITEM B4a thru B4f. Indicators of Delirium-Periodic Disordered Thinking/Awareness	X	X	X
ITEM C1. Hearing	X	X	X
ITEM C2a thru C2e. Modes of Communication	X	X	X
ITEM C3a and C3b. Making Self Understood	X	X	X
ITEM C4. Speech Clarity	X	X	X
ITEM C5a and C5b. Ability to Understand Others	X	X	X
ITEM C6a and C6b. Vision	X	X	X
ITEM D1a thru D1k. Indicators of Depression, Anxiety, Sad Mood	X	X	X
ITEM D2. Mood Persistence	X	X	X
ITEM D3a thru D3e. Behavioral Symptoms	X	X	X
ITEM E1a thru E1l. 3-Day ADL Self-Performance	X	X	X
ITEM E2a thru E2l. ADL Assist codes	X	X	X
ITEM E3a and E3b. ADL Changes	X	X	X
ITEM E4a thru E4f. Instrumental Activities of Daily Living	X	X	X
ITEM E5. IADL Areas Now More Limited	X	X	X
ITEM E6a thru E6j. Devices/Aides	X	X	X
ITEM E7a and E7b. Stamina	X	X	X
ITEM E8a thru E8c. Walking and Stair Climbing	X	X	X
ITEM E9a and E9b. Balance Related to Transitions	X	X	X
ITEM E10a thru E10c. Neuro-musculoskeletal Impairment	X	X	X
ITEM F1a and F1b. Bladder Continence	X	X	X
ITEM F2a thru F2g. Bladder Appliance	X	X	X
ITEM F3. Bladder Appliance Support	X	X	X
ITEM F4. Bowel Continence	X	X	X
ITEM F5a thru F5d. Bowel Appliances	X	X	X
ITEM F6. Bowel Appliance Support	X	X	X
ITEM G1. Impairment Group	X	.....	.....
ITEM G2a thru G2aq. Other Diseases	X	X	X
ITEM G3a thru G3l. Infections	X	X	X
ITEM G4A and G4B. Other Current or More Detailed Diagnoses and ICD–9–CM Codes (Line ''a'' thru line ''e'' as applicable.)	X	X	X
ITEM G5. Complications/Co-Morbidities (Line ''a'' thru line ''d'' as applicable.)	X	X	X
ITEM H1. Vital Signs	X	X	X
ITEM H2a, H2b, H2d thru H2t, and H2w. Problem Conditions	X	X	X
ITEM H2c, H2u, and H2v. Problem Conditions	X	.....	.....
ITEM H3a thru H3h. Respiratory Conditions	X	X	X
ITEM H4a thru H4f. Pressure Ulcers	X	X	X
ITEM H5a and H5b. Other Skin Integrity	X	X	X

TABLE 7C.—MDS–PAC ITEMS REQUIRED BY TYPE OF ASSESSMENT—Continued

MDS–PAC Item	Assessment type		
	Admission	Update	Discharge
ITEM H5c. Other Skin Integrity	X		
ITEM H6a thru H6e. Other Skin Problems or Lesions Present	X	X	X
ITEM I1a and I1b. Pain Symptoms	X	X	X
ITEM I1c. Pain Symptoms	X		
ITEM J1a and J1b. Oral Problems	X	X	X
ITEM J2. Swallowing	X	X	X
ITEM J3a. Height	X		
ITEM J3b. Weight	X	X	X
ITEM J4a and J4b. Weight Change	X		
ITEM J5a and J5b. Parenteral or Enteral Intake	X	X	X
ITEM K1a thru K1e. Clinical Visits and Orders	X	X	X
ITEM K2a thru K2ai. Treatments and Services	X	X	X
ITEM K3a thru K3k. Nursing Practice or Restorative Care	X	X	X
ITEM K4a thru K4f. Therapy Services	X	X	X
ITEM K5a thru K5d. Devices and Restraints	X	X	X
ITEM L1a thru L1h. Functional Improvement Goals	X	X	X
ITEM L2a thru L2c. Attributes Relevant to Rehabilitation	X	X	X
ITEM L3a and L3b. Change over last 3 days	X	X	X
ITEM L4. Estimated Length of Stay from Date of Admission	X	X	X
ITEM M1a thru M1e. Available Social Supports	X	X	X
ITEM M2a and M2b. Caregiver Status	X		X
ITEM M3a and M3b. Living Arrangement	X	X	X

*Note: Data for items AA13 and AA14 would only be recorded and submitted to the HCFA MDS–PAC system if the patient has an interrupted stay according to how interrupted stay is defined in this preamble. This means each time the patient has an interrupted stay, as that term is defined in this preamble, data for items AA13 and AA14 would be recorded and submitted to the HCFA MDS–PAC system. The other items on the interrupted stay tracking form would also be submitted. However, these other interrupted stay tracking form items are identification information items that have previously been collected and recorded by the IRF clinician and, therefore, do not require collection as new items of data.

6. The MDS–PAC Completion Date

We propose in § 412.610(e) that for the Day 4, Day 11, Day 30, and Day 60 assessments that IRFs ''complete'' the MDS–PAC on the calendar day that follows the assessment reference date. Previously we discussed the completion date for the discharge assessment. For all assessments ''completion'' of the MDS–PAC means that accurate information has been recorded for each MDS–PAC item, and that the MDS–PAC has been signed and dated by the clinicians that recorded information on the MDS–PAC. It is our belief that the IRF clinician(s) can easily access or recall specific patient information if only a short period of time has elapsed, between the patient interview/patient observation time period and the recording of that information on the MDS–PAC.

7. Penalties for Late Assessments

In § 412.610(d) we propose that the MDS–PAC assessment is late if the assessment is not in accordance with the assessment reference date specification for the Day 4 assessment discussed previously in this preamble. If the MDS–PAC assessment is late then the IRF would either receive a reduced CMG-determined payment or no payment. If the MDS–PAC assessment is less than or equal to 10 calendar days late then the reduced CMG-determined payment would be a default rate. We propose to set the default rate at 25 percent less than the CMG-determined payment that the IRF would otherwise have received. If any assessment is more than 10 calendar days late, then the IRF would receive no payment for the Medicare-covered Part A services furnished.

G. Computerization of the MDS–PAC Data

1. Encoding the MDS–PAC Data

The data for all MDS–PAC assessments must be encoded. Encoding the data means entering the MDS–PAC data into the IRF's computer using appropriate software, including performing data edits. In § 412.610(e)(3), we propose that IRFs encode and edit the data for Medicare patients within 7 calendar days of the date that the MDS–PAC is completed. We propose to specify a maximum of 7 calendar days because we believe that this is a reasonable amount of time for IRFs to complete these tasks.

In determining the first day to count as being ''within 7 calendar days of the date that the MDS–PAC is completed,'' the assessment completion date itself would be counted as ''day 1'' of the 7 calendar days. For example, if the MDS–PAC completion date is April 6, 2001, then the MDS–PAC must be encoded by April 12, 2001. As previously stated, MDS–PAC records are considered ''locked'' when they pass all HCFA-specified edits and are accepted by the MDS–PAC database to which the IRF transmits its records.

To encode the MDS–PAC data, the IRF may: use a commercial application from a private software vendor; develop its own data entry program based on our specifications; or use the free data entry and data transmission software program developed by HCFA, which is the MDS–PAC Tool (MPACT). The IRF will be able to download MPACT from our Inpatient Rehabilitation Facility Prospective Payment System website. The MPACT data entry tool accommodates standard HCFA edit specifications for MDS–PAC data.

It is preferable for the edits and corrections to be made as soon as possible after the assessment activity, because the clinician's recall of the patient assessment at that point is likely to be more detailed and easier to associate with any clinical notes related to the assessment. Therefore, it is reasonable to expect that IRFs will have the MDS–PAC data encoded, edited, and ready for transmission within 7 calendar days of the completion date. In addition, if the IRF chooses to use the MDS–PAC information in patient care planning, our timeframes would contribute to the facility's efforts to produce a current and workable plan of care.

IRFs will have flexibility in the process used to encode their data. Once the assessment is completed by the clinician(s), the data may be encoded by a clinician, or by a clerical staff member using a paper copy of a completed MDS–PAC, or by a data entry technician. Non-clinical staff may not assess patients or complete clinical assessment items. However, clerical staff or data entry operators may enter the MDS–PAC data that has been collected by the clinician into the computer.

In entering the data, IRFs must comply with requirements for safeguarding the confidentiality of patient identifiable information, as specified in section III.*I.*1. of this preamble. In addition, IRFs must train personnel with access to patient information to disclose that patient information only to those recipients who are authorized to have access to it.

On August 12, 1998, we published in the **Federal Register** a proposed rule entitled ''Security and Electronic Signature Standards'' (63 FR 43242), and on November 3, 1999, we published another proposed rule entitled ''Standards for Privacy of Individually Identifiable Health Information'' (64 FR 59918). When these proposed rules are published as final rules, the security and privacy criteria specified in these rules may supplement or supersede the security and privacy criteria specified in this proposed rule.

Once the IRF encodes the MDS–PAC information, the computer software is used to review and edit the data to create a file that will be transmitted to the HCFA MDS–PAC system. The software program edits are designed to help preclude the transmission of erroneous or inconsistent information.

2. Accuracy of the Encoded MDS–PAC Data

In § 412.610(f) we propose that the encoded MDS–PAC data must accurately reflect the patient's status at the time the data are collected. Because the patient's clinical status may change over time, the MDS–PAC data must accurately represent a patient's clinical status as of a particular assessment reference date. Before transmission, the IRF must ensure that the data items on the MDS–PAC paper copy match the encoded data that are sent to the HCFA MDS–PAC system. We are requiring that once the clinician(s) completes the MDS–PAC assessment, using either a paper copy of the MDS–PAC or an electronic version, the IRF must ensure that the data encoded into the computer and transmitted to the HCFA MDS–PAC system accurately reflects the data collected by the clinician. We will leave to the IRFs the development of methods that ensure the accuracy of the MDS–PAC data that is transmitted. However, it should be noted that because the policies of the IRF prospective payment system only apply to Medicare beneficiaries, the HCFA MDS–PAC system will reject all transmitted assessment data for which a non-Medicare payment source is indicated.

3. Transmission of the MDS–PAC Data

We will utilize the most current technology to secure the safety of the information transmitted to and from the HCFA MDS–PAC system. In § 412.614, we propose to require that the IRF electronically transmit to the HCFA MDS–PAC system accurate, complete, and encoded MDS–PAC data for each Medicare patient. We also propose that the data must be transmitted in a format that meets the general requirements specified in § 412.614. We believe that once the MDS–PAC data are encoded and edited, it is a relatively simple procedure to complete the preparation of the data for transmission to the HCFA MDS–PAC system. Therefore, we are proposing that encoded and edited data that has not previously been transmitted, must be transmitted within 7 calendar days of the day by which the data must be encoded by as specified in Table 4C ''MDS–PAC Assessment Schedule and Associated Dates''. In addition, the data must be transmitted in a manner that meets the locked data criteria previously discussed in this section of the preamble. At the end of the transmission file, an entry concerning the number of records being transmitted is required to complete the transmission process.

We believe that the 7 calendar day transmission requirement would support claim review efforts, because prompt transmission of MDS–PAC data would facilitate our ability to compare a claim promptly against the associated MDS–PAC data which, in turn, would enhance our ability to make any necessary adjustment to the IRF's payment amount in a timely manner. We will maintain a national MDS–PAC repository to which State Agencies, fiscal intermediaries and peer review organizations will have access. An adjustment to the IRF claim may be made if a discrepancy is discovered between what the MDS–PAC data indicated the CMG on the claim should be and what is actually on the claim.

The IRF must have a system that supports dial-up communications for the transmission of MDS–PAC data to the HCFA MDS–PAC system. The MDS–PAC data will be submitted to the HCFA MDS–PAC system via HCFA's Medicare Data Collection Network (MDCN). The MDCN is a secured private network. Specific instructions and telephone numbers will be provided to the IRFs to access the MDCN. For security purposes, there are two levels of user authentication required. To obtain access to the MDCN, the IRF must obtain an individual network-identification code for each person submitting the HCFA MDS–PAC data. This identification code is distributed by the HCFA system administrator or HCFA's agents. To obtain access to the HCFA MDS–PAC system, an IRF must also obtain a facility-identification code from the HCFA system administrator.

The IRF will transmit the MDS–PAC data via secured lines, and not via the Internet, to the HCFA MDS–PAC system, where the data will be checked to ensure it complies with HCFA MDS–PAC system data formatting specifications. The IRF will receive two reports, the initial and final validation reports. The initial validation report will notify the IRF if the submission is accepted or rejected. If the submission is rejected, the IRF is notified of the reason for the rejection. If the submission is accepted, the report alerts the IRF of any changes or discrepancies in the facility and vendor information. After the initial edit checks and acceptance of the file, the MDS–PAC data are validated to ensure that the data conforms to the HCFA specifications. If there are errors found in an assessment record, it will be rejected. Upon completion of the validation, the IRF receives the final validation report. This report includes the total number of assessment records submitted and the total number of assessment records rejected, as well as the total number of assessment records added to the database. The final validation also includes alert messages pertaining to an assessment record when appropriate; for example, ''Assessment was submitted out of sequence.''

In order to test transmission of MDS-PAC data using the HCFA MDS–PAC system IRFs must make a successful test transmission of test MDS–PAC data to the HCFA MDS–PAC system between February 1 and February 28, 2001. The initial test must include the following: (1) a transmission of MDS–PAC data that passes the HCFA edit checks built into the software program used by the IRF to encode the assessment data; and (2) a validation report back from the HCFA MDS–PAC system confirming transmission of data. This test data will not be included in the HCFA national repository. The test data are to contain MDS–PAC data on all Medicare

inpatients, both newly admitted and those previously receiving care, that are inpatients during the test transmission time period.

If an IRF does not have Medicare inpatients receiving care during the specified test transmission time period, we propose that the IRF transmit test MDS–PAC data for Medicare inpatients that received care in the most recent 30 calendar day time period. This would require that these IRFs use the clinical record and professional clinical judgment to obtain the information required for the MDS–PAC items. In this way, these facilities could transmit test data in order to ascertain how well their system is functioning, and become familiar with entering data into the computerized version of the MDS–PAC. In order to both assist all IRFs in constructing MDS–PAC test data and to test the volume data capacity of the HCFA MDS–PAC system we may use and provide the IRFs with ''dummy'' MDS–PAC records or test data.

We will provide training to the IRFs on the MDS–PAC instrument (including any modification arising from research examining the equivalence of the MDS–PAC and the FIM for classifying patients), the HCFA provided MPACT, the data transmission process, and the interpretation of the validation reports. Training will be provided prior to the implementation of IRF prospective payment system. The most current MDS–PAC will be available on our HCFA Inpatient Rehabilitation Facility Prospective Payment System website. IRFs and software vendors will be able to access the website and download the most current MDS–PAC. In addition, the MPACT will be available on the HCFA Inpatient Rehabilitation Facility Prospective Payment System website, and IRFs and software vendors will be able to download the MPACT at no charge. This website will include the data specifications, data dictionaries, the Item-by-Item Guide to the MDS–PAC, and the IRF data submission procedures.

We may also post other educational materials for IRFs on the website. We intend the website to provide current information to IRFs, State agencies, software vendors, professional organizations, and consumers. We encourage vendors, IRFs, and other interested parties to review the website regularly for information and issues related to the IRF prospective payment system.

4. Late Transmission Penalty

In section III.G.2. of this preamble, we propose §§ 412.606 and 412.610 to require that MDS–PAC data be collected and transmitted not only for the items that would be used to classify a patient into a CMG, but also for the other MDS–PAC items, if collection and transmission of that data are appropriate according to one or more of the following: (1) the instructions on the MDS–PAC; (2) the Item-by-Item Guide to the MDS–PAC; and (3) applicable rulemaking provisions. In addition, if the IRF transmits MDS–PAC data for a particular patient that is not in accordance with the data record specifications, that data would be rejected by the HCFA MDS–PAC system. If the data is rejected by the HCFA MDS–PAC system, then the data is not ''locked'' as that term was defined previously, and the data must be re-transmitted.

We propose in § 412.614 to impose a penalty for an IRF's late transmission of MDS–PAC data to the HCFA MDS–PAC system. ''Late transmission'' means that the IRF did not transmit MDS–PAC data in accordance with the transmission timeframes previously specified in Table 4C of section III of this preamble. We propose that if the IRF transmits the MDS–PAC data late, then the IRF is either paid a reduced CMG-determined payment or no CMG-determined payment. If the IRF transmits the MDS–PAC data 10 or less calendar days late then the IRF would receive a payment that is 25 percent less than the CMG payment that the IRF would otherwise have received. If the MDS–PAC data is transmitted more than 10 calendar days late, then the IRF would receive no payment for the Medicare-covered Part A services furnished.

5. The MDS–PAC and Computer Software

In § 412.614(c) we propose that the IRF encode and transmit the MDS–PAC data using the MPACT software available from HCFA or other software that conforms to the HCFA standard data specifications, data dictionary, and other HCFA-specified data requirements, and that includes the MDS–PAC data items that match the most updated version of the MDS–PAC. HCFA's MPACT software will be able to be used for several purposes, such as to encode MDS–PAC data, to maintain IRF and patient-specific MDS–PAC information, to create export files to submit MDS–PAC data, and to test alternative software. MPACT software will provide comprehensive on-line help to users in encoding, editing, and transmitting the MDS–PAC data. Additionally, there will be a toll-free hotline to support this software product.

We caution IRFs that the MPACT software system would provide only the minimum requirements to encode and format the data. We will support these functions and applications; however, we do not intend to provide any other applications related to care planning, financial information, durable medical equipment, medications, or personnel issues. Software vendors are encouraged to use the MPACT software as a minimum system, until they have developed their own software to accommodate HCFA specifications and other applications useful for IRFs.

H. Quality Monitoring

Before we present our specific strategies for quality monitoring in IRFs, we want to discuss our conceptual framework for understanding and advancing quality in the setting of IRFs, as well as other post-acute settings. Quality of care is complex, sometimes difficult to define, and is multi-dimensional in nature. One dimension is that the care achieve its intended result, which in the context of the IRF setting is most often to improve the patient's functioning in order to foster more independent living. A second dimension of quality is the prevention of avoidable complications or other adverse events and minimizing the effects of adverse events. A third related dimension is to improve management of the patient's medical impairments, with the goal being to promote ''improved'' health as well as function, or at least to improve the management of the patient's medical conditions. In addition, it is also important to use data to identify other sentinel events that may potentially impact care negatively. Our specific quality monitoring processes should be developed in a way that supports this multi-dimensional view of quality.

The consequences of detecting quality of care problems may be varied and could include increasing educational efforts to beneficiaries to help them make better informed selections of providers, guiding investigators to survey institutions (including verification surveys performed in JCAHO-accredited facilities), and if the problem(s) is not remedied consideration of whether the IRF should be permitted to continue to participate in the Medicare program. An IRF's own staff may use quality of care information from the MDS–PAC for their own quality assurance and, ultimately, quality improvement activities. We also have the potential to develop refinements to the case-mix methodology which provide incentives for improving quality.

As our payment policies continue to evolve, our objective is to move forward

with a quality assessment and improvement agenda that is based on standardized data, beneficiaries' clinical characteristics, and patient care outcomes. To achieve that objective, we need to collect common data elements and develop standardized assessment tools that will enable us to focus on beneficiary care needs rather than the characteristics of the provider. We believe that the most important short-term goal of post-acute care quality monitoring is to assess the effects of implementing the changes in the payment system and the quality of post-acute care.

We are aware of MedPAC's concern that we may have only a limited ability to assess the impact of Medicare payment changes that either have been implemented or will soon be initiated—for example, the IRF prospective payment system. There is a need to enhance our ability to assess this impact in order to improve the policies associated with our Medicare prospective payment systems.

In the March 2000 MedPAC Report to Congress, MedPAC states that quality monitoring systems are important to ensure that payment systems are designed so that providers are responding appropriately to the system's incentives. MedPAC believes that such information could assist in tracking trends over time or provide an early warning of impending problems in quality. ''Attaining any of these ends requires routine, systematic measurement of health care quality.'' (p. 62) We believe that the MDS–PAC is a first step towards developing such a measure.

The MDS–PAC is a multi-dimensional assessment instrument which provides a detailed picture of the patient. The non-payment related items in the instrument are necessary to provide a comprehensive inventory of patient factors that are necessary to monitor quality and risk adjust. This data can be used by facilities to identify patients at risk for adverse outcomes. In addition, MDS–PAC information may contribute to development of the patient care plan. Information collected can identify patients at risk for adverse outcomes, such as weight loss, aspiration, or pressure ulcers, and support the monitoring of these patients to prevent outcomes that might negatively impact patients' likelihood of optimal rehabilitation.

We believe that the MDS–PAC items are needed to monitor the impact of the IRF prospective payment system upon IRFs and beneficiaries, including beneficiary access to care. Section 125 of the BBRA directs the Secretary to conduct a monitoring study, and to submit a report to the Congress no later than 3 years from the date that the IRF prospective payment is implemented. To both monitor the impact of the IRF prospective payment system upon IRFs and beneficiaries, and support this BBRA-mandated report to the Congress, we need a data-driven monitoring system that would give us the capability to acquire objective (as opposed to anecdotal) data for analysis.

The MDS–PAC discharge assessment would provide data about a patient's clinical status at discharge, and give us the ability to compare a patient's clinical status at discharge with the patient's clinical status at the Day 4 assessment. Comparison of the patient's clinical status at Day 4 and at discharge would give us the data to analyze the relationship between any changes in the patient's clinical status and the quantity and effectiveness of the services the IRF furnished to the patient. That comparison would provide us with data that would indicate the quality of the IRF services furnished, and if an IRF was not furnishing the level of Medicare-covered services the patient needed.

Many studies have examined overall and condition-specific functional gain from admission to discharge as a measure of the effectiveness of a rehabilitation program. National benchmarks of functional gain have been used by providers to measure their performance relative to other facilities. In addition, some work has also been devoted to understanding providers' efficiency by linking measures of length of stay and functional gain.

Update assessments would yield the type of structured data that we can use to analyze the effectiveness of treatment services at a point in time when the services were still being furnished. Update assessments provide the information during treatment and allow measurement of changes in the patient's clinical status during a defined time period when the patient is still in treatment. We can then compare the patient's clinical status at that point in time to the patient's clinical status at either the Day 4 or discharge assessments, which would provide us with data about any changes in the patient's clinical status between the update assessments and these other assessments.

In essence, update assessments provide a ''snapshot'' of the patient while the patient is still being treated. This snapshot provides a method to analyze the changes in the patient's clinical status that are a result of the IRF services furnished either up to, or from, a predetermined point in the patient's hospitalization stay. The snapshot is similar to how a clinician evaluates a patient's reaction to treatment at points in time after the clinician has implemented a plan of care, and, therefore, the snapshot can be used by the IRF in a similar manner. Because we propose to mandate the data requirements for update assessments, the snapshot will provide us with the same structured and detailed data that is comparable across IRFs, permitting us to analyze clinical outcomes related to the IRF services furnished up to, and from, a predetermined point in time at one or many IRFs. The update assessments could also provide us with the some of the data needed to analyze the effectiveness of the services being furnished at more than just the time period between the patient's admission and discharge. That analysis could be used to evaluate the quality and quantity of services the IRF furnished at different periods of time during the patient's hospitalization.

The data associated with each MDS–PAC item would enhance our ability to monitor and, thus, safeguard the quality of care that beneficiaries receive. A quality of care improvement monitoring system that is based on the MDS–PAC data is consistent with other information-based quality monitoring programs, such as the ORYX process used by the Joint Commission on Accreditation of Health Care Organizations.

While only some MDS–PAC items would be used to determine the CMG, we believe that the data provided by MDS–PAC items are an essential first step in developing the type of quality monitoring system that both MedPAC and HCFA favor. Possible uses of the data could include: (1) strengthening existing quality assurance mechanisms; (2) generating indicators that would allow providers to assess their performance, and to compare it against benchmarks derived from standards of care or the performance of peers; and (3) creating a system that assists beneficiaries in making informed decisions when choosing among providers. In addition, MDS–PAC items may be useful in developing core measures that provide meaningful information on patient characteristics and outcomes across post-acute care settings.

1. Monitoring the IRF Prospective Payment System

We are planning a system that can be used to monitor access to rehabilitation facilities as well as to monitor the quality of the care delivered in these

facilities. This will be done through the monitoring of payment for the care and the associated cost of the delivered care. Monitoring will include variables as length of IRF stay, percent of IRF discharges to SNF, long-term care hospital, or intensive outpatient rehabilitation program, change in motor function between admission and discharge, and the case-mix distribution of the facility. We plan to examine changes within ''market areas'' as well as individual facilities.

In addition, we will be developing a variety of methods for monitoring the impact of the IRF prospective payment system. Monitoring may describe changes in access to rehabilitation, in payments to rehabilitation facilities, in quality of care, and in the cost of rehabilitation care. This monitoring would also help to identify unintended changes in the operations of providers, and would help to identify refinements needed in the IRF prospective payment system. In addition, because the IRF prospective payment system may have effects on non-IRF providers, and because changes in the payment systems for other providers may affect IRFs once common core data elements are required across post-acute providers and linked with other data, the monitoring system could also describe changes in access, utilization, quality, and cost of care in different types of post-acute sites including but not limited to HHAs and SNFs. We could start these activities as early as 2002.

2. Quality Indicators

Quality indicators are markers that indicate either the presence or absence of potentially poor facility care practices or outcomes. The development of quality indicators depends on the collection and analysis of sufficient MDS–PAC data from a representative national sample. We are attempting to design a monitoring system that would not only describe quality indicators, but also show how they can be used together to obtain a clear description of access, outcomes, and cost in IRFs. Quality indicators will be developed around the different dimensions of quality discussed earlier in this section. We believe that quality indicators developed for individual IRFs would help identify the IRFs that require attention because they may be coding incorrectly or providing lower quality care. Analysis of the distribution of hospital indicators within specific classes of hospitals (for example, teaching hospitals, rural hospitals, etc.) would help us to evaluate whether facility level adjustments are warranted.

We currently have a contractor conducting analysis for purposes of developing quality indicators to be used in IRFs. Quality indicators are not direct measures of quality but rather point towards potential areas that require further investigation. Quality indicators identify the percent of a patient population with a certain condition and compare this percent to a state level and a national level. If a facility ''flags'' for scoring ''high'' on a particular quality indicator, this does not necessarily mean that the facility has a quality of care problem but simply that further focussed review of care practices may be required. Quality indicators have already been developed by the University of Wisconsin for use in SNFs and are being effectively used by State surveyors to target facilities for closer on-site review of care practices as well as by some nursing homes to identify potential problems within their facility.

We have already begun consideration of quality indicators that may be collected from MDS–PAC data to evaluate care delivered in IRFs. We agree with MedPAC's advice that quality monitoring efforts be closely coordinated across different types of post-acute care providers. We expect to develop measures to be applied across different settings. We anticipate that measures of functional improvement from admission to discharge will be examined. In addition, during 2000, the infrastructure to collect the data to identify quality indicators for IRFs will be under development. Field validation of these indicators is expected to begin in 2001. Once the indicators have been field tested, the State quality infrastructure can begin to utilize these data to monitor quality and to target facilities to survey for accreditation. The next step will be validation of the assessment data. Piloting the reporting of data will be ongoing during this time period. There is funding in the 2001 budget for analysis of the accuracy of the assessment data collected. ''Tool kits'' will be developed for targeted interventions to address common quality issues in these facilities. Examples of quality indicators currently being considered for IRFs are described below.

3. Functional Independence

The main goal of an IRF is to assist the patient in regaining his or her prior level of functional ability. A measure of the quality of a rehabilitation program is the patient's ability to function independently upon discharge to the community. Using MDS–PAC data, it will be possible to measure the percent of all cases discharged to the community who are functionally independent or whose functional status has improved at the time of discharge. Functional independence on the MDS–PAC would be measured using Section E of the instrument. The information collected in this section may be used by staff to calculate the Activities of Daily Living for Post-Acute Care (ADL–PAC) Summary Scale for each patient. The ADL–PAC computes patients' level of dependence on a scale from 0 (fully independent) to 6 (fully dependent). The scale considers level of dependence for each of the following activities: bed mobility, transfer between the bed and chair, locomotion, walking in facility, dressing upper body, dressing lower body, eating, toilet use, transfer to toilet, grooming and personal hygiene, bathing, transfer to and from the tub or shower. This information about the patient's levels of dependence on these various activities of daily living on admission, at intervals during the stay, and at discharge will be particularly useful to describe the patient's progress as a result of rehabilitation care. A patient's progress can be evaluated with respect to thresholds or milestones, developed after analysis of data collected during rehabilitation stays rather than based upon theoretical assumptions. The data will also assist in the development of quality indicators to predict the types of patients who have the best prognosis for improvement in rehabilitation programs. This information may also encourage referrals to IRFs for patients who might otherwise not have been referred. The data derived from functional information may also serve to better match patients with program characteristics to ''fine tune'' the delivery of rehabilitation services.

Additional variables on the MDS–PAC would allow the facility to consider factors which may affect a patient's ability to return to his or her previous level of functional ability or live independently in the community. Item E7 (stamina) helps staff predict how much therapy the patient can tolerate daily. This will impact the intensity of rehabilitation to help the patient regain functional independence. Assessment of stamina will likely affect a patient's ability to function independently once he or she is discharged back to the community. Items M1 (available social supports), M2 (caregiver status) and M3 (living arrangement) will help predict the characteristics of the community to which the patient is being discharged in order to make sure the environment is optimal to the patient's success. Finally,

item L2 (Attributes relevant to rehabilitation) measures whether a patient recognizes his or her limitations. This information will be important to determine whether the patient can function in the community and to determine how much help the patient will need, without taking risks that may cause a fall or other harmful events when not supervised.

Indicators based on functional gain will be useful in public reporting to help beneficiaries make more educated decisions about the facility from which they choose to receive care. In addition, Peer Review Organizations (PROs) can use the data from successful facilities to identify factors that are better at assisting patients in achieving functional independence and returning to the community. This information can be shared with other facilities to help improve their success rate as well.

4. Incidence of Pressure Ulcers

Pressure ulcers (also known as Decubitus Ulcers) are a problem in IRFs as well as in other post-acute and acute settings. In some situations the patient is admitted with these ulcers. Facilities cannot be held responsible for ulcers which were present upon admission, but if these ulcers increase in size or grade, or if new ulcers develop, this can be an indicator of poor quality of care.

Information about pressure ulcers would be collected in section H of the MDS–PAC. Information about bed mobility and transfer ability (items E1a and E1b), bladder incontinence (item F1a), and nutritional status (item J5a and J5b) is useful in identifying patients at high risk for developing new pressure ulcers. A pressure ulcer quality indicator could be used by the facility to institute such measures as staff training or more attention to techniques and equipment intended to prevent the development of pressure ulcers (such as frequent change of position of patients unable to move themselves and use of pressure relieving devices). In addition, quality indicators at the facility and State level can be compared to national averages for a better understanding of a facility's performance relative to its peers. Focused review will help identify which factors are contributing to the higher incidence of pressure ulcers. Analysis of MDS–PAC data can also be used to identify facilities that are successful in resolving and treating existing pressure ulcers. These facilities may have effective pressure ulcer reduction programs in place that can be shared with other facilities that are experiencing difficulty treating and reducing the incidence of pressure ulcers. Public reporting of the rate of pressure ulcers based on quality indicator information may help consumers make more informed choices when choosing a facility.

5. Falls Prevention

Falls prevention is an important component of a rehabilitation program and is critical to avoiding repeat hospitalizations which, in turn, will delay return to independence. Items in the MDS–PAC such as D3a and D3e on wandering and resisting care, item E9 on balance, and item H2 on dizziness and falls, provide critical information regarding fall risk to help facilities identify patients who may be at risk for falls. This indicator may also be used to identify facilities with poorer track records in fall avoidance. Information about falls prevention also provides information so that facilities serving different types of patients can be distinguished. PROs may also use these data to teach facilities how to better identify patients at risk for falls and set up programs to reduce the incidence of falls through such methods as low beds or better monitoring of at-risk patients.

As illustrated by these examples, there are several ways the quality information gathered through the MDS–PAC may be used. As noted, quality indicator data does not necessarily illustrate that a facility is providing a lower level of care, but this information can be useful to surveyors in targeting facilities for closer review of their patient care practices and facility layout. Quality indicators can also be used to identify facilities with best practices. Identifying how these facilities maintain a high-quality level of care may provide valuable information to assist facilities.

6. Quality Improvement

Quality assurance involves the establishment of standards and having a system to enforce compliance with these standards. Quality improvement fosters and facilitates continuous enhancement of whatever service or product an organization is engaged in or produces. The JCAHO require facilities to have quality improvement programs. Currently, the Medicare Conditions of Participation require hospitals to do quality assurance, which we believe can be supported with the information obtained from the MDS–PAC. The proposed change in the Medicare Conditions of Participation for Hospitals, proposed December 19, 1997, would require hospitals, including IRFs, to have quality improvement programs. Also, we are identifying opportunities in which PROs can use their expertise and skill mix to provide valuable information on quality improvement to post-acute providers. PROs have been working with SNFs for the past year, and feedback from facilities has indicated that the information shared by the PRO in a penalty-free environment has been valuable in helping facilities learn how to use the MDS to identify their own opportunities for quality improvement. In addition, many IRFs already have data-based quality improvement systems addressing some aspects of quality. PROs may build on their experience in SNFs and on the current experience of IRFs to become a resource on how to use information derived from the MDS–PAC to identify potential quality concerns. Quality improvement activities may include providing each facility with information derived from its MDS–PAC submissions for use in self-monitoring, providing facilities with information comparing their performance with that of their peers, and maintaining a clearinghouse of ''best practices'' that can be used by facilities to improve the quality of care they deliver.

IRFs may also use MDS–PAC data to generate quality indicators on their own and use this information to help them target specific problems within their facility or identify areas where quality improvement projects may be most effective. IRFs can also use the MDS–PAC to perform their own monitoring of changes in quality of care within the facility.

7. Consumer Information

We plan to use the comprehensive quality information derived from MDS–PAC for use in our public reporting strategy. MDS–PAC data, after appropriate evaluation and validation, can be used to inform consumers about the performance of facilities in their area so that they can make informed decisions when selecting a rehabilitation facility. In addition, information derived from MDS–PAC and the comparable information available in SNFs and other settings will help us understand which patients fare better in which types of post-acute settings, or even within subsets of IRFs, thus informing and shaping future long-term care quality initiatives.

As part of our efforts in designing a monitoring system, we are soliciting comments on whether we should also collect data related to medications and medication administration.

I. MDS–PAC Training and Technical Support for IRFs

We will provide educational and technical resources to IRFs, to support both implementation of the MDS–PAC

assessment instrument and the computerization and transmission of the MDS–PAC data. We will provide training and technical support on the use of the MDS–PAC by clinical staff and on the use of MPACT software to encode and transmit MDS–PAC data.

Although we will be providing both initial and ongoing training and technical support, IRFs will probably find it advantageous to designate a staff member as an IRF trainer, in order to have in-house capability both to train newly hired staff, and to have a designated person who can serve as the in-house resource for other staff.

We would train and support the IRFs in the implementation of the IRF prospective payment system and automation of the MDS–PAC by—

- Training IRFs on MDS–PAC data set administration;
- Answering questions on the clinical aspects of the MDS–PAC and providing information to IRFs on the use of the MDS-PAC to determine CMGs;
- Providing training to State agency staff in using MDS–PAC data for survey activities;
- Training IRFs in interpreting validation reports;
- Providing information relative to hardware and software requirements; and
- Providing support for transmission of test data, supporting callers who request technical assistance, providing passwords to IRFs, and answering questions about the computer edits and reports.

1. Release of Information Collected Using the MDS–PAC

In § 412.616, we propose that the IRF and its agents must ensure the confidentiality of the information collected using the MDS–PAC in the same manner as all other information in the medical record, in accordance with the hospital conditions of participation at § 482.24(b)(3). The facility must ensure that information may be released only to authorized individuals and must ensure that unauthorized individuals cannot gain access to or alter patient records. Information must be released by the facility or its agent only in accordance with Federal or State laws, court orders or subpoenas. In addition, we propose that an agent acting on behalf of an IRF in accordance with a written contract with that IRF may only use the information for the purposes specified in the contract.

We believe that this provision will ensure that access to MDS–PAC data (paper copy as well as electronic data) is secured and controlled by the IRF, in accordance with Federal and State laws. We believe that proposed § 412.616 would provide an adequate safeguard against the unauthorized use of a patient's clinical record and the information it contains, regardless of form or storage method. As discussed in section III.G.1 of this preamble, however, the confidentiality provisions at proposed § 412.616 may be supplemented or superseded by the security and privacy requirements contained in the ''Standards for Privacy of Individually Identifiable Health Information'' regulation (64 FR 59918) and the ''Security and Electronic Signature Standards'' regulation (63 FR 43242), when they are finalized.

As with other regulations that result in the creation of a new system of records, we are in the process of developing a notice describing the new system of records that is unique to MDS–PAC. We have typically issued notices describing new systems of records in conjunction with the issuing of a final rule, rather than at the proposed rule stage. These notices, required by the Privacy Act of 1974, describe both the entities to whom identifiable and non-identifiable data can be routinely disclosed, as well as the safeguards that will protect the privacy and the security of the data. While each system of records notice is unique to the system and the data instrument, readers interested in understanding a recent approach are referred to the notice of the new system of records published June 18, 1999, (64 FR 32992) for the ''Home Health Agency Outcome and Assessment Information Set (OASIS).'' We would welcome comments on issues germane to the notice that we will develop for MDS–PAC.

J. Patient Rights

In § 412.608, we propose that, in order to receive payment for the Medicare IRF services furnished, the authorized clinician must inform the Medicare inpatient of the following rights with respect to the MDS–PAC assessment prior to performing the assessment. These rights include—

- The right to be informed of the purpose of the MDS-PAC data collection;
- The right to have any MDS–PAC information that is collected remain confidential and secure;
- The right to be informed that the MDS–PAC information will not be disclosed to others except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;
- The right to refuse to answer MDS–PAC questions; and
- The right to see, review, and request changes on the MDS–PAC assessment.

We propose requiring the IRF ensure that a clinician documents in the Medicare patient's clinical record that the patient has been informed of the above patient rights. IRFs should note that the above patient rights are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

Our statements of patient rights with regard to the MDS–PAC would also be available via the HCFA Inpatient Rehabilitation Facility Prospective Payment System website. These statements may be revised in accordance with the Office of Management and Budget Paperwork Reduction Act re-approval process. Future revisions to these statements will be available via the HCFA Inpatient Rehabilitation Facility Prospective Payment System website, and in other instructional materials that we issue.

K. Medical Review Under the IRF Prospective Payment System

Under a discharge-based prospective payment system IRFs might have financial incentives to reduce the quality and quantity of services furnished to a patient. To monitor for any reduction in the quality or quantity of services IRFs furnish, medical review may be conducted on both a random and targeted basis. Targeting may include claim-specific data and patterns of case-mix upcoding, as well as the general issues of the medical need for the episode of care and technical eligibility. There will be the capability for both prepayment and post-payment medical review that will deny claims in total or adjust payment to the correct case mix. Medical review will validate MDS–PAC data items against clinical records.

IV. Case-Mix Group Case Classification System

A. Background

As discussed in section I.C.2. of this preamble, section 1886(j)(2)(A) of the Act requires the Secretary to establish a method of classifying patients in rehabilitation facilities within case-mix groups. Further, the Act, as amended by section 125 of the BBRA, requires the Secretary to establish classes of patient discharges of rehabilitation facilities by functional-related groups, based on impairment, age, comorbidities, functional capability of the patient, and other factors as the Secretary considers appropriate to improve the explanatory power of the functional independence measure-function related groups. Under

the classification system that we are proposing, as described at § 412.620(a), patients would be classified into case-mix groups called CMGs based on clinical characteristics and resource needs.

We began our efforts to establish an appropriate classification system by examining the FIM–FRGs, a classification methodology developed by Stineman *et al.* (1994) and extended to incorporate comorbidities in Carter, Relles, *et al.* (1997). In developing the proposed CMGs, we updated the earlier FIM–FRG analysis with more recent data from calendar years 1996 and 1997 Medicare bills as well as functional status measures from UDSmr and Caredata.com for the same calendar years (see Appendix A for a detailed description of the data used to create the CMGs). The results of using more recent data showed that the earlier FIM–FRG classification system continues to be an appropriate basis to predict resource use. Based on our analysis of the more recent data, we are proposing a classification system that reflects general enhancements, including: a refined set of rehabilitation impairment categories; a modified set of relevant comorbidities; groups for cases that expire; and other types of atypical discharges, such as short-stay cases.

B. Case-Mix Groups

1. General Description of the Case-Mix Groups

The data elements used to construct the proposed CMGs include rehabilitation impairment categories (RICs), functional status (both motor and cognitive), age, and comorbidities. We also used other factors to define the CMGs that allow us to improve the explanatory power of the groups. Specifically, we created CMGs to account for short-stays and expired cases. The CMGs are based on an analysis of the Medicare inpatient rehabilitation cases described in Appendix A of this proposed rule. We separated those cases that we believe received a typical, full course of inpatient rehabilitation care from those cases that may not have received a typical, full course of inpatient rehabilitation care such as transfer cases and special cases that are not transfers. As described below, (1) the analysis of cases that receive a typical, full course of inpatient rehabilitation care results in the construction of 21 RICs and 92 CMGs; and (2) the analysis of special cases that are not transfers results in the construction of 4 CMGs for cases that expire and 1 CMG for cases that have a length of stay of 3 days or less. In addition, as described in section V.B. of this preamble, the analysis of transfer cases results in a payment policy that is dependent on which CMG the patient is classified to prior to the patient's transfer.

2. Criteria for Establishing CMGs

We used the following criteria for establishing specific groups within the proposed classification system:

- Group cases that are clinically similar. To do this, we began with the 20 RICs defined by Stineman *et al.* (1997) and examined a variety of changes that were suggested might improve either clinical or resource homogeneity.
- Group cases that have similar resource needs. To do this, we used a statistical classification method, the Classification and Regression Trees (CART), to partition the cases within RICs into groups that are homogeneous with respect to resource use and functional impairment. Thus, each CMG consists of cases that have similar clinical and resource needs.
- Determine which comorbidities affect the cost of rehabilitation cases by RIC.

We describe in more detail the methodology that we used to construct the CMGs.

3. Rehabilitation Impairment Categories

The first partition in creating the CMGs is based on the RIC of the case. RICs are groups of codes that indicate the primary cause of the rehabilitation hospitalization and are clinically homogeneous. The patient is first grouped into a RIC based on the impairment identified in the data described above. Table 1D below lists the RICs used to define and construct the first partition of the inpatient rehabilitation cases.

The earlier RAND research of 1994 data resulted in 20 RICs. We analyzed RAND's statistical analysis of 1997 data, and that showed that the 1997 data performed as well as the 1994 data in predicting resource use in RICs 01 through 20 (except that the impairment code 14.9 ''Status post major multiple fractures'' grouped better in RIC 17). In addition, the 1997 data indicated the need to create a separate RIC for burn cases.

For the majority of CMGs, the RIC represents the first two digits of the CMG. Thus, in Table 2D below, CMGs 0101 through 0111 are cases that are classified to the stroke (01) RIC.

TABLE 1D.—REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES

Rehabilitation impairment category	Associated impairment group codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain) 01.2 Right body involvement (left brain) 01.3 Bilateral Involvement 01.4 No Paresis 01.9 Other Stroke
02 Traumatic brain injury (TBI)	02.21 Open Injury 02.22 Closed Injury
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic 02.9 Other Brain
04 Traumatic spinal cord (TSCI)	04.210 Paraplegia, Unspecified 04.211 Paraplegia, Incomplete 04.212 Paraplegia, Complete 04.220 Quadriplegia, Unspecified 04.2211 Quadriplegia, Incomplete C1–4 04.2212 Quadriplegia, Incomplete C5–8 04.2221 Quadriplegia, Complete C1–4 04.2222 Quadriplegia, Complete C5–8 04.230 Other traumatic spinal cord dysfunction

TABLE 1D.—REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES—Continued

Rehabilitation impairment category	Associated impairment group codes
05 Nontraumatic spinal cord (NTSCI)	04.110 Paraplegia, unspecified 04.111 Paraplegia, incomplete 04.112 Paraplegia, complete 04.120 Quadriplegia, unspecified 04.1211 Quadriplegia, Incomplete C1–4 04.1212 Quadriplegia, Incomplete C5–8 04.1221 Quadriplegia, Complete C1–4 04.1222 Quadriplegia, Complete C5–8 04.130 Other non-traumatic spinal cord dysfunction
06 Neurological (Neuro)	03.1 Multiple Sclerosis 03.2 Parkinsonism 03.3 Polyneuropathy 03.5 Cerebral Palsy 03.8 Neuromuscular Disorders 03.9 Other Neurologic
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture 08.12 Status post bilateral hip fractures 08.2 Status post femur (shaft) fracture 08.3 Status post pelvic fracture
08 Replacement of LE joint (ReplLE)	08.51 Status post unilateral hip replacement 08.52 Status post bilateral hip replacements 08.61 Status post unilateral knee replacement 08.62 Status post bilateral knee replacements 08.71 Status post knee and hip replacements (same side) 08.72 Status post knee and hip replacements (different sides)
09 Other orthopedic (Ortho)	08.9 Other orthopedic
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK) 05.4 Unilateral lower extremity below the knee (BK) 05.5 Bilateral lower extremity above the knee (AK/AK) 05.6 Bilateral lower extremity above/below the knee (AK/BK) 05.7 Bilateral lower extremity below the knee (BK/BK)
11 Amputation, other (AMP–NLE)	05.1 Unilateral upper extremity above the elbow (AE) 05.2 Unilateral upper extremity below the elbow (BE) 05.9 Other amputation
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis 06.9 Other arthritis
14 Cardiac (Cardiac)	09 Cardiac
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease 10.9 Other pulmonary
16 Pain Syndrome (Pain)	07.1 Neck pain 07.2 Back pain 07.3 Extremity pain 07.9 Other pain
17 Major multiple trauma, no brain injury or spinal cord injury (MMT–NBSCI).	08.4 Status post major multiple fractures 14.9 Other multiple trauma
18 Major multiple trauma, with brain or spinal cord injury (MMT–BSCI).	14.1 Brain and spinal cord injury 14.2 Brain and multiple fractures/amputation 14.3 Spinal cord and multiple fractures/amputation
19 Guillian Barre (GB)	03.4
20 Miscellaneous (Misc)	12.1 Spina Bifida* 12.9 Other congenital 13 Other disabling impairments 15 Developmental disability 16 Debility 17.1 Infection 17.2 Neoplasms 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition 17.4 Circulatory disorders 17.51 Respiratory disorders—Ventilator Dependent 17.52 Respiratory disorders—Non-ventilator Dependent 17.6 Terminal care 17.7 Skin disorders 17.8 Medical/Surgical complications 17.9 Other medically complex conditions
21 Burns (Burns)	11 Burns

*We are in the process of analyzing the effect of moving the few cases within this impairment category to one of the other spinal cord RICs (either 05 or 04 depending upon the ''fit'').

4. Functional Status Measures and Age

After using the RIC to define the first split among the inpatient rehabilitation cases, we used functional status measures and age to partition the cases further. We describe below the statistical methodology (Classification and Regression Trees or CART) that we used to incorporate a patient's functional status measures (motor score and cognitive score), and age into the construction of the proposed CMGs.

The CART methodology was used to split the rehabilitation cases further within each RIC. In general, CART can be used to identify statistical relationships among data and, using these relationships, construct a predictive model for organizing and partitioning a large set of data into smaller homogeneous groups. Further, in constructing the proposed CMGs, we analyzed the extent to which the independent variables (motor score, cognitive score, and age) help predict the value of the dependent variable (the log of the cost per case).

The CART methodology will ensure that the proposed CMGs recognize that patients with clinically distinct resource needs are treated separately in the classification and payment systems. CART is an iterative process that creates initial groups of patients then searches for ways to split the initial groups that may further decrease the clinical and cost variances within a group and increase the explanatory power of the CMGs. (Further information regarding this methodology can be found in the seminal literature on CART (Classification and Regression Trees, Leo Breiman, Jerome Friedman, Richard Olshen, Charles Stone, Wadsworth Inc., Belmont CA, 1984: pp 78–80.)

We also used a validation method to assess the predictive accuracy of the RICs and CMGs. Half of the 1996 and 1997 data described in Appendix A was used initially to create the CMGs. Once this was done, the other half of the data was used to test or validate the predictive accuracy of the CMGs. We concluded that the RICs and CMGs we are proposing are valid because the groups performed as well using the second half of the data as they did with the first half. The final definitions of the specific RICs and CMGs was based on 100 percent of the 1997 Medicare cost data with corresponding UDSmr/COS data.

As a result of this analysis, Table 2D lists 92 CMGs and their respective descriptions, including the motor and cognitive scores and age that will be used to classify discharges into CMGs. As described in section II.B. of this preamble, some CMGs may change based on further analysis of available data and comments we receive in response to this proposed rule.

5. Comorbidities

We found comorbidities have major effects on the cost of furnishing inpatient rehabilitation care. RAND's previous analysis, based on 1994 data, found that these comorbidities also increased the cost of furnishing inpatient rehabilitation care. A list of the major comorbidities appears in Appendix C of this proposed rule. A case has to have only one of the listed comorbidities to be classified as a case with comorbidity. We found that the presence of major comorbidities multiplies the expected resource use of a case by the same amount for each CMG in the same RIC.

We matched frequently occurring comorbidities to impairment categories in order to ensure that all of the chosen comorbidities are, in fact, relevant to the RIC. Providing rehabilitation services to a beneficiary with a total hip replacement can become both more complex and more costly if the beneficiary also has pneumonia. By contrast, some pulmonary diagnoses might be determined not to have a cost impact for beneficiaries with chronic obstructive pulmonary disease.

We found comorbidities to affect cost per case for some of the CMGs, but not all. When comorbidities substantially increased the average cost of the CMG and were determined to be clinically relevant, we developed CMG relative weights adjusted for comorbidities. We will continue to analyze the data to determine if refinements to the list of comorbidities in Appendix C are necessary. Further discussion of the effect of comorbidities is described in section V.A.2. of this preamble.

6. Analysis of Special Cases

We analyzed payment-to-cost ratios of special types of cases that were not transfer cases to determine if costs could be predicted. From this analysis, we believe that cases that expire and cases with a length of stay of 3 days or less (not including transfer cases) would be substantially ''overpaid'' if facilities receive the full CMG payment for these cases. To improve the explanatory power of the groups, we added four CMGs to account for cases that expire and one CMG for all cases that have a length of stay of 3 days or less (not including transfer cases). These types of special cases are further explained in section V.C. of this preamble. Therefore, the total number of proposed CMGs is 97 as shown in Table 2D.

7. Methodology To Classify Patients Into CMGs

Data from the MDS–PAC, described in section III of this preamble and specified in proposed § 412.620(a)(3) of the regulations, will be used to classify a patient into a CMG. In Table 3D, we have identified the specific MDS–PAC items that must be completed in order to classify a patient into a CMG and to effectively implement the proposed prospective payment system. (These items, along with other MDS–PAC items, will be used to administer, monitor, and analyze possible refinements to the proposed prospective payment system as described in section III of this preamble.) The MDS–PAC items will be used to establish the motor score, cognitive score, and age of the patient that corresponds with a specific CMG description.

8. Case Example To Classify a Patient Into a CMG

The following example illustrates how a Medicare beneficiary would be classified to a CMG under the proposed classification system. An 82 year old woman has a left total hip replacement because of osteoarthritis, and is admitted to the IRF because of the need for rehabilitation after the hip replacement surgery. The beneficiary is first classified into RIC 08: Replacement of Left Extremity Joint with Associated Impairment Group Code 08.51: Status Post Unilateral Hip Replacement.

Assessment

MDS–PAC SCORE

0 Independent in eating (MDS–PAC section E, 1g);
1 Requires set up to dress upper body (MDS–PAC section E, 1e);
5 Requires maximum assistance to dress lower body (MDS–PAC section E, 1f);
1 Requires set up for grooming (MDS–PAC section E, 1j);
2 Requires minimal assistance for bed mobility (MDS–PAC section E, 1b);
5 Requires maximum assistance for bed to chair transfer (MDS–PAC section E, 1b);
5 Requires maximum assistance for walking (MDS–PAC section E, 1d);
5 Requires maximum assistance for toilet transfer (MDS–PAC section E, 1i);
5 Requires maximum assistance for bathing (MDS–PAC section E, 1k);
6 Dependent shower transfer (MDS–PAC section E, 1k);
6 Dependent stair climbing (MDS–PAC section E, 8c); and
0 Independent bowel and bladder sphincter control (MDS–PAC section F, 1 and 4.

Total MDS–PAC Motor Score: 41

This motor score places the Medicare beneficiary in CMG 0802, which is ''Replacement of lower extremity joint'' with a motor score from 41–33. (See footnote at the bottom of Table 2D)

TABLE 2D.—DEFINITION OF CMGS

CMG number**	CMG description
0101	Stroke with motor score from 29–0
0102	Stroke with motor score from 34–30 and cognitive score from 27–135*
0103	Stroke with motor score from 40–35 and cognitive score from 28–35*
0104	Stroke with motor score from 34–30 and cognitive score from 5–26*
0105	Stroke with motor score from 40–35 and cognitive score from 5–27*
0106	Stroke with motor score from 45–41
0107	Stroke with motor score from 49–46
0108	Stroke with motor score from 55–50
0109	Stroke with motor score from 78–56 and patient is 84 years old or older
0110	Stroke with motor score from 60–56 and patient is 83 years old or younger
0111	Stroke with motor score from 78–61 and patient is 83 years old or younger
0201	Traumatic brain injury with motor score from 33–0 and cognitive score from 30–35*
0202	Traumatic brain injury with motor score from 33–0 and cognitive score from 5–29*
0203	Traumatic brain injury with motor score from 50–34 and cognitive score from 22–35*
0204	Traumatic brain injury with motor score from 50–34 and cognitive score from 5–21*
0205	Traumatic brain injury with motor score from 66–51
0206	Traumatic brain injury with motor score from 78–67
0301	Non-traumatic brain injury with motor score from 33–0 and cognitive score from 22–35*
0302	Non-traumatic brain injury with motor score from 33–0 and cognitive score from 5–21*
0303	Non-traumatic brain injury with motor score from 46–34
0304	Non-traumatic brain injury with motor score from 56–47
0305	Non-traumatic brain injury with motor score from 78–57
0401	Traumatic spinal cord injury with motor score from 36–0
0402	Traumatic spinal cord injury with motor score from 57–37
0403	Traumatic spinal cord injury with motor score from 74–58
0404	Traumatic spinal cord injury with motor score from 78–75
0501	Non-traumatic spinal cord injury with motor score from 23–0
0502	Non-traumatic spinal cord injury with motor score from 36–24
0503	Non-traumatic spinal cord injury with motor score from 45–37
0504	Non-traumatic spinal cord injury with motor score from 57–46
0505	Non-traumatic spinal cord injury with motor score from 78–58
0601	Neurological with motor score from 35–0
0602	Neurological with motor score from 45–36
0603	Neurological with motor score from 53–46
0604	Neurological with motor score from 78–54
0701	Fracture of lower extremity with motor score from 36–0
0702	Fracture of lower extremity with motor score from 45–37
0703	Fracture of lower extremity with motor score from 51–46
0704	Fracture of lower extremity with motor score from 78–52
0801	Replacement of lower extremity joint with motor score from 32–0
0802	Replacement of lower extremity joint with motor score from 41–33
0803	Replacement of lower extremity joint with motor score from 48–42
0804	Replacement of lower extremity joint with motor score from 78–49 and cognitive score from 34–35*
0805	Replacement of lower extremity joint with motor score from 55–50 and cognitive score from 5–33*
0806	Replacement of lower extremity joint with motor score from 78–56 and cognitive score from 5–33*
0901	Other orthopedic with motor score from 32–0
0902	Other orthopedic with motor score from 44–33
0903	Other orthopedic with motor score from 53–45
0904	Other orthopedic with motor score from 78–54
1001	Amputation, lower extremity with motor score from 38–0
1002	Amputation, lower extremity with motor score from 48–39
1003	Amputation, lower extremity with motor score from 78–49
1101	Amputation, non-lower extremity with motor score from 30–0
1102	Amputation, non-lower extremity with motor score from 44–31 and patient is 68 years old or older
1103	Amputation, non-lower extremity with motor score from 44–31 and patient is 67 years old or younger
1104	Amputation, non-lower extremity with motor score from 78–45
1201	Osteoarthritis with motor score from 42–0 and cognitive score from 34–35*
1202	Osteoarthritis with motor score from 42–0 and cognitive score from 5–33*
1203	Osteoarthritis with motor score from 54–43
1204	Osteoarthritis with motor score from 78–55
1301	Rheumatoid, other arthritis with motor score from 30–0
1302	Rheumatoid, other arthritis with motor score from 42–31
1303	Rheumatoid, other arthritis with motor score from 78–43
1401	Cardiac with motor score from 37–0
1402	Cardiac with motor score from 50–38
1403	Cardiac with motor score from 78–51
1501	Pulmonary with motor score from 40–0 and patient is 78 years old or older
1502	Pulmonary with motor score from 40–0 and patient is 77 years old or younger

TABLE 2D.—DEFINITION OF CMGS—Continued

CMG number**	CMG description
1503	Pulmonary with motor score from 63–41
1504	Pulmonary with motor score from 78–64
1601	Pain syndrome with motor score from 41–0 and cognitive score from 33–35*
1602	Pain syndrome with motor score from 41–0 and cognitive score from 5–32*
1603	Pain syndrome with motor score from 78–42
1701	Major multiple trauma with brain or spinal cord injury with motor score from 48–0
1702	Major multiple trauma with brain or spinal cord injury with motor score from 78–49
1801	Major multiple trauma, with brain or spinal cord injury with motor score from 56–0
1802	Major multiple trauma, with brain or spinal cord injury with motor score from 78–57
1901	Guillian Barre with motor score from 36–0
1902	Guillian Barre with motor score from 47–37
1903	Guillian Barre with motor score from 78–48
2001	Miscellaneous with motor score from 21–0 and patient is 59 years old or older
2002	Miscellaneous with motor score from 31–22
2003	Miscellaneous with motor score from 36–32
2004	Miscellaneous with motor score from 21–0 and patient is 58 years old or younger
2005	Miscellaneous with motor score from 43–37 and patient is 65 years old or older
2006	Miscellaneous with motor score from 52–44 and patient is 65 years old or older
2007	Miscellaneous with motor score from 43–37 and patient is 65 years old or younger
2008	Miscellaneous with motor score from 78–53 and patient is 84 years old or older
2009	Miscellaneous with motor score from 59–53 and patient is 84 years old or younger
2010	Miscellaneous with motor score from 52–44 and patient is 65 years old or younger
2011	Miscellaneous with motor score from 78–60 and patient is 84 years old or younger
2101	Burns
5001	Short-stay cases, length of stay is 3 days or fewer
5101	Expired, orthopedic, short stay
5102	Expired, orthopedic, not short stay
5103	Expired, not orthopedic, short stay
5104	Expired, not orthopedic, not short stay

*In developing this example of scoring conventions, we have displayed only the FIM motor scores as MDS–PAC scores. We have not included the cognitive scores as MDS–PAC scores. We are currently studying the aggregation of the MDS-PAC variable into the FIM cognitive categories. RAND, our contractor, will be performing additional analysis on the cognitive scoring conventions, and we will be including this research in the final regulations.

**The first two digits of the CMG number from 01 to 21 correspond with a specific RIC number shown on Table 1D.

TABLE 3D.—CRITICAL MDS–PAC ITEMS

Section/item name	Item number
A. ITEMS FROM THE INTERRUPTED STAY TRACKING FORM	
SECTION AA. IDENTIFICATION INFORMATION:	
Legal Name of Patient	1a–1d
Admission Date	2a–2b
Social Security and Medicare Numbers	6a–6b
Facility Provider Number	8a–8b
Medicaid Number	9
Gender	10
Birthdate	11
Ethnicity/Race	12a–12f
Interrupted Stay	13a–13b
Clinician Completing Assessment	14b–14f
B. ITEMS FROM THE BASIC ASSESSMENT TRACKING FORM	
SECTION AA. IDENTIFICATION INFORMATION:	
Legal Name of Patient	1a–1d
Admission Date	2a–2b
Reason for Assessment	3
Assessment Reference Date	4
Discharge Status	5a–5b*
Social Security and Medicare Numbers	6a–6b
Facility Provider Number	8a–8b
Medicaid Number	9
Gender	10
Birthdate	11*
Ethnicity/Race	12a–12f
SECTION AB. ASSESSMENT ATTESTATION:	
Person Completing Assessment	1b–1g

TABLE 3D.—CRITICAL MDS–PAC ITEMS—Continued

Section/item name	Item number
C. ITEMS FROM COMPLETE ASSESSMENT (ASSESSMENT, READMISSION, DISCHARGE)	
SECTION A. DEMOGRAPHIC/ADMISSION INFORMATION HISTORY:	
Legal Name of Patient	1a–1d
Admission Date	2a–2b
Reason for Assessment	3
Admission Status	4
Goals for Stay	5a–5e
Admitted From	6
Precipitating Event Prior to Admission	7
Primary and Secondary Payment Source for Stay	8A–8B
Marital Status	9
Language	11
SECTION B. COGNITIVE PATTERNS:	
Comatose	1*
Memory/Recall Ability	2a–2d*
Cognitive Skills for Daily Decision Making	3a–3b*
Indicators of Delirium-Periodic Disorder Thinking/Awareness	4a–4f*
SECTION C. COMMUNICATION/VISUAL PATTERNS:	
Modes of Communication	2a–2e*
Making Self Understood	3a–3b*
Speech Clarity	4*
Ability to Understand Others	5a–5b*
SECTION E. FUNCTIONAL STATUS:	
3 Day ADL Self-Performance	1a–1l*
ADL Assist Codes	2a–2l*
ADL Changes	3
Devices and Aids	6a–6j*
Walking and Stair Climbing	8a–8c*
SECTION F. BLADDER/BOWEL MANAGEMENT:	
Bladder Continence	1a–1b*
Bladder Appliance	2a–2g*
Bladder Appliance Support	3*
Bowel Continence	4*
Bowel Appliances	5a–5d*
Bowel Appliance Support	6*
SECTION G. DIAGNOSES:	
Impairment Group	1*
Complications/Comorbidities	5a–5d*
SECTION M. RESOURCES FOR DISCHARGE:	
Living Arrangement	3a–3b (A–C)

*Must be recorded by category, variable, and item number, in order for a patient to be classified into a CMG.

9. Adjustment to the Case-Mix Groups

As described in proposed § 412.620(c) of the regulations and as provided by section 1886(j)(2)(c)(i) of the Act, we adjust the CMGs periodically to reflect changes in treatment patterns, technology, number of discharges, and other factors affecting the relative use of resources.

V. Payment Rates

The IRF prospective payment system proposed in this rule utilizes Federal prospective payment rates across 97 distinct CMGs. The Federal payment rates are established using a standard payment amount (referred to as the budget neutral conversion factor). A set of relative payment weights which account for the relative difference in resource use across the CMGs is applied to the budget neutral conversion factor, and finally a number of facility level and case level adjustments may apply. The facility level adjustments include those which account for geographic variation in wages (wage index), Disproportionate Share (DSH), and location in a rural area. Case level adjustments include those which apply for transfer, short-stay and outlier cases, as described later in this section.

The budget neutral conversion factor provides the basis for determining the CMG based Federal payment rates. It is a standardized payment amount that is based on average costs from a base period and also reflects the combined aggregate effects of the payment weights, various facility and case level adjustments, and other policies discussed in this section. Consequently, in discussing the methodology for development of the Federal payment rates, we begin by describing the various adjustments and factors which serve as the inputs used in establishing the budget neutral conversion factor. Accordingly, we propose to develop prospective payments for IRFs using the following major steps:

- Develop the CMG relative weights.
- Determine the payment adjustments.
- Calculate the budget neutral conversion factor minus 2 percent.
- Calculate the Federal CMG prospective payments.

A detailed description of each step and a discussion of our proposed transfer policy, phase-in implementation and other policies follows.

A. Development of CMG Relative Weights

1. Overview of Development of the CMG Relative Weights

As previously stated, one of the primary goals for the implementation of the proposed IRF prospective payment system is to pay each rehabilitation

facility an appropriate payment for the efficient delivery of the care required by its set of Medicare patients. The system must be able to account adequately for each facility's case-mix in order to ensure both fair distribution of Medicare payments and access to adequate care for beneficiaries whose care is provided at a higher cost. To accomplish these goals, payment for each case is adjusted for case-mix.

In this payment system, under proposed § 412.620(b)(1), relative weights are a primary element in accounting for the variance in cost per discharge and resource utilization among the payment groups. To ensure that beneficiaries classified to each CMG will have access to care and to encourage efficiency, we calculate a relative weight for each CMG that is proportional to the resources needed by an average inpatient rehabilitation case in that CMG. For example, cases in a CMG with a relative weight of 2 will on average cost twice as much as cases in a CMG with a weight of 1.

To calculate the relative weights, we estimate operating (routine and ancillary services) and capital costs from inpatient rehabilitation facilities. Cost-to-charge ratios for ancillary services and per diem costs for routine services were obtained from the most recent available cost report data (FYs 1997, 1996, and/or 1995), charges were obtained from calendar year 1997 Medicare bill data, and corresponding functional measures were derived from the UDSmr/COS data. We omit data from rehabilitation facilities that are classified as all-inclusive providers from the calculation of the relative weights, as well as from the parameters that we use to define transfer cases, because these facilities are paid a single, negotiated rate per discharge and they do not maintain a charge structure.

For ancillary services, we calculate both operating and capital costs by converting charges from Medicare claims into costs using facility-specific, cost-center specific cost-to-charge ratios obtained from cost reports. Some departmental cost-to-charge ratios were missing or found to be outside a plausible range. We replace individual cost-to-charge ratios for all departments except anesthesiology when the values are either greater than 10, or less than 0.05. For anesthesiology, we replace the cost-to-charge ratio only when the value is greater than 10, or less than 0.01. The replacement value that we use for these aberrant cost-to-charge ratios is the mean value of the cost-to-charge ratio for the cost-center within the same type of hospital (either freestanding or unit).

For routine services, per diem operating and capital costs are used to develop the relative weights. In addition, per diem operating and capital costs for special care services are used to develop the relative weights. (Special care services are furnished in intensive care units. We note that fewer than 1 percent of rehabilitation days are spent in intensive care units.) Per diem costs are obtained from each facility's Medicare cost report data. We use per diem costs for routine and special care services because, unlike for ancillary services, cost-to-charge ratios cannot be obtained from Medicare data. To estimate the costs for routine and special care services included in developing the relative weights, we sum the product of routine cost per diem and Medicare inpatient days and the product of the special care per diem and the number of Medicare special care days.

We propose to use a hospital-specific relative value method to calculate relative weights. We believe this method allows us to account for more of the cross-facility variation in costs. Specifically, we remove the variation in costs across providers by converting a facility's cost for a case to a relative value based on the facility's case-mix index. The case-mix index is the average case weight (adjusted to eliminate the effect of comorbidities) for cases at a facility. Under the hospital-specific relative value method, costs are standardized at the facility level using facility-specific costs. Costs are standardized for each case by first dividing the adjusted cost for the case (which reflects comorbidities) by the average adjusted cost for the facility in which the case was treated. The average adjusted cost represents the average intensity of the health care services delivered by a particular facility. The resulting ratio is multiplied by the facility's own costliness (the facility's case-mix index) to determine the standardized cost for the case. The case-mix index accounts for the extent to which the intensity of the services is due to the needs of the facility's patients.

Because costs are standardized in this manner, costs for a beneficiary at a facility with high average costs are counted as less resource intensive than costs at a facility with low average costs. Therefore, the adjusted cost of an individual case more accurately reflects actual resource use for an individual facility. For example, a $7,000 case in a facility with an average adjusted cost of $10,000 reflects a higher level of relative resource use than a $7,000 case in a facility with the same case-mix, but an average adjusted cost of $20,000.

We used the following basic steps to calculate the relative weights in this proposed rule:

The first step in calculating the CMG weights is to estimate the effect that comorbidities have on costs. The second step is to adjust the cost of each Medicare discharge (case) to reflect the effects found in the first step. In the third step, the adjusted costs from the second step are used to calculate ''relative adjusted weights'' in each CMG using the hospital-specific relative value method described above. The final steps are to calculate the CMG relative weights by modifying the ''relative adjusted weight'' with the effects of the existence of a comorbidity and normalize the weights to 1.

We describe each of these steps in greater detail below.

2. Steps for Calculating the Relative Weights

Step 1—Estimate the effect of comorbidities on costs. In general, comorbidities are defined as additional medical conditions that increase the complexity of care delivered. For example, treatment for a beneficiary with a total hip replacement can become more complex if the beneficiary also has pneumonia. Because we found comorbidities to be significant predictors of costs in most RICs, we propose to calculate separate relative weights for cases in a given CMG with comorbidity and without comorbidity to reflect the additional costs incurred by cases classified with a comorbidity. We use regression analyses to determine if the weight for a Medicare discharge (case) should reflect the costs of comorbidities. Specifically, separate regression analyses are performed for each RIC. In the analysis, we found that not all comorbidities have the same effect on each RIC. Therefore, if coefficients by RIC are positive and significant and the comorbidity is deemed to be clinically relevant to the CMG, then we calculate separate relative weights for cases with comorbidity in Step 3 below.

Step 2—Adjust the costs of each discharge for the effects of comorbidities. The second step in the calculation of the weights is to adjust the resource use for each case to eliminate the effect of comorbidities. The adjusted cost (A) for a discharge, with values x for comorbidity is:

A = cost per discharge/exp(a*x)

These adjusted cost for each discharge are then used to calculate the relative adjusted weight in each CMG k, w_k.

Step 3—Calculate the CMG relative weights adjusted for comorbidities, on an iterative basis. The process of calculating the CMG relative weights is iterative. First, we give an initial case-mix index value of 1 to each facility. Then, for each case, we calculate a facility-specific relative value by dividing the comorbidity-adjusted cost of the case by the average comorbidity-adjusted cost of all cases at the facility, and multiplying the result by the facility's case-mix index. The CMG-adjusted weights are then set in proportion to the average of the facility-specific relative values. The result is a new case-mix index for each facility and, therefore, new facility-specific, relative values. The process is continued until there is convergence between the weights produced at adjacent steps, for example, when the maximum difference is less than 0.0001. After the first iteration, statistical outliers are defined as cases that differ from the CMG mean by more than three standard deviations in the log scale of standardized cost. These outliers are removed. Discharges that meet the definition of a transfer case are treated as a fraction of a case. (See discussion of transfers in section V.B, below.) A relative weight for each relevant combination of CMG ''with comorbidity'' and ''without comorbidity'' is calculated using the following formula:

$W(k,x) = \exp(a*x)w_k$

Where x equals 1 if the patient had one or more comorbidities or x equals 0 if no comorbidities were present. The variable (w_k) equals the comorbidity adjusted weight. If the coefficient (a) is not positive and significant as previously discussed in Step 1, then (a) will be set to equal 0 in the formula. This results in exp(a*x), in the formula, to equal 1 and the weight (W) will equal (w_k).

Step 4—Calculate the weight by modifying the relative adjusted weight with the effects of comorbidity and normalizing the weights to 1.0. This step entails calculating a relative weight for each relevant combination of CMG and comorbidity. In this step, we determine the average cost per discharge for all the cases and use that value as the divisor to calculate the relative weights. For example, if the average cost per discharge across all discharges is $12,000, then the relative weight for a CMG with an average cost of $12,000 is 1, and the relative weight for a CMG with an average cost per discharge of $20,000 is 1.67. If ''r'' is the relative adjusted weight for a case in a CMG with a comorbidity given by:

$w = k\ r \exp(a*x)$,

then k is determined so that the average value of w is 1.

Table 1E below lists the CMGs and their respective relative weights. The relative weights reflect the inclusion of cases with a very short interruption (return on day of discharge or either of the next 2 days). As stated previously, comorbidities were found to affect the cost of certain CMGs, but not all. Thus, the value for CMGs not affected by comorbidities is the same in both the ''No Comorbidity'' and the ''With Comorbidity'' columns. Information obtained from the first assessment (Day 4 assessment) will be used to determine the appropriate CMG and corresponding payment, including existence of a comorbidity. If a relevant comorbidity is indicated on this assessment, payment will be based on the relative weight from the comorbidity column. It should also be noted that Table 1E reflects cognitive scores that were derived from UDSmr/COS data.

TABLE 1E.—CMG RELATIVE WEIGHTS

CMG *	Definition (M=motor, C=cognitive, A=age)	Split by comorbidity	Average length of stay		Relative weight	
			No comorbidity	With comorbidity	No comorbidity	With comorbidity
0101	M = 29–0	Y	10.4	9.6	0.6058	0.6613
0102	M = 34–30 and C = 27–35	Y	12.0	11.4	0.7095	0.7746
0103	M = 40–35 and C = 28–35	Y	14.3	15.2	0.8605	0.9394
0104	M = 34–30 and C = 5–26	Y	14.2	16.7	0.8560	0.9344
0105	M = 40–35 and C = 5–27	Y	15.9	16.7	0.9620	1.0501
0106	M = 45–41	Y	17.7	17.2	1.0944	1.1947
0107	M = 49–46	Y	20.1	20.7	1.2630	1.3787
0108	M = 55–50	Y	22.7	21.2	1.4365	1.5682
0109	M = 78–56 and A >= 84	Y	24.0	24.9	1.5989	1.7455
0110	M = 60–56 and A <= 83	Y	25.9	23.4	1.6616	1.8139
0111	M = 78–61 and A <= 83	Y	29.5	29.6	1.9626	2.1425
0201	M = 33–0 and C = 30–35	N	9.4	9.4	0.5504	0.5504
0202	M = 33–0 and C = 5–29	N	13.3	13.3	0.8325	0.8325
0203	M = 50–34 and C = 22–35	N	16.0	16.0	0.9777	0.9777
0204	M = 50–34 and C = 5–21	N	18.3	18.3	1.1640	1.1640
0205	M = 66–51	N	22.3	22.3	1.4739	1.4739
0206	M = 78–67	N	31.6	31.6	2.2179	2.2179
0301	M = 33–0 and C = 22–35	Y	10.6	10.4	0.6399	0.7208
0302	M = 33–0 and C = 5–21	Y	13.5	13.3	0.8393	0.9454
0303	M = 46–34	Y	14.8	15.3	0.9467	1.0664
0304	M = 56–47	Y	19.2	19.3	1.2605	1.4198
0305	M = 78–57	Y	24.8	26.9	1.7517	1.9731
0401	M = 36–0	Y	12.6	10.3	0.7135	0.8560
0402	M = 57–37	Y	17.5	18.6	1.0506	1.2603
0403	M = 74–58	Y	26.6	25.5	1.7459	2.0944
0404	M = 78–75	Y	39.3	48.6	2.9252	3.5092
0501	M = 23–0	Y	8.4	8.2	0.4459	0.5528
0502	M = 36–24	Y	10.6	12.8	0.6197	0.7683
0503	M = 45–37	Y	13.5	15.7	0.8152	1.0107
0504	M = 57–46	Y	18.2	18.8	1.1515	1.4277
0505	M = 78–58	Y	25.9	30.2	1.7816	2.2089
0601	M = 35–0	Y	12.3	12.5	0.6971	0.7970
0602	M = 45–36	Y	15.2	15.6	0.9086	1.0389

TABLE 1E.—CMG RELATIVE WEIGHTS—Continued

CMG*	Definition (M=motor, C=cognitive, A=age)	Split by comorbidity	Average length of stay		Relative weight	
			No comorbidity	With comorbidity	No comorbidity	With comorbidity
0603	M = 53–46	Y	17.7	18.2	1.0833	1.2387
0604	M = 78–54	Y	21.4	22.6	1.3375	1.5292
0701	M = 36–0	Y	11.7	12.1	0.6525	0.7604
0702	M = 45–37	Y	14.3	15.5	0.8337	0.9716
0703	M = 51–46	Y	17.1	17.5	1.0129	1.1803
0704	M = 78–52	Y	19.6	20.9	1.1794	1.3743
0801	M = 32–0	Y	8.6	9.6	0.4822	0.5920
0802	M = 41–33	Y	10.1	11.3	0.5984	0.7346
0803	M = 48–42	Y	12.2	14.3	0.7464	0.9162
0804	M = 78–49 and C = 34–35	Y	13.5	16.8	0.8835	1.0845
0805	M = 55–50 and C = 5–33	Y	15.3	16.7	0.9540	1.1710
0806	M = 78–56 and C = 5–33	Y	18.4	21.2	1.1765	1.4441
0901	M = 32–0	Y	10.4	11.0	0.5587	0.6716
0902	M = 44–33	Y	13.3	14.5	0.7641	0.9185
0903	M = 53–45	Y	16.4	17.0	0.9685	1.1642
0904	M = 78–54	Y	20.0	19.7	1.2144	1.4597
1001	M = 38–0	Y	15.0	14.1	0.8488	0.9278
1002	M = 48–39	Y	18.2	17.5	1.1178	1.2219
1003	M = 78–49	Y	21.4	21.0	1.3785	1.5068
1101	M = 30–0	Y	10.6	9.6	0.6095	0.7489
1102	M = 44–31 and A >= 68	Y	13.4	13.5	0.8278	1.0171
1103	M = 44–31 and A <= 67	Y	17.4	17.8	1.0894	1.3386
1104	M = 78–45	Y	20.7	20.8	1.3232	1.6258
1201	M = 42–0 and C = 34–35	Y	10.7	12.1	0.5965	0.6847
1202	M = 42–0 and C = 5–33	Y	13.3	13.9	0.7181	0.8244
1203	M = 54–43	Y	16.4	17.0	0.9181	1.0540
1204	M = 78–55	Y	20.8	22.4	1.1492	1.3192
1301	M = 30–0	Y	11.3	11.2	0.5927	0.6859
1302	M = 42–31	Y	13.3	14.2	0.7116	0.8234
1303	M = 78–43	Y	18.0	19.1	1.0450	1.2093
1401	M = 37–0	Y	12.4	12.1	0.6511	0.7618
1402	M = 50–38	Y	15.4	16.4	0.9006	1.0537
1403	M = 78–51	Y	19.7	24.3	1.2689	1.4846
1501	M = 40–0 and A >= 78	Y	14.0	12.7	0.7741	0.8327
1502	M = 40–0 and A <= 77	Y	15.0	15.3	0.8529	0.9175
1503	M = 63–41	Y	19.2	19.6	1.1875	1.2774
1504	M = 78–64	Y	29.6	32.6	2.2797	2.4524
1601	M = 41–0 and C = 33–35	Y	11.0	10.6	0.6151	0.7313
1602	M = 41–0 and C = 5–32	Y	12.8	15.1	0.7257	0.8628
1603	M = 78–42	Y	15.9	16.0	0.9725	1.1562
1701	M = 48–0	Y	14.8	15.5	0.8513	1.0565
1702	M = 78–49	Y	22.5	24.9	1.3677	1.6974
1801	M = 56–0	N	16.7	16.7	0.9935	0.9935
1802	M = 78–57	N	29.5	29.5	2.0563	2.0563
1901	M = 36–0	N	11.5	11.5	0.7048	0.7048
1902	M = 47–37	N	18.0	18.0	1.0883	1.0883
1903	M = 78–48	N	31.4	31.4	2.0648	2.0648
2001	M = 21–0 and A >= 59	Y	9.2	8.8	0.5010	0.5604
2002	M = 31–22	Y	11.5	11.5	0.6435	0.7198
2003	M = 36–32	Y	13.0	13.0	0.7468	0.8353
2004	M = 21–0 and A <= 58	Y	13.9	11.2	0.7131	0.7977
2005	M = 43–37 and A >= 65	Y	14.4	14.4	0.8549	0.9562
2006	M = 52–44 and A >= 65	Y	16.5	17	1.0145	1.1348
2007	M = 43–37 and A < 65	Y	16.0	15.7	0.9998	1.1183
2008	M = 78–53 and A >= 84	Y	18.2	20.2	1.1359	1.2705
2009	M = 59–53 and A < 84	Y	19.8	19.9	1.2481	1.3960
2010	M = 52–44 and A < 65	Y	18.1	18.6	1.1570	1.2941
2011	M = 78–60 and A < 84	Y	23.2	24.3	1.4898	1.6664
2101	All burn cases	N	18.5	18.5	1.2863	1.2863
5001	Short stay cases—LOS is 3 days or fewer	N	2.6	2.6	0.1908	0.1908
5101	Expired orthopedic, short stay	N	7.1	7.1	0.4657	0.4657
5102	Expired orthopedic, not short stay	N	20.0	20.0	1.0777	1.0777
5103	Expired not ortho, short stay	N	8.4	8.4	0.5485	0.5485
5104	Expired not ortho, not short stay	N	25.1	25.1	1.5027	1.5027

*The first two digits of the CMG number from 01 to 21 correspond with a specific RIC number shown on Table 1D in section IV of this proposed rule.

B. Transfer Payment Policy

1. Background

We are proposing, under § 412.624(f), a transfer policy to provide for payments that more accurately reflect facility resources used and services delivered. We believe that it is important to minimize the inherent incentives specifically associated with the early transfer of patients in a discharge-based payment system. Without a transfer policy, we are concerned that incentives might exist for IRFs to discharge patients prematurely as well as admit patients that may not be able to endure intense inpatient therapy services. Patients might be transferred before receiving the typical, full course of inpatient rehabilitation, but the IRF would be paid the full CMG payment rate in the absence of a transfer policy. Accordingly, the transfer policy that we are proposing would reduce the full CMG payment rate when a Medicare beneficiary is transferred (as defined below).

2. Statutory Background

Section 125(a)(3) of the BBRA amended section 1886(j)(1) of the Act by adding a new paragraph (E) that states ''Construction relating to transfer authority. ''Nothing in this subsection shall be construed as preventing the Secretary from providing for an adjustment to payments to take into account the early transfer of a patient from a rehabilitation facility to another site of care.''

The statute does not define ''site of care''. ''Site of care'' could be defined as an ''institutional site'' that includes other rehabilitation facilities, long-term care hospitals (as described in section 412.23(e) of the regulations), inpatient hospitals, and nursing homes that accept payment under Title 18 (the Medicare program) or Title 19 (the Medicaid program), or both. ''Site of care'' can also be defined as a ''provider site'' that is more encompassing and could include home health, outpatient rehabilitation, ''day program'' services, as well as the ''institutional sites'' listed above. For the purposes of our transfer policy, we are proposing to define site of care as an ''institutional site'', although we are considering the option to extend the definition of site of care to the ''provider site'' definition. Further, we are soliciting comments regarding the inclusion of nursing homes in the definition of site of care.

3. Criteria for Defining Transfer Cases

We propose that, in order for a discharge from an IRF to be classified as an early transfer, the length of stay for the discharge must be less than the average length of stay for non-transfer cases (cases in which the patient is discharged to the community and the length of stay is more than 3 days) in a given CMG (as shown in Table 1E in this section), and the patient must be discharged to another rehabilitation facility, a long term care hospital, an inpatient hospital, or a nursing home that accepts payment under either the Medicare program or the Medicaid program, or both.

We believe that under a prospective payment system, an IRF may, also, be inclined to discharge beneficiaries prematurely while increasing the volume and intensity of HHA and outpatient therapy services. We expect that some beneficiaries may require HHA or outpatient therapy services as a normal progression of care after their inpatient rehabilitation stay. However, we are concerned that intensive use of these therapy services could be inappropriately used as a substitute for several days of an intensive therapy program in the IRF. We are analyzing claims data to determine the extent to which we can distinguish among services that could be considered a substitution of care rather than an extension of the normal progression for inpatient rehabilitation care and to determine the frequency and intensity of both HHA and outpatient therapy services. Estimating the potential substitution of HHA therapy services is made more challenging because we have just developed the HHA prospective payment system and it is difficult to anticipate how therapy services will be delivered after implementation of that system.

Accordingly, we are not proposing to include HHA, outpatient therapy, and ''day programs'' in our transfer policy. However, we are considering including these services to the extent we can distinguish when HHA and outpatient therapy services are more intensive and used as a substitution for inpatient rehabilitation care. If we can determine that the care is used as a substitution rather than just the normal progression of care, we believe these types of intensive HHA and outpatient therapy services should be included as part of the transfer policy. Therefore, we specifically solicit comments on this option.

In addition, we will be developing a monitoring system that includes transfers or discharges from an IRF to ''provider sites'', previously referenced. This will include transfers or discharges from an IRF to skilled nursing facility, long term care facilities, home health agencies and inpatient hospitals. This system will include discharges and transfers from one IRF to a different IRF including situations where the transfer occurs between organizations of common ownership. Although currently it does not appear that this type of transfer occurs frequently, further analysis of data regarding this type of transfer between IRFs may warrant an adjustment to payments. Therefore, we are specifically soliciting comments on this monitoring system.

4. Transfer Case Payment

We believe that matching payment as closely as possible to expected costs is the best way to reduce opportunities for financial considerations to affect clinical decisions. We found a significant correlation between the length of a patient's stay and the cost of the services received. This correlation indicates that the average length of stay can be used as a proxy measure of a facility's resources needed to treat a specific diagnosis with rehabilitation services. Thus, a per-diem-based payment for the number of days of care prior to a transfer will allow us to pay providers more appropriately for the facility resources used and services delivered.

We propose to compute the per-diem-based payment for a transfer case as follows: First, calculate the unadjusted per-diem amount for each CMG (except the short-stay CMG) by dividing the average length of stay for non-transfer cases (those cases discharged to the community with a length of stay more than 3 days) in the CMG into the Federal prospective payment (with or without comorbidities) for that CMG. Next, multiply the CMG per-diem payment from the first step by the number of days that the beneficiary was in the IRF prior to their transfer. The result equals the unadjusted Federal prospective payment for the transfer case. See section V.D of this preamble for specific adjustments that are applicable to this Federal prospective payment. We solicit comments on the appropriateness of our proposed methodology for computing payments for transfer cases.

We will examine the distribution of costs to determine if and to what extent costs vary during the course of an episode. If costs vary during the course of an episode, an alternative transfer policy could be developed to better reflect the costs of care. The results of this analysis will be considered as well as the incentives inherent in an alternative transfer payment methodology.

C. Special Cases That Are Not Transfers

Section 1886(j)(3)(A)(v) of the Act permits us to adjust the payment rates by factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

Certain cases that have stays of less than the typical length of time and that receive less than the full course of rehabilitation treatment for a specific CMG would be paid inappropriately if the facility were to receive the full CMG payment. Further, because of the budget neutrality requirements, ''overpayment'' for these cases would reduce payments for all other cases that warrant full payment based on the rehabilitation services actually delivered. We discuss the special cases below in terms of the definitions, policy rationale, and the proposed payment methodology. The three subsets are short-stay outliers, cases that expire, and interrupted stays.

1. Short-Stay Outlier

We propose, under § 412.620(b)(2), to define a short-stay outlier as a case that has a length of stay of 3 days or fewer (regardless of the CMG) and that does not meet the definition of a transfer as discussed in section V.B. of this preamble. A short-stay may occur when a beneficiary receives less than the full course of rehabilitative treatment because he or she leaves the facility against medical advice. Another circumstance warranting classification as a short-stay outlier involves patients who are admitted to rehabilitation facilities but are unable to tolerate intensive rehabilitative services. These patients may be discharged home and be readmitted once they are able to tolerate intensive rehabilitative services (see the interrupted stay policy in section V.C.3. of this preamble, for further clarification regarding length of stay criteria), or they may be discharged and not readmitted because they remain unable to tolerate these services.

An incomplete assessment submitted when the patient's length of stay is 3 days or fewer is another example of a short-stay case. In this situation, the facility may not have the appropriate information to complete the MDS–PAC patient assessment. We believe that a payment adjustment is necessary to reduce incentives for facilities to complete an assessment with inadequate information. Further, we believe that providing a special payment for incomplete assessments neither encourages facilities to submit incomplete assessments without obtaining the appropriate information, nor severely penalizes providers that occasionally may be unable, despite good faith efforts, to complete assessments.

Making a short-stay outlier payment for these types of cases will allow us to counteract the incentives inherent in a discharge-based prospective payment system for this pattern to emerge. Payment-to-cost ratios for the cases described above show that if facilities receive a full CMG payment, they would be ''overpaid'' for the resources they have expended. One of the primary objectives of the prospective payment system is to provide incentives for facilities to become more efficient and, in doing so, to ensure that they can still receive adequate and appropriate payments. Because the rates are set to be budget neutral minus 2 percent, excessive payment for those cases that do not actually entail the full course of rehabilitative treatment would reduce payments for cases that warrant full payment based on the rehabilitation services delivered. A short-stay outlier policy would permit more equitable payment to those facilities that manage to increase efficiencies while still providing the full course of rehabilitative treatment.

We propose to pay short-stay outliers a relative weight of 0.1908. We computed this relative weight for short-stay outlier discharges by identifying all cases in which the length of stay is 3 days or fewer and the discharge does not meet the policy criteria to be considered a transfer. The relative weight for these cases is calculated in the same manner discussed previously, using the hospital-specific relative value methodology.

However, we believe that the considerations underlying the short-stay policy might also apply to cases with a length of stay greater than 3 days. More specifically, we note that some beneficiaries may have longer lengths of stay, and yet may not require intensive inpatient rehabilitative care, or may lack the capacity to participate in an intensive rehabilitation program. Therefore, we are also considering a short-stay policy that would encompass cases with a length of stay longer than 3 days. We are in the process of further analyzing claims data for Medicare beneficiaries to determine the most appropriate number of days to use in the definition of a short-stay case. If analysis of the data supports increasing the number of days for the short-stay criteria, we might adopt in the final rule a definition covering a longer period than the 3-day period. We specifically solicit comments on the appropriate time period for our short-stay criteria.

2. Cases That Expire

In general, cases that end in death would be substantially ''overpaid'' if facilities received the full CMG payment for these cases; even excluding all of the very short-stay cases with a length of stay of 3 days or fewer, the remaining expired cases as a whole would still be ''overpaid''. We analyzed payment-to-cost ratios and found that we can improve the accuracy of the payments if we split expired cases into two categories based on the RIC—one for orthopedic cases and one for all other types of RICs. We further find that splitting these cases based on length of stay also improves the accuracy of the payment system. Therefore, we propose, under § 412.620(b)(3), that, for expired cases where a beneficiary dies within 3 days from admission or fewer, the case would be classified into the short-stay CMG. We propose that, for expired cases with a length of stay greater than 3 days, the case would be classified into one of four CMGs, based on length of stay and whether or not the discharge falls within the orthopedic RIC. More specifically, one group includes orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay for expired cases classified within the orthopedic RIC. The second group includes orthopedic discharges with a length of stay greater than the average length of stay for expired cases classified within the orthopedic RIC. The third group includes non-orthopedic discharges with a length of stay of more than 3 days but less than or equal to the average length of stay of expired cases that are not classified within the orthopedic RIC. The fourth group includes non-orthopedic discharges with a length of stay greater than the average length of stay of expired cases that are not classified within the orthopedic RIC. Relative weights for each expired CMG are calculated using the hospital-specific relative value methodology discussed previously in this preamble.

3. Interrupted Stay

We propose to define interrupted stay cases as those involving cases in which the beneficiary returns to the rehabilitation facility by midnight of the third day following a discharge. We propose to pay one discharge payment for these cases. The assessment from the initial stay would be used to determine the appropriate CMG.

D. Adjustments

Section 1886(j)(6) of the Act requires an adjustment to the Federal

prospective payments to account for geographical wage variation. Section 1886(j)(3)(A)(v) of the Act confers broad discretion on the Secretary to adjust prospective payments ''by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.'' Section 1886(j)(4) of the Act authorizes (but does not require) the Secretary to make specified payment adjustments (including an adjustment for outlier cases). In addition to the geographical wage adjustment, we propose to adjust payments for facilities located in rural areas. Further, we propose to adjust payments to reflect the percentage of low income patients. These adjustments and the proposed payment methodologies are discussed below.

1. Area Wage Adjustment

Section 1886(j)(6) of the Act specifies that payment rates under the IRF prospective payment system must be adjusted to account for geographic area wage variation. The statute requires the Secretary to adjust the labor-related portion of the prospective payment rates for area differences in wage levels by a factor reflecting the relative facility wage level in the geographic area of the rehabilitation facility compared to the national average wage level for these facilities. We propose, under § 412.624(e)(1), to adjust the payment rates for geographic wage variations using the following methodology.

To account for wage differences, we first identify the proportion of labor and non-labor components of costs. In general, the labor-related share is the sum of relative importances of wages, fringe benefits, professional fees, postal services, labor-intensive services, and a portion of the capital share from an appropriate market basket. We determine a labor-related share for rehabilitation facilities by first estimating the portion related to operating costs. We use the excluded market basket with capital to determine the labor-related share. The excluded market basket with capital is derived from available cost data for facilities including rehabilitation, long-term care, psychiatric, cancer, and children's hospitals. Using the excluded hospital market basket with capital, the labor-related share of operating costs is 67.03 percent in fiscal year 2001. Table 2E shows that the sum of the relative importance for wages and salaries, employee benefits, professional fees, postal services and all other labor intensive services equals 67.03 percent for FY 2001. The labor-related share of capital costs needs to be considered as well. The portion of capital attributed to labor is estimated to be 46 percent, the same percentage used for the hospital inpatient capital-related prospective payment system. Because the relative importance for capital is 9.285 percent of the excluded hospital with capital market basket in FY 2001, we multiply 46 percent by 9.285 percent to determine the labor-related share for capital costs in FY 2001, which is 4.271 percent. We add 4.271 percent for capital costs to 67.03 percent for operating costs to determine the total labor-related share. Thus, the labor-related share that we propose to use for rehabilitation facilities in FY 2001 is 71.301 percent as shown in the Table 2E below.

TABLE 2E.—TOTAL LABOR-RELATED SHARE

Cost category	Relative importance (%) FY 2001
Wages and salaries	48.895
Employee benefits	10.790
Professional fees	1.979
Postal services	0.245
All other labor intensive services	5.121
SUBTOTAL	67.03
Labor related share of capital	4.271
TOTAL	71.301

We note that a precedent exists for using this method to adjust for geographic differences in costs. Specifically, the labor-related portion for acute care hospitals is determined from cost report data, and is established in conjunction with the hospital operating market basket. We further validated the labor-related share by analyzing the results of the wage index coefficient derived from the regressions. The wage index coefficient allows us to approximate the labor-related portion of cost per case. The coefficient confirms that 71.301 percent is an appropriate labor-related share.

The labor-related portion of the unadjusted Federal payment is multiplied by a wage index value to account for area wage differences. We are proposing to use inpatient acute care hospital wage data to compute the wage indices. Wage data to compute IRF-specific wage indices are currently not available. We believe that the inpatient acute care hospital wage data reflect wage levels similar to those of post-acute care facilities, including IRFs. We believe that IRFs and other post-acute care facilities (such as, SNFs and HHAs) generally compete in the same labor market as inpatient acute care hospitals. (Inpatient acute care hospital data is currently being used to compute wage indices for the SNF and HHA prospective payment systems.) Accordingly, we believe that inpatient acute care hospital wage data is appropriate to use as a basis of computing the IRF wage index in accordance with section 1886(j)(6) of the Act.

The inpatient acute care hospital wage data that we propose to use includes the following categories of data associated with costs paid under the inpatient acute care hospital prospective payment system (as well as outpatient costs): salaries and hours from short-term, acute care hospitals, home office costs and hours, certain contract labor costs and hours, and wage-related costs. The wage data excludes the wages for services provided by teaching physicians, interns and residents, and nonphysician anesthetists under Medicare Part B, because these services are not covered under the IRF prospective payment system. These wages are currently being phased out of the hospital inpatient prospective payment system wage index over a 5-year period. The wage data used to compute the FY 2000 SNF and hospital wage indices are based on a blend of 80 percent of an average hourly wage that includes these costs and 20 percent of an average hourly wage that excludes these costs. Unlike the inpatient prospective payment system for acute care hospitals, a transition is unnecessary for IRF prospective payment system because payment for inpatient rehabilitation services has never been based on a wage index that includes data for these services. The difference across geographic areas between a wage index that uses the 80/20 blend and a wage index that excludes 100 percent of wages for teaching physicians, residents, and nonphysician anesthetists is less than 2 percent on average.

Consistent with the wage index methodologies in other prospective payment systems, we propose to divide hospitals into labor market areas. For purposes of defining labor market areas, we are proposing to define an urban area as a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA), as defined by the Executive Office of Management and Budget. We are proposing to define a rural area as any area outside an urban area. For the purposes of computing the wage index for IRFs, the wage index values for urban and rural areas are determined without regard to

geographic reclassification under section 1886(d)(8) or (d)(10) of the Act.

We are proposing to use an IRF wage index that is based on FY 1996 inpatient acute care hospital wage data. These data were also used to compute the FY 2000 hospital inpatient PPS wage indices. The FY 1997 inpatient acute care hospital wage data was used to develop the FY 2001 hospital wage index, and we will consider using this data for developing the final Federal prospective payments.

The proposed IRF wage indices are computed as follows:

- Compute an average hourly wage for each urban and rural area.
- Compute a national average hourly wage.
- Divide the average hourly wage for each urban and rural area by the national average hourly wage—the result is a wage index for each urban and rural area.

To calculate the adjusted facility payments, the prospectively determined Federal prospective payment is multiplied by the labor-related percentage (0.71301) to determine the labor-related portion of the Federal prospective payments. This labor-related portion is then multiplied by the applicable IRF wage index shown in Table 3E for urban areas and Table 4E for rural areas.

TABLE 3E.—WAGE INDEX URBAN AREAS

MSA	Urban area (Constituent counties or county equivalents)	Wage index
0040 ..	Abilene, TX	0.8275
	Taylor, TX	
0060 ..	Aguadilla, PR	0.3859
	Aguada, PR	
	Aguadilla, PR	
	Moca, PR	
0080 ..	Akron, OH	1.0093
	Portage, OH	
	Summit, OH	
0120 ..	Albany, GA	1.6055
	Dougherty, GA	
	Lee, GA	
0160 ..	Albany-Schenectady-Troy, NY.	0.8751
	Albany, NY	
	Montgomery, NY	
	Rensselaer, NY	
	Saratoga, NY	
	Schenectady, NY	
	Schoharie, NY	
0200 ..	Albuquerque, NM	0.8366
	Bernalillo, NM	
	Sandoval, NM	
	Valencia, NM	
0220 ..	Alexandria, LA	0.7960
	Rapides, LA	
0240 ..	Allentown-Bethlehem-Easton, PA.	1.0226
	Carbon, PA	
	Lehigh, PA.	
	Northampton, PA.	
0280 ..	Altoona, PA	0.9410
	Blair, PA	
0320 ..	Amarillo, TX	0.8450
	Potter, TX	
	Randall, TX	
0380 ..	Anchorage, AK	1.3010
	Anchorage, AK	
0440 ..	Ann Arbor, MI	1.1354
	Lenawee, MI	
	Livingston, MI	
	Washtenaw, MI	
0450 ..	Anniston,AL	0.8562
	Calhoun, AL	
0460 ..	Appleton-Oshkosh-Neenah, WI.	0.9018
	Calumet, WI	
	Outagamie, WI	
	Winnebago, WI	
0470 ..	Arecibo, PR	0.4871
	Arecibo, PR	
	Camuy, PR	
	Hatillo, PR	
0480 ..	Asheville, NC	0.8969
	Buncombe, NC	
	Madison, NC	
0500 ..	Athens, GA	0.9819
	Clarke, GA	
	Madison, GA	
	Oconee, GA	
0520 ..	Atlanta, GA	1.0173
	Barrow, GA	
	Bartow, GA	
	Carroll, GA	
	Cherokee, GA	
	Clayton, GA	
	Cobb, GA	
	Coweta, GA	
	De Kalb, GA	
	Douglas, GA	
	Fayette, GA	
	Forsyth, GA	
	Fulton, GA	
	Gwinnett, GA	
	Henry, GA	
	Newton, GA	
	Paulding, GA	
	Pickens, GA	
	Rockdale, GA	
	Spalding, GA	
	Walton, GA	
0560 ..	Atlantic City-Cape May	1.1469
	Atlantic City, NJ	
	Cape May, NJ	
0580 ..	Auburn-Opelika, AL	0.7718
	Lee, AL	
0600 ..	Augusta-Aiken, GA–SC	0.9091
	Columbia, GA	
	McDuffie, GA	
	Richmond, GA	
	Aiken, SC	
	Edgefield, SC	
0640 ..	Austin-San Marcos, TX	0.9112
	Bastrop, TX	
	Caldwell, TX	
	Hays, TX	
	Travis, TX	
	Williamson, TX	
0680 ..	Bakersfield, CA	0.9622
	Kern, CA	
0720 ..	Baltimore, MD	0.9614
	Anne Arundel, MD	
	Baltimore, MD	
	Baltimore City, MD	
	Carroll, MD	
	Harford, MD	
	Howard, MD	
	Queen Annes, MD	
0733 ..	Bangor, ME	0.9696
	Penobscot, ME	
0743 ..	Barnstable-Yarmouth, MA	1.3573
	Barnstable, MA	
0760 ..	Baton Rouge, LA	0.8782
	Ascension, LA	
	East Baton Rouge	
	Livingston, LA	
	West Baton Rouge	
0840 ..	Beaumont-Port Arthur, TX	0.8715
	Hardin, TX	
	Jefferson, TX	
	Orange, TX	
0860 ..	Bellingham, WA	1.1528
	Whatcom, WA	
0870 ..	Benton Harbor, MI	0.8557
	Berrien, MI	
0875 ..	Bergen-Passaic, NJ	1.2128
	Bergen, NJ	
	Passaic, NJ	
0880 ..	Billings, MT	1.0154
	Yellowstone, MT	
0920 ..	Biloxi-Gulfport-Pascagoula, MS.	0.7960
	Hancock, MS	
	Harrison, MS	
	Jackson, MS	
0960 ..	Binghamton, NY	0.8689
	Broome, NY	
	Tioga, NY	
1000 ..	Birmingham, AL	0.9009
	Blount, AL	
	Jefferson, AL	
	St. Clair, AL	
	Shelby, AL	
1010 ..	Bismarck, ND	0.7746
	Burleigh, ND	
	Morton, ND	
1020 ..	Bloomington, IN	0.8694
	Monroe, IN	
1040 ..	Bloomington-Normal, IL	0.9099
	McLean, IL	
1080 ..	Boise City, ID	0.9144
	Ada, ID	
	Canyon, ID	
1123 ..	Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH.	1.1327
	Bristol, MA	
	Essex, MA	
	Middlesex, MA	
	Norfolk, MA	
	Plymouth, MA	
	Suffolk, MA	
	Worcester, MA	
	Hillsborough, NH	
	Merrimack, NH	
	Rockingham, NH	
	Strafford, NH	
1125 ..	Boulder-Longmont, CO	1.0030

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Boulder, CO	
1145 ..	Brazoria, TX	0.8616
	Brazoria, TX	
1150 ..	Bremerton, WA	1.1141
	Kitsap, WA	
1240 ..	Brownsville-Harlingen-San Benito, TX.	0.9294
	Cameron, TX	
1260 ..	Bryan-College Station, TX	0.8601
	Brazos, TX	
1280 ..	Buffalo-Niagara Falls, NY	0.9549
	Erie, NY	
	Niagara, NY	
1303 ..	Burlington, VT	1.0796
	Chittenden, VT	
	Franklin, VT	
	GrandIsle, VT	
1310 ..	Caguas, PR	0.4596
	Caguas, PR	
	Cayey, PR	
	Cidra, PR	
	Gurabo, PR	
	San Lorenzo, PR	
1320 ..	Canton-Massillon, OH	0.8770
	Carroll, OH	
	Stark, OH	
1350 ..	Casper, WY	0.9286
	Natrona, WY	
1360 ..	Cedar Rapids, IA	0.9082
	Linn, IA	
1400 ..	Champaign-Urbana, IL	0.9225
	Champaign, IL	
1440 ..	Charleston-North Charleston, SC.	0.9073
	Berkeley, SC	
	Charleston, SC	
	Dorchester, SC	
1480 ..	Charleston, WV	0.9157
	Kanawha, WV	
	Putnam, WV	
1520 ..	Charlotte-Gastonia-Rock Hill, NC–SC.	0.9471
	Cabarrus, NC	
	Gaston, NC	
	Lincoln, NC	
	Mecklenburg, NC	
	Rowan, NC	
	Stanly, NC	
	Union, NC	
	York, SC	
1540 ..	Charlottesville, VA	1.0662
	Albemarle, VA	
	Charlottesville City, VA	
	Fluvanna, VA	
	Greene, VA	
1560 ..	Chattanooga, TN–GA	0.9824
	Catoosa, GA	
	Dade, GA	
	Walker, GA	
	Hamilton, TN	
	Marion, TN	
1580 ..	Cheyenne, WY	0.8272
	Laramie, WY	
1600 ..	Chicago, IL	1.0889
	Cook, IL	
	De Kalb, IL	
	Du Page, IL	
	Grundy, IL	
	Kane, IL	
	Kendall, IL	
	Lake, IL	
	McHenry, IL	
	Will, IL	
1620 ..	Chico-Paradise, CA	1.0513
	Butte, CA	
1640 ..	Cincinnati, OH–KY–IN	0.9424
	Dearborn, IN	
	Ohio, IN	
	Boone, KY	
	Campbell, KY	
	Gallatin, KY	
	Grant, KY	
	Kenton, KY	
	Pendleton, KY	
	Brown, OH	
	Clermont, OH	
	Hamilton, OH	
	Warren, OH	
1660 ..	Clarksville-Hopkinsville, TN–KY.	0.8185
	Christian, KY	
	Montgomery, TN	
1680 ..	Cleveland-Lorain-Elyria, OH.	0.9667
	Ashtabula, OH	
	Geauga, OH	
	Cuyahoga, OH	
	Lake, OH	
	Lorain, OH	
	Medina, OH	
1720 ..	Colorado Springs, CO	0.9326
	El Paso, CO	
1740 ..	Columbia MO	0.9072
	Boone, MO	
1760 ..	Columbia, SC	0.9456
	Lexington, SC	
	Richland, SC	
1800 ..	Columbus, GA–AL	0.8529
	Russell, AL	
	Chattanoochee, GA	
	Harris, GA	
	Muscogee, GA	
1840 ..	Columbus, OH	0.9952
	Delaware, OH	
	Fairfield, OH	
	Franklin, OH	
	Licking, OH	
	Madison, OH	
	Pickaway, OH	
1880 ..	Corpus Christi, TX	0.8848
	Nueces, TX	
	San Patricio, TX	
1890 ..	Corvallis, OR	1.1217
	Benton, OR	
1900 ..	Cumberland, MD–WV	0.8905
	Allegany MD	
	Mineral WV	
1920 ..	Dallas, TX	0.9559
	Collin, TX	
	Dallas, TX	
	Denton, TX	
	Ellis, TX	
	Henderson, TX	
	Hunt, TX	
	Kaufman, TX	
	Rockwall, TX	
1950 ..	Danville, VA	0.9167
	Danville City, VA	
	Pittsylvania, VA	
1960 ..	Davenport-Moline-Rock Island, IA–IL.	0.8787
	Scott, IA	
	Henry, IL	
	Rock Island, IL	
2000 ..	Dayton-Springfield, OH	0.9478
	Clark, OH	
	Greene, OH	
	Miami, OH	
	Montgomery, OH	
2020 ..	Daytona Beach, FL	0.9048
	Flagler, FL	
	Volusia, FL	
2030 ..	Decatur, AL	0.8781
	Lawrence, AL	
	Morgan, AL	
2040 ..	Decatur, IL	0.8380
	Macon, IL	
2080 ..	Denver, CO	1.0202
	Adams, CO	
	Arapahoe, CO	
	Denver, CO	
	Douglas, CO	
	Jefferson, CO	
2120 ..	Des Moines, IA	0.8793
	Dallas, IA	
	Polk, IA	
	Warren, IA	
2160 ..	Detroit, MI	1.0310
	Lapeer, MI	
	Macomb, MI	
	Monroe, MI	
	Oakland, MI	
	St. Clair, MI	
	Wayne, MI	
2180 ..	Dothan, AL	0.7890
	Dale, AL	
	Houston, AL	
2190 ..	Dover, DE	0.9445
	Kent, DE	
2200 ..	Dubuque, IA	0.8620
	Dubuque, IA	
2240 ..	Duluth-Superior, MN–WI	1.0279
	St. Louis, MN	
	Douglas, WI	
2281 ..	Dutchess County, NY	1.0674
	Dutchess, NY	
2290 ..	Eau Claire, WI	0.9030
	Chippewa, WI	
	Eau Claire, WI	
2320 ..	El Paso, TX	0.9004
	El Paso, TX	
2330 ..	Elkhart-Goshen, IN	0.9490
	Elkhart, IN	
2335 ..	Elmira, NY	0.8634
	Chemung, NY	
2340 ..	Enid, OK	0.8047
	Garfield, OK	
2360 ..	Erie, PA	0.8880
	Erie, PA	
2400 ..	Eugene-Springfield, OR	1.0715
	Lane, OR	
2440 ..	Evansville-Henderson, IN–KY.	0.8329
	Posey, IN	
	Vanderburgh, IN	
	Warrick, IN	
	Henderson, KY	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
2520 ..	Fargo-Moorhead, ND–MN	0.8721
	Clay, MN	
	Cass, ND	
2560 ..	Fayetteville, NC	0.8594
	Cumberland, NC	
2580 ..	Fayetteville-Springdale-Rogers, AR.	0.7768
	Benton, AR	
	Washington, AR	
2620 ..	Flagstaff, AZ–UT	1.0470
	Coconino, AZ	
	Kane, UT	
2640 ..	Flint, MI	1.1037
	Genesee, MI	
2650 ..	Florence, AL	0.8020
	Colbert, AL	
	Lauderdale, AL	
2655 ..	Florence, SC	0.8668
	Florence, SC	
2670 ..	Fort Collins-Loveland, CO	1.0335
	Larimer, CO	
2680 ..	Ft. Lauderdale, FL	1.0297
	Broward, FL	
2700 ..	Fort Myers-Cape Cora, FL.	0.9056
	Lee, FL	
2710 ..	Fort Pierce-Port St. Lucie, FL.	1.0116
	Martin, FL	
	St. Lucie, FL	
2720 ..	Fort Smith, AR–OK	0.7936
	Crawford, AR	
	Sebastian, AR	
	Sequoyah, OK	
2750 ..	Fort Walton Beach, FL	0.8816
	Okaloosa, FL	
2760 ..	Fort Wayne, IN	0.9158
	Adams, IN	
	Allen, IN	
	De Kalb, IN	
	Huntington, IN	
	Wells, IN	
	Whitley, IN	
2800 ..	Forth Worth-Arlington, TX	0.9673
	Hood, TX	
	Johnson, TX	
	Parker, TX	
	Tarrant, TX	
2840 ..	Fresno, CA	1.0311
	Fresno, CA	
	Madera, CA	
2880 ..	Gadsden, AL	0.8791
	Etowah, AL	
2900 ..	Gainesville, FL	0.9879
	Alachua, FL	
2920 ..	Galveston-Texas City, TX	0.9767
	Galveston, TX	
2960 ..	Gary, IN	0.9494
	Lake, IN	
	Porter, IN	
2975 ..	Glens Falls, NY	0.8707
	Warren, NY	
	Washington, NY	
2980 ..	Goldsboro, NC	0.8432
	Wayne, NC	
2985 ..	Grand Forks, ND–MN	0.9199
	Polk, MN	
	Grand Forks, ND	
2995 ..	Grand Junction, CO	0.9102
	Mesa, CO	
3000 ..	Grand Rapids-Muskegon-Holland, MI.	1.0151
	Allegan, MI	
	Kent, MI	
	Muskegon, MI	
	Ottawa, MI	
3040 ..	Great Falls, MT	1.0582
	Cascade, MT	
3060 ..	Greeley, CO	0.9667
	Weld, CO	
3080 ..	Green Bay, WI	0.9224
	Brown, WI	
3120 ..	Greensboro-Winston-Salem-High Point, NC.	0.9091
	Alamance, NC	
	Davidson, NC	
	Davie, NC	
	Forsyth, NC	
	Guilford, NC	
	Randolph, NC	
	Stokes, NC	
	Yadkin, NC	
3150 ..	Greenville, NC	0.9451
	Pitt, NC	
3160 ..	Greenville-Spartanburg-Anderson, SC.	0.9264
	Anderson, SC	
	Cherokee, SC	
	Greenville, SC	
	Pickens, SC	
	Spartanburg, SC	
3180 ..	Hagerstown, MD	0.8946
	Washington, MD	
3200 ..	Hamilton-Middletown, OH	0.9051
	Butler, OH	
3240 ..	Harrisburg-Lebanon-Carlisle, PA.	0.9749
	Cumberland, PA	
	Dauphin, PA	
	Lebanon, PA	
	Perry, PA	
3283 ..	Hartford, CT	1.1758
	Hartford, CT	
	Litchfield, CT	
	Middlesex, CT	
	Tolland, CT	
3285 ..	Hattiesburg, MS	0.7723
	Forrest, MS	
	Lamar, MS	
3290 ..	Hickory-Morganton-Lenoir, NC.	0.9219
	Alexander, NC	
	Burke, NC	
	Caldwell, NC	
	Catawba, NC	
3320 ..	Honolulu, HI	1.1599
	Honolulu, HI	
3350 ..	Houma, LA	0.7878
	Lafourche, LA	
	Terrebonne, LA	
3360 ..	Houston, TX	0.9405
	Chambers, TX	
	Fort Bend, TX	
	Harris, TX	
	Liberty, TX	
	Montgomery, TX	
	Waller, TX	
3400 ..	Huntington-Ashland, WV–KY–OH.	0.9859
	Boyd, KY	
	Carter, KY	
	Greenup, KY	
	Lawrence, OH	
	Cabell, WV	
	Wayne, WV	
3440 ..	Huntsville, AL	0.8926
	Limestone, AL	
	Madison, AL	
3480 ..	Indianapolis, IN	0.9802
	Boone, IN	
	Hamilton, IN	
	Hancock, IN	
	Hendricks, IN	
	Johnson, IN	
	Madison, IN	
	Marion, IN	
	Morgan, IN	
	Shelby, IN	
3500 ..	Iowa City, IA	0.9532
	Johnson, IA	
3520 ..	Jackson, MI	0.8944
	Jackson, MI	
3560 ..	Jackson, MS	0.8379
	Hinds, MS	
	Madison, MS	
	Rankin, MS	
3580 ..	Jackson, TN	0.8701
	Chester, TN	
	Madison, TN	
3600 ..	Jacksonville, FL	0.9020
	Clay, FL	
	Duval, FL	
	Nassau, FL	
	St. Johns, FL	
3605 ..	Jacksonville, NC	0.7944
	Onslow, NC	
3610 ..	Jamestown, NY	0.7950
	Chautaqua, NY	
3620 ..	Janesville-Beloit, WI	0.9677
	Rock, WI	
3640 ..	Jersey City, NJ	1.1742
	Hudson, NJ	
3660 ..	Johnson City-Kingsport-Bristol, TN–VA.	0.8949
	Carter, TN	
	Hawkins, TN	
	Sullivan, TN	
	Unicoi, TN	
	Washington, TN	
	Bristol City, VA	
	Scott ,VA	
	Washington, VA	
3680 ..	Johnstown, PA	0.8589
	Cambria, PA	
	Somerset, PA	
3700 ..	Jonesboro, AR	0.7316
	Craighead, AR	
3710 ..	Joplin, MO	0.7766
	Jasper, MO	
	Newton, MO	
3720 ..	Kalamazoo-Battlecreek, MI.	1.0098
	Calhoun, MI	
	Kalamazoo, MI	
	Van Buren, MI	
3740 ..	Kankakee, IL	0.8699

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Kankakee, IL	
3760 ..	Kansas City, KS–MO	0.9281
	Johnson, KS	
	Leavenworth, KS	
	Miami, KS	
	Wyandotte, KS	
	Cass, MO	
	Clay, MO	
	Clinton, MO	
	Jackson, MO	
	Lafayette, MO	
	Platte, MO	
	Ray, MO	
3800 ..	Kenosha, WI	0.9139
	Kenosha, WI	
3810 ..	Killeen-Temple, TX	1.0078
	Bell, TX	
	Coryell, TX	
3840 ..	Knoxville, TN	0.9238
	Anderson, TN	
	Blount, TN	
	Knox, TN	
	Loudon, TN	
	Sevier, TN	
	Union, TN	
3850 ..	Kokomo, IN	0.9023
	Howard, IN	
	Tipton, IN	
3870 ..	La Crosse, WI–MN	0.9020
	Houston, MN	
	La Crosse, WI	
3880 ..	Lafayette, LA	0.8437
	Acadia, LA	
	Lafayette, LA	
	St. Landry, LA	
	St. Martin, LA	
3920 ..	Lafayette, IN	0.8913
	Clinton, IN	
	Tippecanoe, IN	
3960 ..	Lake Charles, LA	0.8056
	Calcasieu, LA	
3980 ..	Lakeland-WinterHaven, FL.	0.8919
	Polk, FL	
4000 ..	Lancaster, PA	0.9325
	Lancaster, PA	
4040 ..	Lansing-East Lansing, MI	1.0075
	Clinton, MI	
	Eaton, MI	
	Ingham, MI	
4080 ..	Laredo, TX	0.8421
	Webb, TX	
4100 ..	Las Cruces, NM	0.8606
	DonaAna, NM	
4120 ..	Las Vegas, NV–AZ	1.1285
	Mohave, AZ	
	Clark, NV	
	Nye, NV	
4150 ..	Lawrence, KS	0.8319
	Douglas, KS	
4200 ..	Lawton, OK	0.9645
	Comanche, OK	
4243 ..	Lewiston-Auburn, ME	0.8962
	Androscoggin ME	
4280 ..	Lexington, KY	0.8568
	Bourbon, KY	
	Clark, KY	
	Fayette, KY	
	Jessamine, KY	
	Madison, KY	
	Scott, KY	
	Woodford, KY	
4320 ..	Lima, OH	0.9010
	Allen, OH	
	Auglaize, OH	
4360 ..	Lincoln, NE	0.9723
	Lancaster NE	
4400 ..	Little Rock-North Little, AR.	0.8708
	Faulkner, AR	
	Lonoke, AR	
	Pulaski, AR	
	Saline, AR	
4420 ..	Longview-Marshall, TX	0.8841
	Gregg, TX	
	Harrison, TX	
	Upshur, TX	
4480 ..	Los Angeles-Long Beach, CA.	1.2103
	Los Angeles, CA	
4520 ..	Louisville, KY–IN	0.9415
	Clark, IN	
	Floyd, IN	
	Harrison, IN	
	Scott, IN	
	Bullitt, KY	
	Jefferson, KY	
	Oldham, KY	
4600 ..	Lubbock, TX	0.8512
	Lubbock, TX	
4640 ..	Lynchburg, VA	0.8908
	Amherst, VA	
	Bedford City, VA	
	Bedford, VA	
	Campbell, VA	
	Lynchburg City, VA	
4680 ..	Macon, GA	0.8501
	Bibb, GA	
	Houston, GA	
	Jones, GA	
	Peach, GA	
	Twiggs, GA	
4720 ..	Madison, WI	0.9869
	Dane, WI	
4800 ..	Mansfield, OH	0.8575
	Crawford, OH	
	Richland, OH	
4840 ..	Mayaguez, PR	0.4729
	Anasco, PR	
	CaboRojo, PR	
	Hormigueros, PR	
	Mayaguez, PR	
	Sabana Grande, PR	
	San German, PR.	
4880 ..	McAllen-Edinburg-Mission, TX.	0.8208
	Hidalgo, TX	
4890 ..	Medford-Ashland, OR	1.0607
	Jackson, OR	
4900 ..	Melbourne-Titusville-Palm Bay, FL.	0.9405
	Brevard, FL	
4920 ..	Memphis, TN–AR–MS	0.8321
	Crittenden, AR	
	De Soto, MS	
	Fayette, TN	
	Shelby, TN	
	Tipton, TN	
4940 ..	Merced, CA	1.0313
	Merced, CA	
5000 ..	Miami, FL	1.0368
	Dade, FL	
5015 ..	Middlesex-Somerset-Hunterdon, NJ.	1.1128
	Hunterdon, NJ	
	Middlesex, NJ	
	Somerset, NJ	
5080 ..	Milwaukee-Waukesha, WI	0.9848
	Milwaukee, WI	
	Ozaukee, WI	
	Washington, WI	
	Waukesha, WI	
5120 ..	Minneapolis-St. Paul, MN–WI.	1.0979
	Anoka, MN	
	Carver, MN	
	Chisago, MN	
	Dakota, MN	
	Hennepin, MN	
	Isanti, MN	
	Ramsey, MN	
	Scott, MN	
	Sherburne, MN	
	Washington, MN	
	Wright, MN	
	Pierce, WI	
	St. Croix, WI	
5140 ..	Missoula, MT	0.9192
	Missoula, MT	
5160 ..	Mobile, AL	0.8171
	Baldwin, AL	
	Mobile, AL	
5170 ..	Modesto, CA	1.0233
	Stanislaus, CA	
5190 ..	Monmouth-Ocean, NJ	1.1332
	Monmouth, NJ	
	Ocean, NJ	
5200 ..	Monroe, LA	0.8315
	Ouachita, LA	
5240 ..	Montgomery, AL	0.7794
	Autauga, AL	
	Elmore, AL	
	Montgomery, AL	
5280 ..	Muncie, IN	1.0533
	Delaware, IN	
5330 ..	Myrtle Beach, SC	0.8612
	Horry, SC	
5345 ..	Naples, FL	0.9955
	Collier, FL	
5360 ..	Nashville, TN	0.9368
	Cheatham, TN	
	Davidson, TN	
	Dickson, TN	
	Robertson, TN	
	Rutherford, TN	
	Sumner, TN	
	Williamson, TN	
	Wilson, TN	
5380 ..	Nassau-Suffolk, NY	1.4087
	Nassau, NY	
	Suffolk, NY	
5483 ..	New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT.	1.2260
	Fairfield, CT	
	New Haven, CT	
5523 ..	New London-Norwich, CT	1.2572

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	New London, CT	
5560 ..	New Orleans, LA	0.9140
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. James, LA	
	St. John The Baptist, LA	
	St. Tammany, LA	
5600 ..	New York, NY	1.4338
	Bronx, NY	
	Kings, NY	
	New York, NY	
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
5640 ..	Newark, NJ	1.1729
	Essex, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Warren, NJ	
5660 ..	Newburgh, NY–PA	1.1035
	Orange, NY	
	Pike, PA	
5720 ..	Norfolk-Virginia Beach-Newport News, VA–NC.	0.8483
	Currituck, NC	
	Chesapeake City, VA	
	Gloucester, VA	
	Hampton City, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
	York, VA	
5775 ..	Oakland, CA	1.5277
	Alameda, CA	
	Contra Costa, CA	
5790 ..	Ocala, FL	0.9728
	Marion, FL	
5800 ..	Odessa-Midland, TX	0.8951
	Ector, TX	
	Midland, TX	
5880 ..	Oklahoma City, OK	0.8551
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Pottawatomie, OK	
5910 ..	Olympia, WA	1.1023
	Thurston, WA	
5920 ..	Omaha, NE–IA	1.0405
	Pottawattamie, IA	
	Cass, NE	
	Douglas, NE	
	Sarpy, NE	
	Washington, NE	
5945 ..	Orange County, CA	1.1720
	Orange, CA	
5960 ..	Orlando, FL	0.9845
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
5990 ..	Owensboro, KY	0.8199
	Daviess, KY	
6015 ..	Panama City, FL	0.9277
	Bay, FL	
6020 ..	Parkersburg-Marietta, WV–OH.	0.8503
	Washington, OH	
	Wood, WV	
6080 ..	Pensacola, FL	0.8529
	Escambia, FL	
	Santa Rosa, FL	
6120 ..	Peoria-Pekin, IL	0.8201
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
6160 ..	Philadelphia, PA–NJ	1.1076
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
	Salem, NJ	
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
6200 ..	Phoenix-Mesa, AZ	0.9420
	Maricopa, AZ	
	Pinal, AZ	
6240 ..	Pine Bluff, AR	0.7777
	Jefferson, AR	
6280 ..	Pittsburgh, PA	0.9478
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
6323 ..	Pittsfield, MA	1.0173
	Berkshire, MA	
6340 ..	Pocatello, ID	0.9063
	Bannock, ID	
6360 ..	Ponce, PR	0.4970
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403 ..	Portland, ME	0.9499
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440 ..	Portland-Vancouver, OR–WA.	1.1087
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483 ..	Providence-Warwick-Pawtucket, RI.	1.0766
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520 ..	Provo-Orem, UT	0.9916
	Utah, UT	
6560 ..	Pueblo, CO	0.8922
	Pueblo, CO	
6580 ..	Punta Gorda, FL	0.9620
	Charlotte, FL	
6600 ..	Racine, WI	0.9325
	Racine, WI	
6640 ..	Raleigh-Durham-Chapel Hill, NC.	0.9683
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660 ..	Rapid City, SD	0.8415
	Pennington, SD	
6680 ..	Reading, PA	0.9496
	Berks, PA	
6690 ..	Redding, CA	1.1376
	Shasta, CA	
6720 ..	Reno, NV	1.0781
	Washoe, NV	
6740 ..	Richland-Kennewick-Pasco, WA.	1.1356
	Benton, WA	
	Franklin, WA	
6760 ..	Richmond-Petersburg, VA	0.9569
	Charles City County, VA	
	Chesterfield, VA	
	Colonial Heights City, VA	
	Dinwiddie, VA	
	Goochland, VA	
	Hanover, VA	
	Henrico, VA	
	Hopewell City, VA	
	New Kent, VA	
	Petersburg City, VA	
	Powhatan, VA	
	Prince George, VA	
	Richmond City, VA	
6780 ..	Riverside-San Bernardino, CA	1.1256
	Riverside, CA	
	San Bernardino, CA	
6800 ..	Roanoke, VA	0.7971
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820 ..	Rochester, MN	1.1619
	Olmsted, MN	
6840 ..	Rochester, NY	0.9066
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880 ..	Rockford, IL	0.8885
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895 ..	Rocky Mount, NC	0.8837

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Edgecombe, NC	
	Nash, NC	
6920 ..	Sacramento, CA	1.2473
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960 ..	Saginaw-Bay City-Midland, MI.	0.9365
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980 ..	St. Cloud, MN	0.9525
	Benton, MN	
	Stearns, MN	
7000 ..	St. Joseph, MO	0.9048
	Andrews, MO	
	Buchanan, MO	
7040 ..	St. Louis, MO–IL	0.8943
	Clinton, IL	
	Jersey, IL	
	Madison, IL	
	Monroe, IL	
	St. Clair, IL	
	Franklin, MO	
	Jefferson, MO	
	Lincoln, MO	
	St. Charles, MO	
	St. Louis, MO	
	St. Louis City, MO	
	Warren, MO	
	Sullivan City, MO	
7080 ..	Salem, OR	1.0065
	Marion, OR	
	Polk, OR	
7120 ..	Salinas, CA	1.4900
	Monterey, CA	
7160 ..	Salt Lake City-Ogden, UT	0.9919
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200 ..	San Angelo, TX	0.7938
	Tom Green, TX	
7240 ..	San Antonio, TX	0.8429
	Bexar, TX	
	Comal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320 ..	San Diego, CA	1.2100
	San Diego, CA	
7360 ..	San Francisco, CA	1.4287
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400 ..	San Jose, CA	1.3848
	Santa Clara, CA	
7440 ..	San Juan-Bayamon, PR	0.4698
	Aguas Buenas, PR	
	Barceloneta, PR	
	Bayamon, PR	
	Canovanas, PR	
	Carolina, PR	
	Catano, PR	
	Ceiba, PR	
	Comerio, PR	
	Corozal, PR	
	Dorado, PR	
	Fajardo, PR	
	Florida, PR	
	Guaynabo, PR	
	Humacao, PR	
	Juncos, PR	
	Los Piedras, PR	
	Loiza, PR	
	Luguillo, PR	
	Manati, PR	
	Morovis, PR	
	Naguabo, PR	
	Naranjito, PR	
	Rio Grande, PR	
	San Juan, PR	
	Toa Alta, PR	
	Toa Baja, PR	
	Trujillo Alto, PR	
	Vega Alta, PR	
	Vega Baja, PR	
	Yabucoa, PR	
7460 ..	San Luis Obispo-Atascadero-PasoRobles, CA.	1.0593
	San Luis Obispo, CA	
7480 ..	Santa Barbara-Santa Maria-Lompoc, CA.	1.0939
	Santa Barbara, CA	
7485 ..	Santa Cruz-Watsonville, CA.	1.4091
	Santa Cruz, CA	
7490 ..	Santa Fe, NM	1.0511
	Los Alamos, NM	
	Santa Fe, NM	
7500 ..	Santa Rosa, CA	1.3172
	Sonoma, CA	
7510 ..	Sarasota-Bradenton, FL	1.0022
	Manatee, FL	
	Sarasota, FL	
7520 ..	Savannah, GA	0.9995
	Bryan, GA	
	Chatham, GA	
	Effingham, GA	
7560 ..	Scranton-Wilkes-Barre-Hazleton, PA.	0.8442
	Columbia, PA	
	Lackawanna, PA	
	Luzerne, PA	
	Wyoming, PA	
7600 ..	Seattle-Bellevue-Everett, WA.	1.1376
	Island, WA	
	King, WA	
	Snohomish, WA	
7610 ..	Sharon, PA	0.8374
	Mercer, PA	
7620 ..	Sheboygan, WI	0.8299
	Sheboygan, WI	
7640 ..	Sherman-Denison, TX	0.9439
	Grayson, TX	
7680 ..	Shreveport-Bossier City, LA.	0.9126
	Bossier, LA	
	Caddo, LA	
	Webster, LA	
7720 ..	Sioux City, IA–NE	0.8552
	Woodbury, IA	
	Dakota, NE	
7760 ..	Sioux Falls, SD	0.8813
	Lincoln, SD	
	Minnehaha, SD	
7800 ..	South Bend, IN	0.9732
	St. Joseph, IN	
7840 ..	Spokane, WA	1.0898
	Spokane, WA	
7880 ..	Springfield, IL	0.8710
	Menard, IL	
	Sangamon, IL	
7920 ..	Springfield, MO	0.8062
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003 ..	Springfield, MA	1.0488
	Hampden, MA	
	Hampshire, MA	
8050 ..	State College, PA	0.9212
	Centre, PA	
8080 ..	Steubenville-Weirton, OH–WV.	0.8716
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120 ..	Stockton-Lodi, CA	1.0571
	San Joaquin, CA	
8140 ..	Sumter, SC	0.8335
	Sumter, SC	
8160 ..	Syracuse, NY	0.9310
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	
8200 ..	Tacoma, WA	1.1583
	Pierce, WA	
8240 ..	Tallahassee, FL	0.8529
	Gadsden, FL	
	Leon, FL	
8280 ..	Tampa-St. Petersburg-Clearwater, FL.	0.9136
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320 ..	Terre Haute, IN	0.8614
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	
8360 ..	Texarkana, AR–TX	0.8101
	Miller, AR	
	Bowie, TX	
8400 ..	Toledo, OH	0.9764
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440 ..	Topeka, KS	0.9440
	Shawnee, KS	
8480 ..	Trenton, NJ	1.0180
	Mercer, NJ	
8520 ..	Tucson, AZ	0.8846
	Pima, AZ	
8560 ..	Tulsa, OK	0.8181
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600 ..	Tuscaloosa, AL	0.8104
	Tuscaloosa, AL	
8640 ..	Tyler, TX	0.9499
	Smith, TX	
8680 ..	Utica-Rome, NY	0.8370
	Herkimer, NY	
	Oneida, NY	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
8720 ..	Vallejo-Fairfield-Napa, CA	1.3503
	Napa, CA	
	Solano, CA	
8735 ..	Ventura, CA	1.1603
	Ventura, CA	
8750 ..	Victoria, TX	0.8476
	Victoria, TX	
8760 ..	Vineland-Millville-Bridgeton, NJ.	1.0640
	Cumberland, NJ	
8780 ..	Visalia-Tulare-Porterville, CA.	1.0533
	Tulare, CA	
8800 ..	Waco, TX	0.8099
	McLennan, TX	
8840 ..	Washington, DC–MD–VA–WV.	1.1088
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fauquier, VA	
	Fredericksburg City, VA	
	King George, VA	
	Loudoun, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Prince William, VA	
	Spotsylvania, VA	
	Stafford, VA	
	Warren, VA	
	Berkeley, WV	
	Jefferson, WV	
8920 ..	Waterloo-Cedar Falls, IA	0.8597
	BlackHawk, IA	
8940 ..	Wausau, WI	0.9556
	Marathon, WI	
8960 ..	West Palm Beach-Boca, FL	1.0130
	Palm Beach, FL	
9000 ..	Wheeling, OH–WV	0.7662
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040 ..	Wichita, KS	0.9559
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080 ..	Wichita Falls, TX	0.7743
	Archer, TX	
	Wichita, TX	
9140 ..	Williamsport, PA	0.8472
	Lycoming, PA	
9160 ..	Wilmington-Newark, DE–MD.	1.1000
	New Castle, DE	
	Cecil, MD	
9200 ..	Wilmington, NC	0.9818
	New Hanover, NC	
	Brunswick, NC	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
9260 ..	Yakima, WA	1.0331
	Yakima, WA	
9270 ..	Yolo, CA	0.9833
	Yolo, CA	
9280 ..	York, PA	0.9255
	York, PA	
9320 ..	Youngstown-Warren, OH	1.0025
	Columbiana, OH	
	Mahoning, OH	
	Trumbull, OH	
9340 ..	Yuba City, CA	1.0787
	Sutter, CA	
	Yuba, CA	
9360 ..	Yuma, AZ	1.0040
	Yuma, AZ	

TABLE 4E.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage Index
Alabama	0.7467
Alaska	1.2175
Arizona	0.8625
Arkansas	0.7317
California	1.0066
Colorado	0.8915
Connecticut	1.2559
Delaware	0.9240
Florida	0.9089
Georgia	0.8176
Guam	
Hawaii	1.0853
Idaho	0.8707
Illinois	0.8122
Indiana	0.8493
Iowa	0.7976
Kansas	0.7513
Kentucky	0.8127
Louisiana	0.7456
Maine	0.8679
Maryland	0.8730
Massachusetts	1.1499
Michigan	0.8896
Minnesota	0.8743
Mississippi	0.7374
Missouri	0.7802
Montana	0.8479
Nebraska	0.8024
Nevada	0.9197
New Hampshire	0.9827
New Jersey [1]	
New Mexico	0.8472
New York	0.8604
North Carolina	0.8378
North Dakota	0.7662
Ohio	0.8746
Oklahoma	0.7332
Oregon	0.9966
Pennsylvania	0.8559
Puerto Rico	0.4299
Rhode Island [1]	
South Carolina	0.8353
South Dakota	0.7625
Tennessee	0.7738
Texas	0.7545
Utah	0.8998

TABLE 4E.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage Index
Vermont	0.9518
Virginia	0.7991
Virgin Islands	
Washington	1.0548
West Virginia	0.8116
Wisconsin	0.8838
Wyoming	0.8955

[1] All counties within the State are classified urban.

The resulting wage-adjusted labor-related portion is added to the nonlabor related portion, resulting in a wage-adjusted payment. The following example illustrates how a Medicare fiscal intermediary would calculate the Adjusted Facility Federal prospective payment for inpatient rehabilitation facility services with a hypothetical Federal prospective payment of $10,000 for services provided in the rehabilitation facility located in Heartland, USA. The rehabilitation wage index value for facilities located in Heartland, USA is 1.0234. The labor-related portion (71.301 percent) of the Federal prospective payment is $7130.10=($10,000*71.301 percent), and the nonlabor related portion (28.699 percent) of the Federal prospective payment is $2869.90=($10,000*28.699 percent). Therefore, the wage-adjusted payment calculation, rounded to the nearest dollar is as follows:

$10,167=($7130.10*1.0234) + $2,869.90

2. General Specifications to Determine Other Adjustments

As indicated earlier, section 1886(j)(3)(A)(v) of the Act confers broad authority on the Secretary to adjust prospective payments ''by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities''. To determine whether other payment adjustments are warranted for the IRF prospective payment system, we conducted extensive regression analysis of the relationship between IRF costs (including both operating and capital costs per case) and several factors that may affect costs. The appropriateness of potential payment adjustments are based on both cost effects estimated by regression analysis and other factors, including simulated payments that we discuss in section VIII.B.2. of this preamble.

Our analyses included 624 facilities for which cost and case-mix data were available. We estimated costs for each case by multiplying facility specific,

cost-center specific cost-to-charge ratios by charges. Cost-to-charge ratios were obtained from FYs 1995, 1996, and/or 1997 cost report data and charges were obtained from the calendar years 1996 and 1997 Medicare claims data. The cost per case is calculated by summing all costs and dividing by the number of equivalent full cases. When we had cost per case data for both years, the number of cases and total costs are combined for both years. We accounted for the difference in the year by adjusting the 1996 cost per case by the case-weighted average change in cost per case between 1996 and 1997. Using the data from both years should provide more stability in the payment adjustments than would using data for a single year. When data for only one year are available, we use the costs and number of equivalent cases for that year.

Multivariate regression analysis is a standard way to examine facility cost variation and analyze potential payment adjustments. We looked at two standard models: (1) Fully specified explanatory models to examine the impact of all relevant factors that might potentially affect facility cost per case; and (2) payment models that examine the impacts of those factors specifically used to determine payment rates. The general specification for the multivariate regression is that the estimated average cost per case (the dependent variable) at the facility can be explained or predicted by several independent variables, including the case-mix index, the wage index for the facility, and a vector of additional explanatory variables that affect a facility's cost per case, such as its teaching program or the proportion of low-income patients. The case-mix index is the average of the CMG weights derived by the hospital-specific relative value method for each facility. Transfer cases are given a partial weight based on the ratio of the length of stay for the transfer to the average length of stay for nontransfer cases. Using the regression coefficients, we then simulated payments and calculated payment-to-cost ratios for different classes of hospitals, for specific combinations of payment policies.

We use payment variables from the hospital inpatient prospective payment system, including disproportionate share patient percentage, both capital and operating teaching variables (resident-to-average daily census and resident-to-bed ratios, respectively) as well as the teaching variable (resident-to-adjusted average daily census ratio) used in the analyses for the hospital outpatient prospective payment system, and variables to account for location in a rural or large urban area. A discussion of the major payment variables and our findings appears below.

3. Adjustments for Rural Location

We examined costs per case for both large urban and rural facilities. In the regression models, both explanatory and payment, the variable for rural facilities was positive and significant ($p<0.05$). The standardized cost per case for rural hospitals is 15 percent higher than the national average. On average, rural facilities tend to have fewer cases, a longer length of stay, and a higher average cost per case. The difference in costs becomes more evident when the average cost per case is standardized for the case-mix index and the wage index. In the regression models, large urban facilities were not significantly different from other urban facilities. We propose, under § 412.624(e)(3), to adjust for rural facilities by multiplying the payment by 1.1589. This adjustment was determined by using the coefficients derived from the regressions.

4. Adjustments for Indirect Teaching Costs

Facilities with major teaching programs tend to be located in large urban areas and have more cases, a higher case-mix and a higher proportion of low-income patients. We found that when only the payment variables that might warrant an adjustment (that is, DSH or rural/urban status, rather than for-profit/not for profit) under the prospective payment system are used in the regression models, the indirect teaching cost variable is not significant. We looked at different specifications for the teaching variable. We used a resident-to-average daily census ratio and a resident-to-bed ratio that we based on the estimated number of residents assigned to the inpatient area of the rehabilitation facility. We also used a resident-to-adjusted average daily census ratio based on the total number of residents at the hospital complex and outpatient as well as inpatient volume. We also looked for a teaching threshold. In all our payment regressions, the teaching variable was not significant. Therefore, we are not proposing an adjustment for indirect teaching costs.

5. Adjustments for Disproportionate Share of Low-Income Patients

We assessed the appropriateness of adjustments for facilities serving a disproportionate share of low income patients. We limited our analysis to the effects of serving low-income patients on costs per case, rather than a subsidy for uncompensated care.

We evaluated a facility-level adjustment that takes into account both the percentage of Medicare patients who are on Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. As a facility's percentage of low income patients increases, there is an incremental increase in the facility's cost. This suggests that additional payments are appropriate. We propose to use the same measure of disproportionate patient percentage currently used for the acute care hospital inpatient prospective payment system. Payments for each facility would be adjusted to reflect the facility's disproportionate share percentage.

Section 4403(b) of the BBA requires HCFA to develop a Report to the Congress containing a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Act. In determining the formula, the Secretary must:

- Establish a single threshold for costs incurred by hospitals serving low-income patients.
- Consider the costs incurred in furnishing hospital services to individuals who are entitled to benefits under Part A of Medicare and who receive Supplemental Security Income benefits under Title XVI.
- Consider the costs incurred in furnishing hospital services to individuals who receive medical assistance under the State plan under the Medicare program and are not entitled to benefits under Part A of Medicare.

Further, MedPAC recommends including the costs of uncompensated care in calculating low-income shares and using the same formula to distribute payments to all facilities covered by prospective payments. In light of HCFA's current study of a new payment formula for determining adjustments for hospitals serving low income patients and MedPAC's recommendations, we will consider these study results and other information as it becomes available and potentially refine the DSH adjustment in the future so that we ensure that facilities are paid in the most consistent and equitable manner possible. At this time, we propose, under § 412.624(e)(2), to adjust each rehabilitation facility payment by the following formula to account for the cost of furnishing care to low income patients: ((.0001+DSH) raised to the power of .0905)/(.0001 raised to the power of .0905));

$$\text{Where DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

6. Adjustments for Alaska and Hawaii

Section 1886(j)(4)(B) provides that the Secretary is authorized but not required to take into account the unique circumstances of IRFs located in Alaska and Hawaii. There are currently three IRFs in Hawaii and one in Alaska. However, we have cost and case-mix data for only one of the facilities in Hawaii (982 cases) and the facility in Alaska (117 cases). In the absence of a cost-of-living adjustment, our simulations indicate that the facility in Hawaii may profit and the facility in Alaska may experience a loss. Due to the small number of cases, analyses of the simulation results are inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we are not proposing an adjustment for rehabilitation facilities located in Alaska and Hawaii.

7. Adjustments for Cost Outliers

Section 1886(j)(4) of the Act specifies that the Secretary is authorized, but not required, to provide for additional payments for outlier cases. Further, section 1886(j)(4)(A)(iii) of the Act specifies that the total amount of the additional payments cannot be projected to exceed 5 percent of the total payments in a given year. Providing additional payments for costs that are beyond facilities' control can strongly improve the accuracy of the IRF prospective payment system in determining resource costs at the patient and facility level. In general, outlier payments reduce the financial risk which would otherwise be substantial because of the relatively small size of many rehabilitation facilities. These additional payments reduce the financial losses caused by treating patients who require more costly care and, therefore, will reduce the incentives to under serve these patients.

We considered various outlier policy options. Specifically, we examined outlier policies using 3, 4, and 5 percent of the total estimated payments. In order to determine the most appropriate outlier policy, we analyzed the extent to which the various options reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the system. We believe an outlier policy of 3 percent will allow us to achieve a balance of the above stated goals. Additional increments of outlier payments reduce risk by successively smaller amounts. Further, additional amounts of outlier payments are funded by prospectively reducing the non-outlier payment rates in a budget neutral manner. Therefore, we propose an outlier policy of 3 percent of total estimated payments because we believe this option optimizes the extent to which we can protect vulnerable facilities, while still providing adequate payment for all other cases.

We propose, under § 412.624(e)(4), to make outlier payments for discharges whose estimated cost exceeds an adjusted threshold amount ($7,066 multiplied by the facility's adjustments) plus the adjusted CMG payment. Both the loss threshold and the CMG payment amount are adjusted for wages, rural location, and disproportionate share. The estimated cost of a case will be calculated by multiplying an overall facility-specific cost-to-charge ratio by the charge. Based on analysis of payment-to-cost ratios for outlier cases, and consistent with the marginal cost factor used under section 1886(d) of the Act, we propose to pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the CMG payment and the loss amount of $7,066, as adjusted). The outlier threshold was calculated by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being equal to 3 percent of total payments under the simulation.

E. Calculation of the Budget Neutral Conversion Factor Minus Two Percent

1. Overview of Development of the Budget Neutral Conversion Factor

Section 1886(j)(3)(B) of the Act and proposed § 412.624(d) of the regulations specify that, for prospective payment units during FYs 2001 and 2002, the amount of total payments, including any payment adjustments under sections 1886(j)(4) and (6) of the Act, shall be projected to equal 98 percent of the amount of payments that would have been made during these fiscal years for operating and capital costs of rehabilitation facilities had section 1886(j) not been enacted.

We propose, under § 412.624(c)(1), to calculate the budget neutral conversion factor using the following steps:

Step 1—Update the latest cost report data to the midpoint of the year 2001.

Step 2—Estimate total payments under the current payment system.

Step 3—Calculate the average weighted payment per discharge amount under the current payment system.

Step 4—Estimate new payments under the proposed payment system without a budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor.

2. Steps for Developing the Budget Neutral Conversion Minus 2 Percent

- Data Sources

The data sources that we propose under § 412.624(a)(1) to construct the budget neutral adjustment factor include the cost report data from FYs 1995, 1996, and 1997, a list obtained from the fiscal intermediaries of facility-specific target amounts applicable for providers that applied to rebase their target amount in fiscal year 1998, and calendar year 1996 and 1997 Medicare claims with corresponding UDSmr or COS data. We used data from 508 facilities to calculate the budget neutral conversion factor. These facilities represent those providers for which we had cost report data available from FYs 1995, 1996, and 1997. We used the 3 years cost report data to trend the data to the midpoint of the year 2001 based on the facilities' historical relationship of costs and target amounts. The FY 1995 cost report data was used to determine the update to be used for FY 1999, the FY 1996 cost report data was used to determine the update to be used for FY 2000, and the FY 1997 cost report data was used to determine the update to be used for FY 2001. We were unable to calculate payment under the current payment system for some inpatient rehabilitation facilities because cost report data were unavailable. We will attempt to obtain the most recent payment amounts for these facilities through their Medicare fiscal intermediary and we will consider using this data to construct the payment rates for the final rule. We will also examine the extent to which certain facilities, such as new facilities, are not included in the construction of the budget neutral conversion factor and consider the appropriateness of an adjustment to better reflect total estimated payments for IRFs.

Step 1—Update the latest cost report data to the midpoint of the year 2001. Section 1886(j)(3)(A)(i) of the Act and proposed § 412.624(b) of the regulations

specify that the per-payment-unit amount is to be updated to the midpoint of the fiscal year 2000, using the weighted average of the applicable percentage increases provided under Section 1886(b)(3)(B)(ii) of the Act. The statute allows us more discretion in determining an appropriate methodology to update from the year 2000 to 2001. We propose, under § 412.624(c)(2), to update from the midpoint of the year 2000 to the midpoint of the year 2001 using the same methodology provided under Section 1886(b)(3)(B)(ii). We determine the appropriate update factor for each facility by using one of the four methodologies described below:

- For facilities with costs that equal or exceed their target amounts by 10 percent or more for the most recent cost reporting period for which information is available, the update factor is the market basket percentage increase; or
- For facilities that exceed their target by less than 10 percent, the update factor would be equal to the market basket minus .25 percentage points for each percentage point by which operating costs are less than 10 percent over the target (but in no case less than 0); or
- For facilities that are at or below their target but exceed two-thirds of the target amount, the update factor is the market basket minus 2.5 percentage points (but in no case less than 0); or
- For facilities that do not exceed two-thirds of their target amount, the update factor is 0 percent.

Step 2—Estimate total payments under the current payment system.

Operating payments are calculated using the following methodology:

Step 2a—We determine the facility-specific target amount, subject to the applicable cap on the target amounts for rehabilitation facilities. There are two national caps on the target amounts for rehabilitation facilities. We used the cap amounts published in the July 30, 1999 **Federal Register**. For older facilities certified before October 1, 1997, the applicable cap amount for FY 2000 is $14,654 for the labor-related share adjusted by the appropriate geographic wage index and added to $4,169 for the nonlabor-related share. For newer facilities certified on or after October 1, 1997, the cap amount applicable for FY 2000 is $12,574 for the labor-related share adjusted by the appropriate geographic wage index and added to $4,999 for the nonlabor-related share. These target amounts are then inflated to the midpoint of the year 2001 by applying the excluded hospital operating market basket.

Step 2b—We calculate the lower of the results of step 2a.

- The facility-specific target amount (including application of the cap) times the Medicare discharges (the ceiling) or;
- The facility average operating cost per case times Medicare discharges. Payment for operating costs are determined by using one of the following methods:
- For facilities whose operating costs are lower than or equal to the ceiling, payment would be the lower of either the operating cost plus 15 percent of the difference between the operating cost and the ceiling or the operating costs plus 2 percent of the ceiling; or
- For facilities whose operating costs are more than 110 percent of the ceiling, payment would be the lower of either the ceiling multiplied by 1.10 or half of the difference between the 110 percent of the ceiling and the operating costs.
- For facilities whose operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment would be the ceiling.

Step 2c—After operating payments are computed, we determine capital payments. Section 4412 of the BBA amended section 1886(g) of the Act by reducing capital payments that would otherwise be made for rehabilitation facilities. Payments for capital costs are made on a reasonable cost basis. The BBA mandated the reduction of capital payments by 15 percent. Therefore, we reduce capital payments for inpatient rehabilitation facilities or units by multiplying the costs by .85.

Step 2d—The next step in determining total payments under the current payment system is to add operating and capital payments. Section 1886(j)(1)(A) of the Act specifies that the IRF prospective payment system will include both operating and capital costs. Once appropriate payments for operating costs are determined (including bonus and penalty payments as appropriate), and after reductions are made for capital payments, we would add the operating costs and the reduced capital costs together.

Step 2e—The statute provides for the Secretary to adjust the rates so that the amount of total payments under this section are projected to equal 98 percent of the payments that would have been paid under this section in the absence of this new payment methodology. Payments made for cost reporting periods beginning on or after the implementation of this prospective payment system through FY 2002 are based on both the facility-specific payment and the Federal prospective payment that we propose in this regulation. Therefore under proposed § 412.624(d)(2), we reduce total estimated payments calculated under the current payment system to ensure that the 98 percent budget neutrality provision is applicable to all payments. In addition, total estimated payments are adjusted to reflect the estimated proportion of additional outlier payments, under proposed § 412.624(d)(1) and for coding and classification changes under proposed § 412.624(d)(3). These payments are the proposed numerator of the equation used to calculate the budget neutral adjustment.

Step 3—Calculate the average weighted payment per discharge amount under the current payment system. Once total payments are calculated under the current payment system, an average per discharge payment amount weighted by the number of Medicare discharges under the current payment system can be calculated. This is done by first determining the average payment per discharge amount under the current payment system for each facility. Cost report data are used to calculate each facility's average payment per discharge by dividing the number of discharges into the total payments. The next step is to determine the weighted average per discharge payment amount. To calculate this amount, we multiply the number of discharges from the Medicare bills (with corresponding UDSmr/COS data) by each facility's average payment per discharge amount. We then sum the amounts for all facilities and divide by the total number of discharges from the Medicare bills (with corresponding UDSmr/COS data) to derive an average payment per discharge amount that is weighted by the number of Medicare discharges.

Step 4—Estimate payments under the proposed payment system without a budget neutral adjustment. Payments under the proposed payment system are then simulated without a budget neutral adjustment. To do this, we multiply the following: each facility's case-mix index, the number of discharges from the Medicare bills (with corresponding UDSmr/COS data), the appropriate wage index, the rural adjustment (if applicable), an appropriate disproportionate share adjustment, and the weighted average per discharge payment amount computed in Step 3. Total payments for each facility are then added together. This total is the denominator in the calculation of the budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor. The denominator of the budget neutral adjustment equation is the total estimated payments for the

proposed prospective payment system without a budget neutral adjustment (the total amount calculated in Step 4). The budget neutral adjustment is calculated by dividing total reduced payments under the current payment system (the total amount calculated in Step 2) by estimated payments for the proposed prospective payment system. The resulting budget neutral adjustment is then multiplied by the average weighted per discharge payment amount under the current payment system to derive the budget neutral conversion factor.

Because we do not have UDSmr and COS data for all rehabilitation facilities, for the final rule we will further analyze the extent to which the data used to construct the budget neutral conversion factor accurately reflect the relationship between case-mix and cost. We are considering the use of weighted averages to more fully account for those types of facilities that may be under-represented with the given data.

Once the budget neutral conversion factor is calculated, the factor is further adjusted to include a behavioral offset. As previously stated, to calculate the budget neutral conversion factor, we had to estimate what would have been paid under the current payment system. However, due to the incentives for premature discharge inherent in the new payment system, we expect that differences in the utilization of these services might result. In the case of the proposed payment system, discharges to other settings of care may take place earlier than under the current payment system. This would result in lower payments under the current payment system for this care, which must be taken into account when computing budget neutral payment rates. Accounting for this effect through an adjustment is commonly known as a behavioral offset. The budget neutral conversion factor with a behavioral offset is $6,024. This represents a .64 percent (that is, sixty four hundredths of one percent) reduction in the budget neutral conversion factor otherwise calculated under the methodology described in the preceding pages. In determining this adjustment, we assumed that the IRFs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with CMG or home health care at any point.

F. Development of the Federal Prospective Payment

Once the relative weights for each CMG and the budget neutral conversion factor are calculated, the Federal prospective payments can be determined. Under proposed § 412.624(c)(4), these CMG payments are calculated by multiplying the budget neutral conversion factor by each of the CMG relative weights. The equation is as follows:

Federal Prospective Payment = CMG Relative Weight * Budget Neutral Conversion Factor

Table 5E displays the CMGs and the corresponding Federal prospective payments.

TABLE 5E.—FEDERAL PROSPECTIVE PAYMENTS

CMG	Without comorbidities	With comorbidities
0101	$3,649.34	$3,983.67
0102	4,274.03	4,666.19
0103	5,183.65	5,658.95
0104	5,156.54	5,628.83
0105	5,795.09	6,325.80
0106	6,592.67	7,196.87
0107	7,608.31	8,305.29
0108	8,653.48	9,446.84
0109	9,631.77	10,514.89
0110	10,009.48	10,926.93
0111	11,822.70	12,906.42
0201	3,315.61	3,315.61
0202	5,014.98	5,014.98
0203	5,889.66	5,889.66
0204	7,011.94	7,011.94
0205	8,878.77	8,878.77
0206	13,360.63	13,360.63
0301	3,854.76	4,342.10
0302	5,055.94	5,695.09
0303	5,702.92	6,423.99
0304	7,593.25	8,552.88
0305	10,552.24	11,885.95
0401	4,298.12	5,156.54
0402	6,328.81	7,592.05
0403	10,517.30	12,616.67
0404	17,621.40	21,139.42
0501	2,686.10	3,330.07
0502	3,733.07	4,628.24
0503	4,910.76	6,088.46
0504	6,936.64	8,600.46
0505	10,732.36	13,306.41
0601	4,199.33	4,801.13
0602	5,473.41	6,258.33
0603	6,525.80	7,461.93
0604	8,057.10	9,211.90
0701	3,930.66	4,580.65
0702	5,022.21	5,852.92
0703	6,101.71	7,110.13
0704	7,104.71	8,278.78
0801	2,904.77	3,566.21
0802	3,604.76	4,425.23
0803	4,496.31	5,519.19
0804	5,322.20	6,533.03
0805	5,746.90	7,054.10
0806	7,087.24	8,699.26
0901	3,365.61	4,045.72
0902	4,602.94	5,533.04
0903	5,834.24	7,013.14
0904	7,315.55	8,793.23
1001	5,113.17	5,589.07
1002	6,733.63	7,360.73
1003	8,304.08	9,076.96
1101	3,671.63	4,511.37
1102	4,986.67	6,127.01
1103	6,562.55	8,063.73
1104	7,970.96	9,793.82
1201	3,593.32	4,124.63
1202	4,325.83	4,966.19
1203	5,530.63	6,349.30
1204	6,922.78	7,946.86
1301	3,570.42	4,131.86
1302	4,286.68	4,960.16
1303	6,295.08	7,284.82
1401	3,922.23	4,589.08
1402	5,425.21	6,347.49
1403	7,643.85	8,943.23
1501	4,663.18	5,016.18
1502	5,137.87	5,527.02
1503	7,153.50	7,695.06
1504	13,732.91	14,773.26
1601	3,705.36	4,405.35
1602	4,371.62	5,197.51
1603	5,858.34	6,964.95
1701	5,128.23	6,364.36
1702	8,239.02	10,225.14
1801	5,984.84	5,984.84
1802	12,387.15	12,387.15
1901	4,245.72	4,245.72
1902	6,555.92	6,555.92
1903	12,438.36	12,438.36
2001	3,018.02	3,375.85
2002	3,876.44	4,336.08
2003	4,498.72	5,031.85
2004	4,295.71	4,805.34
2005	5,149.92	5,760.15
2006	6,111.35	6,836.04
2007	6,022.80	6,736.64
2008	6,842.66	7,653.49
2009	7,518.55	8,409.50
2010	6,969.77	7,795.66
2011	8,974.56	10,038.39
2101	7,748.67	7,748.67
5001	1,149.38	1,149.38
5101	2,805.38	2,805.38
5102	6,492.06	6,492.06
5103	3,304.16	3,304.16
5104	9,052.26	9,052.26

G. Examples of Computing the Adjusted Facility Prospective Payments

The Federal prospective payments, described above, will be adjusted to account for geographic wage variation, disproportionate share and, if applicable, facilities located in rural areas.

To illustrate the methodology that we propose to use for adjusting the Federal prospective payments, we provide the following example. One beneficiary is in rehabilitation facility A and another beneficiary is in rehabilitation facility B. Rehabilitation facility A has a disproportionate share adjustment of 1.0648, a wage index of 0.987, and is located in a rural area. Rehabilitation facility B has a disproportionate share amount of 1.1337, a wage index of 1.234, and is located in an urban area. Both Medicare beneficiaries are classified to CMG 0111 (without

comorbidity). This CMG represents a stroke with motor scores in the 78–61 range and the patient is 83 years old or younger. To calculate the facility's total adjusted Federal prospective payment, we compute the wage adjusted Federal prospective payment and multiply the result by: the appropriate disproportionate share adjustment, and the rural adjustment (if applicable). Table 6E illustrates the components of the adjusted payment calculation.

TABLE 6E.—EXAMPLES OF COMPUTING A FACILITY'S FEDERAL PROSPECTIVE PAYMENT

		Facility A
Federal Prospective Payment (From Table 5E)	$11,822.70	$11,822.70
Labor Share (From Table 2E)	× .71301	× .71301
Labor Portion of Federal Payment	= $8,429.70	= $8,429.70
Wage Index (From Tables 3E or 4E)	× 0.987	× 1.234
Wage Adjusted Amount	$8,320.12	$10,402.25
Non-Labor Amount	+ $3,393.00	+ $3,393.00
Wage Adjusted Federal Payment	= $11,713.11	= $13,795.25
Rural Adjustment	× 1.1589	× 1.0000
Subtotal	= $13,574.33	= $13,795.25
DSH Adjustment	× 1.0648	× 1.1337
Total Adjusted Federal Prospective Payment	$14,453.94	$15,639.68

Thus, the adjusted payment for facility A will be $14,453.64 and the adjusted payment for facility B will be $15,639.68.

H. Computing Total Payments

As described in proposed § 412.626, for cost reporting periods beginning on or after April 1, 2001 and before October 1, 2001, payments will be based on 66⅔ percent of the facility specific payment and 33⅓ percent of the IRF adjusted facility Federal prospective payment. The facility specific payment is the amount the facility would have been paid if the prospective payment system had not been implemented. Medicare fiscal intermediaries will continue to compute the facility specific payment amount according to § 412.22(b) of the regulations and sections 1886(d) and (g) of the Act.

I. Method of Payment

A beneficiary will be classified into a CMG based on data obtained during the initial MDS–PAC assessment. The CMG will determine the Federal prospective payment the IRF will receive for the Medicare-covered Part-A services the IRF furnished during the Medicare beneficiary's episode of care. However, we are proposing, under § 412.632(a), that the payment be based on the submission of a discharge bill. This will allow us to account for the occurrence of an event during the stay which would result in a reclassification to one of the five special CMGs (for cases that expire or have a very short length of stay) or an adjustment to the payment to reflect an early transfer and determine if the case qualifies for an outlier payment. Accordingly, the CMG and other information to determine if an adjustment to the payment is necessary will be recorded by the IRF on the beneficiary's discharge bill and submitted to its Medicare fiscal intermediary for processing. The payment made represents payment in full, under proposed § 412.622(b), for inpatient operating and capital costs, but not for the costs of an approved medical education program, bad debts, or other costs not paid for under the proposed IRF prospective payment system.

Under the current payment system, (1) An IRF may be paid using the periodic interim payment (PIP) method described in § 413.64(h) of the regulations, (2) rehabilitation units are paid under the PIP method if the hospital of which they are a part is paid under § 412.116(b), and (3) IRFs may be eligible to receive accelerated payments as described in § 413.64(g) or for rehabilitation units under § 412.116(f). We presently see no reason to discontinue administratively our existing policy of allowing the PIP and accelerated payment methods under the prospective payment system for qualified IRFs, though we may choose to evaluate its continuing need in the future. Therefore, we are proposing to permit the continued availability of PIP and accelerated payments for services of IRFs paid under the prospective payment system at proposed paragraphs (b) and (e) of § 412.632 of the regulations.

For those services paid under the PIP method, the amount is based on estimated prospective payments for the year rather than on estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in § 412.632 and receives approval by its intermediary. Likewise, if an intermediary determines that an IRF which received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in § 412.632, intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the regulations at § 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method it may qualify to receive an accelerated payment. Under § 412.632, the IRF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IRF or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation. A request for an accelerated payment must be made by the IRF and approved by the intermediary and

HCFA. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment is made as bills are processed or by direct payment by the IRF.

J. Update to the Adjusted Facility Federal Prospective Payment

Under section 1886(j)(3)(C) of the Act and under proposed § 412.624(c)(3)(ii) of the regulations, future updates to the adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under the proposed IRF prospective payment system. This increase factor may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act. A description of IRF market basket that we propose to use in developing an increase factor under section 1886(j)(3)(C) is found in Appendix D of this proposed rule.

VI. Provisions of the Proposed Rule

We are proposing to make a number of revisions to the regulations in order to implement the prospective payment system for inpatient rehabilitation facilities. We are proposing to make conforming changes in 42 CFR parts 412 and 413. We are proposing to establish a new subpart P in part 412, ''Prospective Payment for Inpatient Rehabilitation Facilities''. This subpart would implement section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation facilities. This subpart would set forth the framework for the inpatient rehabilitation facility prospective payment system, including the methodology used for the development of the payment rates and related rules. These revisions and others are discussed in detail below.

Section 412.1 Scope of Part

We are proposing to revise § 412.1 by redesignating paragraph (a) as paragraph (a)(1) and adding a paragraph (a)(2) that specifies that this part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services provided to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit for cost reporting periods beginning on or after April 1, 2001. As a result of our proposed changes to § 412.1, we would make a number of conforming changes to various sections of the regulations text. These changes include adding references to the inpatient hospital prospective payment systems as described in § 412.1(a)(1).

Currently, § 412.1(b) ''Summary of content'' describes the content of each subpart in part 412. To make this paragraph more user friendly, we would restructure the paragraph by dividing it into 12 subparagraphs. In addition, we would add references to § 412.1(a)(1)(where appropriate) and add a new subparagraph (b)(12) that summarizes the content of the new subpart P.

Section 412.20 Hospital Services to the Prospective Payment Systems

We propose to revise § 412.20 by revising paragraph (a) to add a reference to inpatient hospital prospective payment system, redesignating paragraph (b) as paragraph (c), and adding a new paragraph (b). Section 412.20(b) would specify that effective for all cost reporting periods beginning on or after April 1, 2001, the services furnished by an inpatient rehabilitation hospital or rehabilitation unit specified in § 412.604 are paid for under the prospective payment system described in subpart P. We would also add a reference to § 412.1(a)(1) to the introductory text of § 412.20(c).

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

We propose to revise §§ 412.22(a), (b), (e), and (h)(2) to add references to § 412.1(a)(1) or § 412.20 (b).

Section 412.23 Retroactive Adjustments for Incorrectly Excluded Hospital Units

We propose to revise the introductory text of §§ 412.23 and 412.23(b)(2) to add references to § 412.1(a)(1) and (a)(2). We propose to revise the introductory text of paragraph (b) to add references to § 412.1(a)(1) and (a)(2). We proposed to revise paragraphs (b)(8) and (b)(9) to specify that in order to be classified as a rehabilitation hospital a patient assessment instrument must be completed in accordance with § 412.606 for each Medicare patient admitted or discharged on or after April 1, 2001.

Section 412.25 Excluded Hospital Units: Common Requirements

We propose to revise §§ 412.25(a) and (e)(2) to add references to § 412.1(a)(1).

Section 412.29 Excluded Rehabilitation Units: Additional Requirements

We propose to revise the introductory text of § 412.29 to add a reference to § 412.1(a)(1) and (a)(2).

Section 412.116 Method of Payments

We propose to restructure and revise paragraph (a) by creating paragraphs (a)(1) and (a)(2). New paragraph (a)(2) would be revised to specify that payments for inpatient hospital services furnished by an excluded psychiatric or rehabilitation unit (not paid under the provisions of subpart P of this part) are made as described in § 413.64(a), (c), (d) and (e) of this chapter. We also propose to add a new paragraph (a)(3) that specifies how payments for inpatient hospital services are made to a qualified IRF.

Section 412.130 Retroactive Adjustments for Incorrectly Excluded Hospital Units

We would revise paragraphs (a)(1) and (a)(2) to add references to §§ 412.1(a)(1) and (a)(2). In addition, § 412.130 (a)(1) and (a)(2) would be revised to specify that for cost reporting periods on or after October 1, 1991, rehabilitation hospitals and units that were excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the inpatient rehabilitation prospective payment system, as a new rehabilitation hospital or unit will have its payments adjusted if the inpatient population actually treated in the hospital during the cost reporting period did not meet the requirements of § 412.23(b)(2). In § 412.130(b), we would add the provisions that specify that the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section for cost reporting periods beginning on or after April 1, 2001 as follows:

- The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems described in § 412.1(a)(1) for services furnished during that period.
- The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems described in § 412.1(a)(1).

Subpart P Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

We propose to reserve subparts N and O, and add a new subpart P.

Section 412.600 Basis and Scope of the Subpart

We are proposing to add a new § 412.600. Section 412.600(a) provides for the implementation of a prospective payment system for inpatient rehabilitation facilities. In § 412.600(b), we would specify that this subpart sets forth the framework for the prospective payment system, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules for inpatient rehabilitation facilities for cost reporting periods beginning on or after April 1, 2001.

Section 412.602 Definitions

In § 412.602, we are proposing the following definitions for purposes of this new subpart:

- Assessment reference date;
- Authorized clinician;
- Discharge;
- Encode;
- Functional-related groups;
- Interrupted stay;
- MDS–PAC;
- Outlier payment;
- Rural area
- Transfer; and
- Urban area.

Section 412.604 Conditions for Payment Under the Prospective Payment System for Inpatient Rehabilitation Facilities

In proposed § 412.604(a), we would specify that IRFs must meet the following general requirements to receive payment under the IRF prospective payment system:

- The IRF must meet the conditions of this section;
- If the IRF fails to comply with the provisions of the section then we can—
- Withhold (in full or in part) or reduce payment to the IRF; or
- Classify the IRF as an inpatient hospital subject to the inpatient hospital prospective payment system.

In proposed paragraph (b), we would specify that an IRF must meet the rehabilitation hospital or rehabilitation unit classification criteria set forth in §§ 412.22, 412.23(b) and 412.30 for exclusion from the inpatient hospital prospective payment system. In addition, we propose to specify that qualifying IRFs are subject to the payment provisions for the IRF prospective payment system.

Proposed paragraph (c) would specify that the IRF must complete a patient assessment instrument for each Medicare patient admitted or discharged on or after April 1, 2001.

Proposed paragraph (d) would specify the prohibited and permitted charges that can be imposed on Medicare beneficiaries. In proposed paragraph (d)(1), we would specify that an IRF may not charge a beneficiary for any services for which payment is made by Medicare, even if the IRF's costs are greater than the amount the facility is paid under the IRF prospective payment system. In addition, proposed paragraph (d)(2) would specify that an IRF receiving payment for a covered stay may charge the Medicare beneficiary or other person for only the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87.

Proposed paragraph (e) would specify the following provisions for furnishing IRF services directly or under arrangements:

- Applicable payments made under the IRF prospective payment system are in full for all inpatient hospital services (as defined in § 409.10) other than physicians' services to individual patients (as specified in § 415.102(a)) which are reimbursable on a reasonable cost basis.
- Payment is not made to a provider or supplier other than the IRF, except for physicians' services reimbursable under § 405.550(b) and the services of an anesthetist employed by a physician reimbursable under § 415.102(a).
- The IRF must furnish all necessary covered services to the Medicare beneficiary directly or under arrangements (as defined in § 409.3).

Lastly, proposed paragraph (f) would specify that IRFs must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24.

Section 412.606 Patient Assessments

In proposed § 412.606, we set forth the requirements regarding patient assessment. Proposed § 412.606(a) would specify that at the time each Medicare patient is admitted the facility must have physician orders for the patient's care during his or her hospitalization. Proposed § 412.606(b) would specify that MDS–PAC is the instrument used to assess Medicare inpatients who are admitted on or after April 1, 2001, or were admitted before April 1, 2001, and are still inpatients as of April 1, 2001. In proposed § 412.606(c), we would specify that an inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS–PAC. This assessment must be in accordance with the assessment schedule. A clinician must record appropriate and applicable data accurately and completely for each MDS–PAC item. The assessment process must include direct patient observation and communication with the patient; and when appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, the patient's clinical record and other sources. The authorized clinician must sign the MDS–PAC attesting to its completion and accuracy.

Section 412.608 Patients' Rights Regarding MDS–PAC Data Collection

Proposed § 412.608 specifies patient rights regarding MDS–PAC data collection. In proposed paragraph (a) we would specify the rights that a Medicare inpatient must be informed of by the IRF authorized clinician before an assessment can be performed. Proposed paragraph (b) would require the authorized clinician to document in the Medicare inpatient's clinical record that the patient was informed of the rights listed in paragraph (a). Proposed paragraph (c) specifies that the patient rights included in this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

Section 412.610 Assessment Schedule

In proposed § 412.610, we would specify the following:

- The start of the assessment schedule day count.
- The determination of the assessment reference date.
- The date when an MDS–PAC assessment reference is late.
- MDS–PAC completion and encoding dates.
- The accuracy of the MDS–PAC data.
- The length of time that an IRF has to retain MDS–PAC patient data sets.

Section 412.612 Coordination of MDS–PAC Data Collection

We proposed to add a new § 412.612. Paragraph (a) of this section would specify the responsibilities of the IRF's authorized clinician. Section 412.612(b) states that the IRF's authorized clinician must certify the accuracy and completion date of the MDS–PAC assessment by signing and dating the appropriate lines of section AB of the MDS–PAC. Proposed paragraph (c) specifies the signature requirements for any clinician who contributes data for an MDS–PAC item. Proposed paragraph (d) specifies the penalty for falsification of a patient assessment.

Section 412.614 Transmission of MDS–PAC Data

Proposed § 412.614 specifies the requirements for transmittal of MDS–PAC data that include the following:

- The format for submitting data.
- How the data is to be submitted.
- The timeframe for submitting data.
- The penalties for late transmission of data.

Section 412.616 Release of Information Collected Using the MDS–PAC

In proposed § 412.616, we specify that the IRF and its agents must ensure the confidentiality of the information collected using the MDS–PAC in the same manner as all other information in the medical record, in accordance with the hospital conditions of participation at § 482.24(b)(3). An IRF may release patient-identifiable information to an agent of the IRF only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purpose specified in the contract and only to the extent that the IRF itself is permitted to so under § 412.616(a).

Section 412.618 Interrupted Stay

In proposed § 412.618 (a), we specify that for purposes of the MDS–PAC assessment process, if a Medicare inpatient has an interrupted stay then the following applies:

- The initial case-mix group classification from the ''initial'' (Day 4) MDS–PAC assessment remains in effect.
- The required scheduled MDS–PAC Day 11, Day 30, Day 60, and discharge assessments must be performed.
- The authorized clinician must record the interrupted stay data on the interrupted stay tracking form of the MDS–PAC.
- The recorded and encoded interrupted stay data must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date that the Medicare patient returns to IRF. In proposed paragraph (d), we specify the revised assessment schedule. Proposed paragraph (d)(1) specifies that if the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission for the Day 4 and Day 11 MDS–PAC assessments are advanced by the same number of calendar days as the length of the Medicare patient's interrupted stay. Proposed paragraphs (d)(2), (d)(3) and (d)(4), specify the provisions under which the Day 11, Day 30, and Day 60 are advanced in the same manner.

Section 412.620 Patient Classification System

Proposed § 412.620 specifies the classification methodology, weighting factors, and case-mix adjustments as they relate to the patient classification system.

Section 412.622 Basis of Payment

Proposed § 412.622(a), we would specify that under the prospective payment system, IRFs received a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries. This paragraph also specifies the basis for the amount of payment under the prospective system.

Proposed § 412.622(b) specifies that payments made under the prospective payment system represent payment in full for inpatient operating and capital costs associated with services furnished in an IRF, but not for the costs of an approved medical education program. Paragraph (b) also specifies the additional payments that an IRFs receive.

Section 412.624 Methodology for Calculating the Prospective Payment Rates

This proposed section specifies the methodology for calculating the prospective payment rates for IRFs. The items specified in this section are as follows:

- Proposed paragraph (a) specifies the data used to calculate the prospective payment rates;
- Proposed paragraph (b) specifies the methodology for calculating the Federal per discharge payment rates that includes—
- Determination of the per discharge payment rate; and
- Adjustments to the data.
- Proposed paragraph (c) specifies how the Federal prospective payment rates for IRFs will be determined. This includes the general rules, the update per discharge, the computation of the budget neutral conversion factor and the determination of the Federal prospective payment rate for each case-mix group.
- Proposed paragraph (d) specifies the adjustments to the budget neutral conversion factor. The adjustments include the following: (1) outlier payments; (2) budget neutrality; and (3) coding and classification changes.
- Proposed paragraph (e) specifies the calculation of the adjusted Federal prospective payment is computed for each discharge on the basis of the Federal prospective payment rate determined in paragraph (c) of this section and adjusted to account for area wage levels, payments for outliers, transfers, and other appropriate factors.

Section 412.626 Transition Period

Proposed § 412.626(a) specifies the duration of the transition period to IRF prospective payment system. It also specifies that IRFs will receive a payment that is comprised of a blend of the adjusted facility Federal prospective payment and the facility-specific payment. Proposed paragraph (b) specifies how the facility-specific payment is calculated.

Section 412.628 Publication of the Federal Prospective Payment Rates

Proposed § 412.628 specifies that we will publish information pertaining to the IRF prospective payment system effective for each fiscal year in the **Federal Register**. In addition, it specifies that the information regarding the IRF prospective payment system will be published on or before August 1 prior to the beginning of each fiscal year.

Section 412.630 Limitation on Review

Proposed § 412.630 specifies that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

Section 412.632 Method of Payment Under the Inpatient Rehabilitation Facility Prospective Payment System

Proposed § 412.632 specifies the method of payment under the inpatient rehabilitation facility prospective payment system. This section specifies the following:

- General rule for receiving payment, including exceptions;
- The requirements for periodic interim payments that include—
- Criteria for receiving periodic interim payments;
- Frequency of payments; and
- Termination of periodic interim payments;
- Interim payment for Medicare bad debts and for Part A costs not paid under the prospective payment system.
- Outlier payments.
- The requirements for accelerated payments that include—
- General rule regarding request for accelerated payments;
- Approval of request for accelerated payments;
- Amount of the accelerated payment; and

• Recovery of the accelerated payment.

Section 413.1 Introduction

We propose to revised § 413.1(d)(ii) to remove the reference to rehabilitation hospitals and units. We also propose to add a new § 413.1(d)(iv) that specifies that for cost reporting periods beginning on or before April 1, 2001, payment to rehabilitation hospitals and units that are excluded under subpart B of part 412 of this subchapter from the prospective payment system is on a reasonable cost basis in accordance with the provisions of § 413.40. In addition, we propose to add a new § 413.1(d)(v) that specifies that for cost reporting periods on or after April 1, 2001, payment to rehabilitation hospitals and units (as described in § 412.604) is based on the prospectively determined rates under the provisions of subpart P of part 412.

Section 413.40 Ceiling on the Rate of Increase in Hospital Costs

Section 413.40(a)(2)(i) specifies the types of facilities to which the ceiling on the rate of increase in hospital inpatient costs is not applicable. We propose to add a new paragraph § 413.40(a)(2)(i)(C) to specify that for cost reporting periods beginning on or after October 1, 2002, § 413.40 is not applicable to rehabilitation hospitals and rehabilitation units that meet the conditions for payment under § 412.604 and are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) and subpart P of part 412.

We propose to revise § 413.40(a)(2)(ii) and to add (a)(2)(iii) to specify the cost reporting periods under which rehabilitation hospitals and units that are excluded from the prospective payment system specified in § 412.1(a)(1) meet the terms of this section

Section 413.64 Payment to Providers: Specific Rules

We propose to revise § 413.64 to include hospitals paid under the IRF prospective payment system and add a reference to § 412.1(a)(1).

VII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and we will respond to the comments in the preamble to the final rule.

VIII. Regulatory Impact Analysis

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

• An annual effect on the economy of $100 million or more;

• A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

• Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises to compete with foreign based enterprises in domestic and export markets.

We have examined the impacts of this proposed rule as required by Executive Order (EO) 12866, the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), the Regulatory Flexibility Act (RFA) (Public Law 96–354), and EO 13132 (Federalism). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This proposed regulation would be a major rule because the aggregate amount of savings is estimated to be 1.54 billion dollars over 7 years.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, businesses 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. Intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or Tribal governments, in the aggregate, or by the private sector, of at least $100 million. This rule will not have an effect on the governments mentioned nor will it affect private sector costs, rather, the proposed rule will affect Medicare payments.

In addition, we examined this rule in accordance with Executive Order 13132 and determined that this proposed rule would not have any negative impact on the rights, roles, or responsibilities of State, local, or Tribal governments.

Section 1102(b) of the 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 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

For these reasons, we are preparing analyses under the RFA and section 1102(b) of the Act because we determine, and we certify, that this proposed rule would have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. As discussed earlier in this preamble, we propose to adjust payments for facilities located in rural areas. Therefore, the impacts shown below reflect the adjustments that are designed to minimize or eliminate the negative impact that the prospective payment system would otherwise have on rural facilities.

A. Background

This proposed rule sets forth the prospective payments to be used to determine payments under the Medicare program for inpatient rehabilitation facilities.

While section 1886(j) of the Act specifies the basic methodology of constructing a case-mix adjusted prospective payment system, the statute does allow us some discretion in designing the key elements of the system, and we had some opportunity to consider alternatives for these elements. These include the patient assessment instrument, the patient classification methodology based on functional-related groups, and adjustments to the prospective payments. These elements, and alternatives that we considered, were discussed in detail earlier in the preamble of this proposed rule.

B. Anticipated Effects of This Proposed Rule

We discuss the impact of this proposed rule in terms of its fiscal impact on the budget and in terms of its

impact on providers. The estimated fiscal impact is discussed first.

1. Budgetary Impact

Under section 1886(j)(3)(B) of the Act, payment rates set forth in this proposed rule must be set at levels such that total payments under this prospective payment system are projected to equal 98 percent of the amount that would have been paid for operating and capital costs if this prospective payment system had not been implemented. The provision to implement the IRF prospective payment system is projected to save the Medicare program $1.54 billion over 7 years, as follows:

$60 million for FY 2001
$200 million for FY 2002
$220 million for FY 2003
$240 million for FY 2004
$250 million for FY 2005
$270 million for FY 2006
$300 million for FY 2007

2. Impacts on Providers

In order to understand the impact of the new prospective payment system on different categories of facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the proposed prospective payment system (proposed prospective payments). To estimate the impacts among the various classes of providers it is imperative that current payments and proposed prospective payments contain similar inputs. More specifically, we simulate proposed prospective payments only for those providers that we are able to calculate current payment. Further, we calculate current payment only for those providers that we are able to simulate proposed prospective payments.

As previously stated in section V. of this preamble, we have both case-mix and cost data for 624 rehabilitation facilities. Data from these facilities were used to analyze the appropriateness of various adjustments to the Federal unadjusted payment rates. However, for the impact analyses shown in the following tables, we simulate payments for 505 facilities. These impacts reflect the estimated losses/gains among the various classifications of providers for FY 2001. The methodology used to update the data to the midpoint of FY 2001, necessitated the use of historical cost report data to determine the relationship of the facilities' costs and target amount. Thus, the number of providers reflects only those providers for which we had cost report data available from FYs 1995, 1996, and 1997 (see discussion in section V.E.1. of this proposed rule).

3. Calculation of Current Payments

To calculate current payments, cost report data is trended forward from the midpoint of the cost reporting period to the midpoint of FY 2001 using the methodology set forth in section V. of this preamble. To estimate current payments, we calculate operating payments for each rehabilitation facility in accordance with section 1886(b). Further, we compute capital payments by reducing reasonable costs by 15 percent, consistent with section 1886(g)(4) of the Act, as added by section 4412 of the BBA. To determine each facility's average per discharge payment amount under the current payment system, operating and capital payments are added together, and then the total payment is divided by the number of Medicare discharges from the cost reports. Total payments for each facility are then computed by multiplying the number of discharges from the Medicare bills (with corresponding UDSmr/COS data) by the average per discharge payment amount.

4. Calculation of Proposed Prospective Payments

To estimate payments under the proposed prospective payment system, we multiply each facility's case-mix index by the facility's number of Medicare discharges, the budget neutral conversion factor, the applicable wage index, a disproportionate share adjustment, and a rural adjustment, (if applicable). The specific adjustments follow:

- The wage adjustment is calculated as (.2897 + (.7103 × Wage Index)),
- The disproportionate share adjustment is calculated as:

((.0001 + Disproportionate Share) raised to the power of .0905)/(.0001 raised to the power of .0905)),

- The rural adjustment, if applicable, is calculated by multiplying payments by 1.1589.

After the proposed Federal rate payments are calculated for each facility, the appropriate percentages of the current payments and the proposed Federal rate payments are blended together to determine the appropriate amount for the first three years of implementation of the IRF prospective payment system. Specifically, for cost reporting periods beginning on or after implementation of the prospective payment system through FY 2001 we combine 66⅔ percent of the current payment amount with 33⅓ percent of the proposed Federal rate payment amount. For cost reporting periods beginning in FY 2002, we combine 33⅓ percent of the current payment amount with 66⅔ percent of the proposed Federal rate payment amount. For cost reporting periods beginning in FY 2003, we show the impacts of the fully phased-in IRF prospective payment amount. All payment simulations reflect data trended to the midpoint FY 2001. These data were not trended out to the midpoint of FYs 2002 or 2003.

Tables 1G, 2G, and 3G illustrate the aggregate impact of the proposed payment system among various classifications of facilities. The first column, Facility Classifications, identifies the type of facility. The second column identifies the number of cases. The third column lists the number of facilities of each classification type, and the fourth column is the ratio of proposed prospective payments to current payments. The impacts reflect the adjustments that we propose, including the specific geographic wage adjustment, the adjustment for rural facilities (if applicable), and a disproportionate share adjustment for all facilities.

TABLE 1G.—IMPACTS REFLECTING ⅓ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅔ OF CURRENT PAYMENTS

Facility classifications	Number of cases	Number of Facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.98
Other Urban	88232	238	0.98

TABLE 1G.—IMPACTS REFLECTING ⅓ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅔ OF CURRENT PAYMENTS—Continued

Facility classifications	Number of cases	Number of Facilities	Proposed payment to current payment ratio
Rural	9814	49	1.00
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.98
South Atlantic	34845	79	0.99
East North Central	33018	120	0.98
East South Central	12344	26	1.00
West North Central	9175	44	0.98
West South Central	22995	73	0.95
Mountain	5659	25	0.96
Pacific	9097	55	0.99
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.98
Urban—South Atlantic	31314	72	1.00
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	0.99
Urban—West North Central	7979	36	0.98
Urban—West South Central	21929	64	0.95
Urban—Mountain	5349	22	0.96
Urban—Pacific	8610	51	0.99
Rural by Region			
Rural—New England	118	1	1.01
Rural—Middle Atlantic	586	3	1.01
Rural—South Atlantic	3531	7	0.99
Rural—East North Central	2025	12	1.03
Rural—East South Central	495	2	1.09
Rural—West North Central	1196	8	0.98
Rural—West South Central	1066	9	0.96
Rural—Mountain	310	3	1.02
Rural—Pacific	487	4	0.97
Type and Size of Facility			
Unit of acute hospital	101518	398	0.99
Average Daily Census < 10	12962	102	0.98
Average Daily Census 10–24	51783	211	0.99
Average Daily Census > 24	36773	85	0.99
Freestanding hospital	65872	107	0.96
Average Daily Census less than 25	3527	18	0.96
Average Daily Census 25–50	19248	40	0.97
Average Daily Census greater than 50	43097	49	0.96
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.98
Disproportionate share 10%–19%	56138	190	0.99
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	0.99
Missing	14379	28	0.97
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.98
Resident to ADC 10%–19%	7309	20	0.97
Resident to ADC greater than 19%	1267	11	0.97
Alaska/Hawaii	1099	2	0.99

TABLE 2G.—IMPACTS REFLECTING ⅔ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅓ OF CURRENT PAYMENTS

Facility classifications	Number of cases	Number of facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.99
Other Urban	88232	238	0.97
Rural	9814	49	1.01
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.97
South Atlantic	34845	79	1.01
East North Central	33018	120	0.98
East South Central	12344	26	1.01
West North Central	9175	44	0.98
West South Central	22995	73	0.93
Mountain	5659	25	0.94
Pacific	9097	55	0.99
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.97
Urban—South Atlantic	31314	72	1.01
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	1.01
Urban—West North Central	7979	36	0.99
Urban—West South Central	21929	64	0.93
Urban—Mountain	5349	22	0.93
Urban—Pacific	8610	51	0.99
Rural by Region			
Rural—New England	118	1	1.04
Rural—Middle Atlantic	586	3	1.03
Rural—South Atlantic	3531	7	1.00
Rural—East North Central	2025	12	1.08
Rural—East South Central	495	2	1.20
Rural—West North Central	1196	8	0.97
Rural—West South Central	1066	9	0.95
Rural—Mountain	310	3	1.06
Rural—Pacific	487	4	0.96
Type and Size of Facility			
Unit of acute hospital	101518	398	1.00
Average Daily Census < 10	12962	102	0.99
Average Daily Census 10–24	51783	211	1.00
Average Daily Census > 24	36773	85	1.00
Freestanding hospital	65872	107	0.95
Average Daily Census less than 25	3527	18	0.93
Average Daily Census 25–50	19248	40	0.95
Average Daily Census greater than 50	43097	49	0.95
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.97
Disproportionate share 10%–19%	56138	190	0.99
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	1.01
Missing	14379	28	0.96
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.99
Resident to ADC 10%–19%	7309	20	0.96
Resident to ADC greater than 19%	1267	11	0.95
Alaska/Hawaii	1099	2	1.00

TABLE 3G.—IMPACTS REFLECTING THE FULLY PHASED-IN PROSPECTIVE PAYMENTS

Facility classifications	Number of cases	Number of facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.99
Other Urban	88232	238	0.97
Rural	9814	49	1.03
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.97
South Atlantic	34845	79	1.02
East North Central	33018	120	0.99
East South Central	12344	26	1.03
West North Central	9175	44	0.99
West South Central	22995	73	0.90
Mountain	5659	25	0.92
Pacific	9097	55	1.00
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.97
Urban—South Atlantic	31314	72	1.03
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	1.02
Urban—West North Central	7979	36	0.99
Urban—West South Central	21929	64	0.90
Urban—Mountain	5349	22	0.91
Urban—Pacific	8610	51	1.00
Rural by Region			
Rural—New England	118	1	1.07
Rural—Middle Atlantic	586	3	1.06
Rural—South Atlantic	3531	7	1.01
Rural—East North Central	2025	12	1.13
Rural—East South Central	495	2	1.31
Rural—West North Central	1196	8	0.97
Rural—West South Central	1066	9	0.93
Rural—Mountain	310	3	1.10
Rural—Pacific	487	4	0.96
Type and Size of Facility			
Unit of acute hospital	101518	398	1.01
Average Daily Census < 10	12962	102	0.99
Average Daily Census 10–24	51783	211	1.02
Average Daily Census > 24	36773	85	1.02
Freestanding hospital	65872	107	0.93
Average Daily Census less than 25	3527	18	0.91
Average Daily Census 25–50	19248	40	0.94
Average Daily Census greater than 50	43097	49	0.93
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.97
Disproportionate share 10%–19%	56138	190	1.00
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	1.03
Missing	14379	28	0.94
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.99
Resident to ADC 10%–19%	7309	20	0.95
Resident to ADC greater than 19%	1267	11	0.94
Alaska/Hawaii	1099	2	1.00

5. Costs Associated With The MDS-PAC

We propose that all IRFs furnishing Medicare-covered Part A services assess their Medicare patients using the standardized data set known as the MDS–PAC. Costs associated with MDS–PAC data collection and data reporting are related to both personnel and equipment. These two classes of costs include the costs associated with using the MDS–PAC to assess patients (MDS–PAC data collection costs), the IRF's costs to start the MDS–PAC process, and the IRF's ongoing costs after the MDS–PAC process has been initiated. It should be noted that many of the components of the costs associated with initiation of the MDS–PAC process and the IRF's ongoing costs are the same.

a. MDS–PAC Data Collection Costs

In calculating the cost to perform an MDS–PAC assessment we made the following assumptions: (1) That physicians, registered nurses, occupational therapists, or physical therapists are the only clinicians with the training to complete all, or the vast majority, of the MDS–PAC items. Other clinicians may contribute data to complete some MDS–PAC items. (2) That a physician would not record the data for all or most of the MDS–PAC items. We believe that the majority of the items would be completed by registered nurses, occupational therapists, or physical therapists.

We then applied the above assumptions to the following data:

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of registered nurses in 1998 were $40,690. That is equivalent to a median hourly wage of $19.56. ($40,690/52 weeks = $782.50/week. $782.50/40 hours = $19.5625).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of occupational therapists in 1998 were $48,230. That is equivalent to a median hourly wage of $23.19. ($48,230/52 weeks = $927.50. $927.50/40 hours = $23.1875).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of physical therapists in 1998 were $56,600. That is equivalent to a median hourly wage of $27.21. ($56,600/52 weeks = $1088.46/week. $1088.46/40 hours = $27.2115).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of dietitians and nutritionists in 1998 were $35,020. That is equivalent to a median hourly wage of $16.84. ($35,020/52 weeks = $673.46/week. $673.46/40 hours = $16.8365).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of social workers in 1998 were $30,590. That is equivalent to a median hourly wage of $14.71. ($30,590/52 weeks = $588.27/week. $588.27/40 hours = $14.7067).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of speech-language pathologists and audiologists in 1998 were $43,080. That is equivalent to a median hourly wage of $20.71. ($43,080/52 weeks = $828.46/week. $828.46/40 hours = $20.7115).

• IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 85 minutes to complete an initial intake assessment.

• IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 48 minutes to complete an update assessment.

• According to one external source IRF staff familiar with the UDSmr FIM required a median of 20 minutes to complete the initial FIM instrument.

• According to another external source IRF staff familiar with the FIM required a range of 30 to 45 minutes to complete the FIM instrument. It was not specified if this was the UDSmr or COS instrument. Also, although it was not specified, we believe that this range of time was the time to complete an initial FIM assessment.

• It should be noted that the information from both external sources concerning the length of time it takes to complete the FIM instrument has not been verified.

• Our data indicates that in 1997 there were 359,032 IRF admissions and 1,123 IRFs. Therefore, there were an average of 319.70 admissions per IRF.

Based on the above data and assumptions, and depending on the type of clinician that completes all, or the vast majority, of the MDS–PAC items, the range of the incremental average cost difference per year per IRF to complete the initial MDS–PAC when compared to the initial FIM is illustrated in Table 4G below. In addition, considering the hourly wage rates specified above it would make no difference in cost if a dietitian or social worker completed all or most of the MDS–PAC items, and only a slight difference at the low end of the range if a speech-language pathologist completed all or most of the MDS–PAC items.

TABLE 4G.—RANGE OF INCREMENTAL COST—COMPARISON OF THE INITIAL MDS–PAC TO THE INITIAL FIM

Range of hourly wages per clinician	Minimum incremental time of 40 minutes—range of Incremental Cost per IRF per year	Maximum incremental time of 65 minutes—range of incremental cost per IRF per year
$19.56 (R.N.)	$4,169.02	$6,774.61
23.19 (O.T.)	4,942.72	8,031.86
27.21 (P.T.)	5,799.54	9,424.18

We believe that the FIM data are inconclusive, and we have several concerns and observations regarding the data. The data from both external sources were collected from a survey of a sample of IRFs. We do not know the size of one of the samples, and if either sample is representative of all IRFs. We do not know if the data are estimates of time or controlled measurements of time. Nor do we know the details of the survey method that was used to collect the data. The data may be biased at the source where the data was collected, that is, the sources of the data may be reflecting institutionalized biases when reporting their data. In addition, the data was reported by organizations with vested interests in the FIM, and they may have used a different approach than the one we used in estimating completion time of an assessment instrument. For example, we do not know whether they measured only the time necessary to enter information on the FIM form or also included—(1) the time it took to obtain information from

the patient and/or clinical record; (2) the time it took to actually assess the patient; and (3) the time it took clinicians before filling out the FIM to apply clinical judgment, or to consult with other clinicians, or to examine the clinical record regarding their assessment observations. In addition, unlike the MDS–PAC estimates, the information from both external sources was survey information, instead of a controlled study. For the above reasons, when we conduct a test of the UDSmr, COS, and the MDS–PAC instruments we will include in the test measurements of the time it takes to complete each one.

Previously in this preamble we state that testing indicated that IRF staff familiar with the MDS–PAC can complete an update MDS–PAC in a median of 48 minutes. SNF staff familiar with the MDS–PAC can complete an update MDS–PAC in a median of 45 minutes.

Although we are proposing to require more items to be collected on an update assessment, the update assessment still requires less data collection than an initial assessment. Table 7C (found in section II of this preamble), entitled ''MDS–PAC Items Required by Type of Assessment,'' listed the items that we propose be collected on the Day 4 (admission), update (Day 11, Day 30, Day 60), and the discharge assessments. Counting the items in each column gives a simple total of the items required on each type of assessment. The update assessment requires that 85.2 percent of the items on the initial assessment be addressed on the update assessment. The discharge assessment requires that 87.5 percent of the items on the initial assessment be addressed on the discharge assessment. Consequently, we believe that the time required by IRF staff to complete an update MDS–PAC assessment is likely more than 48 minutes but less than the time it takes to complete the initial MDS–PAC assessment. We do not have data that specifically states the time it takes to complete a patient's discharge FIM, which, in essence, is the patient's update FIM. Therefore, we cannot currently compare MDS–PAC update or discharge assessment completion times to FIM update or discharge assessment completion times.

Most patients would require a Day 11 update assessment, because our data indicates that the mean length of stay is 15.81 days and the median length of stay is 14 days. Patients would also require a discharge assessment. But our data indicates that less than 9 percent of patients would require a Day 30 assessment, and less than ½ of one percent of patients would require a Day 60 assessment.

b. Start-Up Costs

The IRF's costs to start the MDS–PAC process consists of material costs and personnel costs. Our data indicates that in 1997 there were 1,123 IRFs. As presented in detail in Table 5G below entitled ''MDS–PAC IRF Start-up Costs'' we estimate that the costs for all IRFs to start the MDS–PAC process, excluding the MDS–PAC data collection costs discussed above, to be approximately $5,121,722 to $5,247,498, which is equal to approximately $4,561 to $4,673 per IRF.

The costs presented below are based on the profile of an average IRF, because certain costs are constant regardless of the size of the IRF. For both start-up costs and on-going costs, cost estimates are based on an assumption that IRFs would perform the encoding and transmission functions themselves.

TABLE 5G.—MDS–PAC IRF START-UP COSTS

Task/equipment	Hours per IRF	Cost per IRF	Estimated number of staff per IRF to be trained	Total per IRF	National costs
Hard drive, printer, RAM, MODEM, Internet Browser.		$0 [a]		$0 [a]	None
Training on MDS–PAC data collection at initial assessment, update assessment, discharge assessment, and data auditing.	16	PT [b] $27/hr; OT [b] $23/hr; RN [b] $20/hr	1 [c]	PT [d] $432; OT [e] $368; RN [f] $320	$359,360–$485,136 [g]
	12	$23/hr (average cost of the 3 disciplines)	9 [h]	$2,484 [i]	$2,789,532 [j]
Data Entry (encoding/transmission) training.	5.5	$12.50/hr [k]	1	$68.75 [l]	$77,206.25 [m]
Data Entry	96 [n]	$1,200 [o]		$1,200	$1,347,600 [p]
Data Entry Audits [q]		$38 [r]		$38	$42,674 [s]
Data Transmissions—Staff time.	1	$150 [t]		$150	$168,450 [u]
Running the data edit check program @ 20 minutes per month and actual transmission by staff @ 40 minutes per month.					
Systems Maintenance		$100		$100	$112,300
Supplies		$200		$200	$224,600
Total					$5,121,722–$5,247,498

[a] We believe that all IRFs have the computer capability to process the MDS–PAC-related software.

[b] These are the 1998 median hourly wages for these occupations based on the US Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000–2001 Edition.* We are providing a range of median hourly wages as the IRFs must determine the discipline specific clinician they will send to training.

[c] We expect the IRF to send a lead clinician to a HCFA sponsored training session and then that lead clinician would train the other IRF clinicians.

[d] 16 × $27.

[e] 16 × $23.

[f] 16 × $20.
[g] 1,123 × $320 to 1,123 × $432.
[h] This number represents the average number of clinicians per IRF that would require training. These clinicians would be trained in their facility.
[i] 12 hrs × $23/hr × 9 staff=$2,484.
[j] 1,123 × $2,484.
[k] We estimate that the hourly wage for data entry personnel is $12.50 per hour.
[l] 5.5 hrs × $12.50.
[m] 1,123 × $68.75.
[n] The average total of admissions per year per IRF is a approximately 320. We estimate that on average approximately 91 percent of IRF admissions will require 3 assessments. Approximately 9 percent of IRF admissions will require 4 assessments. This time includes data review and entry of 3 min. per assessment for up-front review & another 3 min. of post data entry review for a total of 6 min. 6 minutes × 291=1746 minutes/60=29.1 hrs × 3=87.3. 6 minutes × 29=174 minutes/60=2.9 hrs × 3=8.7 hrs. 87.3 + 8.7=96 hrs.
[o] We estimate an hourly rate for data entry costs of $12.50. 96 hrs × $12.50=$1200.
[p] 1,123 × $1200.
[q] We estimate a 15 minute monthly data entry audit for quality assurance purposes.
[r] $12.50 hr/4 × 12 months=$37.50 per year.
[s] 1,123 × $38.
[t] 1 hr × 12 (mos.) × $12.50/hr.
[u] 1,123 × $150.

Note: We anticipate that the IRFs will designate a lead licensed clinician to attend all training. That lead clinician would then provide training to other IRF staff.

(1) Computer Hardware and Software

Because we will supply to the IRFs free of charge the MDS–PAC software that performs the MDS–PAC process electronic functions, the IRFs will incur no software costs. We believe that IRFs possess the computer hardware capability to handle the MDS–PAC computerization, data transmission, and grouper software requirements. Our belief is based upon indications that—(1) Approximately 99 percent of hospital inpatient claims currently are submitted electronically; (2) close to 100 percent of IRFs submit their cost reports electronically; and (3) approximately 55 percent of IRFs submit FIMs electronically. Although we will supply the MPACT software, IRFs may incur costs, which we are not able to estimate, associated with making changes to their information management systems to incorporate the MPACT software. Therefore, we are specifically soliciting comments regarding MDS–PAC computerization issues.

IRFs have the option of purchasing data collection software that can be used to support other clinical or operational needs (for example, care planning, quality assurance, or billing) or other regulatory requirements for reporting patient information. However, we are developing an MDS–PAC data system (that is, MPACT) that would be available to IRFs at no charge through our website. MPACT would allow users to computerize their MDS–PAC assessment data and transmit the data in a HCFA-standard format to the HCFA MDS–PAC system. Therefore, IRFs that plan to use MPACT will need Internet access and a dial-up Internet Service Provider account in order to be able to download and install MPACT into their computer system. We believe that all IRFs currently have the capability to access the Internet. However, we are specifically soliciting comments from any IRFs that do not possess Internet access capability, in order for us to consider if we should make MPACT available to these facilities by some other means.

(2) Training

IRF staff will require training in performing MDS–PAC assessments, encoding assessments, preparing MDS–PAC data for electronic submission, and actually transmitting the data. We believe that the initial training of IRF personnel would require about 75.5 hours of staff time. We estimate training to cost an IRF approximately $1,242 for training of clinical staff, based on an average hourly payroll rate of $23 for licensed clinical staff. We estimate training to cost an IRF approximately $69 for training data entry staff, based on an average hourly payroll rate of $12.50 for data entry staff.

(3) Data Entry

IRFs have flexibility in choosing the data entry software used to computerize the MDS–PAC data, but the software must, at a minimum, perform the MPACT functions. In addition, when IRFs are performing data entry functions themselves, or contracting for the performance of these functions, the IRFs must ensure that performance of data entry complies with our requirement for safeguarding the confidentiality of clinical records.

IRFs must collect and transmit MDS–PAC data to the HCFA MDS–PAC system in accordance with the assessment schedule and transmission requirements specified elsewhere in this preamble. The data may be entered by an IRF staff member from a paper document completed by a licensed clinical staff member, or by a data entry operator under contract to the IRF to key in data. IRFs must allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the HCFA MDS–PAC system. We estimate that an average IRF will incur a cost of an hourly rate for data entry of $12.50. This cost includes data review and entry, as well as a (recommended) 15 minute monthly data entry audit for quality assurance purposes.

(4) Data Transmission

MDS–PAC data would be transmitted to the HCFA MDS–PAC system. This system is similar to the ones that HHAs use to report OASIS data and that SNFs use to report MDS 2.0 data. IRF staff must also manage the data transmission function, correct transmission problems, and manage report logs and validation reports transmitted by the HCFA MDS–PAC system. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program. This staff time will cost an average-sized IRF about $150 per year based on an hourly rate of $12.50. IRFs will be able to transmit the MDS–PAC data using the toll-free MDCN line.

(5) Systems Maintenance

There are costs associated with normal maintenance related to computer equipment, such as the replacement of disk drives or memory chips. Typically, this maintenance is provided through warranty agreements with the original equipment manufacturer, system retailer, or a firm that provides computer support. These maintenance costs are estimated to average no more than $100 per year IRF.

(6) Supplies

Supplies necessary for collection and transmission of data, including forms, diskettes, computer paper, and toner, will vary according to the size of the IRF, the number of patients served, and the number of assessments conducted.

We anticipate that an average IRF with approximately $200 in costs for supplies.

c. Ongoing Costs

We wanted to differentiate between one-time start-up costs for the IRF and costs we believe the IRFs will incur on a regular, yearly basis. Therefore, Table 6G entitled ''Agency Ongoing Costs'' include only data that we consider will be a repeated cost to the IRF.

TABLE 6G.—MDS–PAC IRF ONGOING COSTS

Task/equipment	Hours per IRF	Cost per IRF	Estimated number of staff	Total per IRF	National costs
Data Entry	96[a]	$1,200[b]		$1,200	$1,347,600[c]
Data Entry Audit(d)		$38[e]	1	$38	$42,674[f]
Data Transmissions—Staff time Running the data edit check program @ 20 minutes per month and actual transmission by staff @ 40 minutes per month.	1	$150[g]		$150	$168,450[h]
Systems Maintenance		$100		$100	$112,300
Supplies		$200		$200	$224,600
Annual Training:					
Clinical	12	$20–27/hr[i]	1	$240–$324[j]	$269,520–$363,852[k]
Data Entry	12	12.50/hr[l]	1	$150[m]	$168,450[n]
Clinical[o]	2	$20–27/hr.	9	$360–$486	$404,280–$545,778
Total					$2,737,874–$2,973,704

[a] The average total of admissions per year per IRF is approximately 320. We estimate that on average approximately 91 percent of IRF admissions will require 3 assessments. Approximately 9 percent of IRF admissions will require 4 assessments. This time includes data review and entry of 3 min. per assessment for up-front review & another 3 min. of post data entry review for a total of 6 min. 6 minutes × 291=1746 minutes/60=29.1 hrs × 3=87.3. 6 minutes × 29=174 minutes/60=2.9 hrs × 3=8.7 hrs. 87.3 + 8.7=96 hrs.

[b] We estimate an hourly rate for data entry costs of $12.50. 96 hrs × $12.50=$1,200.

[c] 1,123 × $1,200.

[d] We estimate a 15 minute monthly data entry audit for quality assurance purposes.

[e] $12.50 hr/4 × 12 months=$37.50 per year.

[f] 1,123 × $38.

[g] 1 hr × 12 (mos.) × $12.50/hr.

[h] 1,123 × $150.

[i] Based on the 1998 U.S. Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000–2001 Edition,* the median hourly wage for an RN is $20, $23 for an OT, and $27 for a PT. We are providing a range of median hourly wages as the IRFs must determine the discipline specific clinician they will send to training. We expect that the IRF will send one discipline specific clinician to a HCFA sponsored training session and then that individual would train the other IRF clinicians.

[j] 12 hours × $20 to 12 hours × $27.

[k] 1,123 × $240 to 1,123 × $324.

[l] We estimate that the hourly wage for data entry personnel is $12.50 per hour.

[m] 12 hours × $12.50.

[n] 1,123 × $150.

[o] This entry represents the average annual cost of IRF in-house training for the MDS–PAC.

Our data indicates that in 1997 there were 1,123 IRFs. Therefore, we estimate annual ongoing costs for an average-sized IRF, excluding MDS–PAC data collection costs discussed previously, to be approximately $2,438 to $2,648.

d. Conclusion

As discussed in detail above, IRFs will incur costs associated with the MDS–PAC process. Table 7G below is a further analysis of these costs.

TABLE 7G.—MDS–PAC COST PER CASE

[Based on IRFs currently completing a FIM instrument]

	Percent of MDS–PAC items completed	Maximum incremental clinician (physical therapist) cost per IRF (from table 4G)	Total incremental maximum cost per IRF (Col. 2 times Col. 3)	Average maximum incremental cost per case (Col. 4 divided by 320 average admissions per IRF)
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Assessment Type:				
Initial	100.00	$9,424.18	$9,424.18	$29.45
Update	[1] 85.20	9,424.18	8,029.40	25.09
Discharge	[2] 87.50	9,424.18	8,246.16	25.77
Average Estimated Cost to Complete MDS–PAC	.....	.....	25,699.74	80.31
Estimated Maximum MDS–PAC Start-up Cost per IRF [3]	.....	.....	4,673.00	14.60
Total Estimated Maximum first year Cost	.....	.....	30,372.74	94.91

[1] Assumes the time to complete each MDS–PAC item weighted equally at 1.000.

[2] Same as footnote 1.

[3] This amount is based on the maximum costs shown in Table 5G divided by 1,123 IRFs. This amount will decline after the first year of implementation to reflect the ongoing costs shown in Table 6G.

We assessed the relationship between the estimated cost of completing the MDS–PAC with an estimate of the average cost of one RIC. For analysis we used RIC 7: Hip Fractures. This RIC has an estimated average cost of $9,848 (based upon secondary analysis of data from 1996 and 1997 MEDPAR and cost reports). We compared the assumed cost for completing the initial, update and discharge assessments using the MDS–PAC. We found that the average maximum incremental cost per case of completing the MDS–PAC for one year, assuming the completion of three assessments represents approximately 0.008 per cent of the cost of the estimated average cost of RIC 7. We used a single RIC for comparison because there is a large variation of cost across RICs. We believe that the estimated costs of completing the MDS–PAC are well justified when considered within the context of the statutory requirement and the methodology needed to implement the IRF prospective payment system, the probability that the MDS–PAC process will lead to increased quality of care for IRF patients, as well as the potential uses of the automated data by the IRFs themselves, the States, fiscal intermediaries, and HCFA. Our cost estimates may actually overstate anticipated costs, because they do not take into account cost-savings that IRFs may achieve by improving their management information systems, as well as potential improvements in the quality of patients' clinical care resulting from improved care planning under the MDS–PAC assessment process.

C. Alternatives Considered

We propose to use the MDS–PAC as the patient assessment instrument instead of the patient assessment instruments marketed by UDSmr or COS. These other patient assessment instruments are used by approximately 56 percent of the IRFs. But these patient assessment instruments are not as precise in assessing patients as the MDS–PAC, because they do not collect as much detailed data as the MDS–PAC. For example, the MDS–PAC provides a better description of a patient's cognitive functioning (the processing of empirical factual concepts) than these other assessment instruments. The MDS–PAC is also better at assessing a patient's mood and behavior patterns, measures of a patient's emotional and psychological status. Nor do these other assessment instruments allow for collecting patient assessment data in sufficient detail to allow us to develop the IRF quality of care monitoring system that we need. In addition, we believe that neither of these other patient assessment instruments permits a comparison of patients across different settings of post-acute care as recommended by MedPAC.

In constructing our proposed assessment schedule we decided not to use the patient assessment schedules associated with the patient assessment instruments marketed by UDSmr or COS. These other patient assessment instruments are used to assess patients only upon admission and discharge. We believe that the data provided by our update assessments would yield the type of structured data that we can use to monitor the quality of treatment being furnished. We also propose not to use the FIM items exactly as they are contained in the patient assessment instruments of UDSmr or COS, or the MDS–PAC with the FIM payment items pasted in exactly as contained in the patient assessment instruments of UDSmr or COS. These two approaches were not selected as they would not support HCFA's long-term quality monitoring strategy nor the goal to establish a common core post-acute care assessment instrument. In addition, we propose not to collect only the assessment items that would be used to generate a case-mix group determined payment rate, because these few items do not provide the scope of information needed to monitor access to care, quality of care, and to determine if future adjustments to the payment system are needed.

However, as we discussed earlier in the preamble, the process for arriving at the number of elements on the MDS–PAC was based on a consensus of clinical expert panels, which focused on the scope of elements necessary to support both quality monitoring and payment. Similarly, our proposed assessment schedule, including the number of assessments performed, was designed to meet both payment and quality monitoring objectives of the MDS–PAC. Alternatives to the approaches we have proposed in this rule could include either a reduction in the number of elements on the instrument or in the number of assessments performed while maintaining the MDS–PAC's ability to facilitate both payment and comprehensive quality monitoring. We are specifically requesting comments on these facets of the patient assessment methodology.

In accordance with the provisions of Executive Order 12866 this regulation was reviewed by the Office of Management and Budget.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. 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.

We are soliciting public comment on each of these issues for the sections that contain information collection requirements (ICRs).

Section 412.23 Excluded Hospitals: Classifications

- Paragraph (b)(2) requires that, except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, the entity show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more specified conditions.
- Paragraph (b)(8) requires that a hospital seeking classification under this paragraph as a rehabilitation hospital, for the first 12-months cost reporting period that occurs after it becomes a Medicare participating hospital, may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this

section, instead of showing that it has treated this population during its most recent 12-month cost reporting period.

The information collection requirements of these two paragraphs of this section are currently approved under OMB approval number 0938–0358 (Psychiatric Unit Criteria Work Sheet, Rehabilitation Hospital Criteria Work Sheet, Rehabilitation Unit Criteria Work Sheet) through November 30, 2000. The proposed changes to the information collection requirements in these two paragraphs are clarifying changes.

Section 412.116 Method of Payment

Under 412.116 (b), *Periodic interim payments,* a hospital that meets the criteria in § 413.65(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph.

The burden associated with this provision is the time it takes a hospital to write its request for periodic interim payments. We estimate that 34 facilities would request these payments and that it would take each 1 hour to write and mail its request.

Sections 412.606 Patient Assessment and 412.610(c) Assessment Schedule

• Paragraph (a) of § 412.606 requires that at the time each Medicare patient is admitted the facility must have physician orders for the patient's immediate care.

This requirement is subject to the PRA. However, we believe that the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with the requirement are incurred by persons in the normal course of their activities.

• Paragraph (c) of § 412.606, *Comprehensive assessments,* requires that an IRF clinician initially and periodically perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare patient using the MDS–PAC as the patient assessment instrument and that the assessment process must include—

• Direct patient observation and communication with the patient; and

• When appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, and the patient's clinical record and other sources.

• Section 412.610(c), *Assessment reference dates,* requires assessments upon admission (Day 4); Day 11, Day 30, and Day 60; upon discharge or when the patient stops receiving part A benefits.

In 1997, there were approxiamtely 359,000 admissions to IRFs and there are 1,123 facilities, averaging 320 admissions annually. We estimate that it would take 85 minutes for the initial assessment and at least 48 minutes for each subsequent assessment.

Under these proposed rules, all Medicare beneficiaries would be assessed two times: upon admission and upon discharge. Sixty-six percent would be assessed on the 11th day as well. Fewer than 9 percent of Medicare beneficiaries in IRFs would also be assessed at 30 days. Fewer than ½ of a percent would require an assessment at 60 days.

Below is a chart showing burden.

Type of assessment	Estimated time for completion (in minutes)	Hours per year per facility (in hours)	Hours per year nationwide (in hours)
Admission (Day 4)	85	453	508,719
Day 11	48	169	189,787
Day 30	48	23	25,829
Day 60	48	1	1,123
Discharge	48	256	287,488
Total/Facility (5 assessment)		902	1,012,946

The total ongoing annual burden for all facilities for five assessments would be 902 hours × 1,123 or 1,012,946 hours.

We are also including training in our burden estimates: 16 hours to train the lead clinician and 12 hours to train the other clinicians (an average of 9). This totals 121,284 nationally for a one-time burden. We also estimate an on-going burden for training of 14 hours per IRF per year (15,722 nationally).

Section 412.608 Patient Rights Regarding MDS–PAC Data Collection.

Under paragraph (a) of this section, before performing an assessment of a Medicare inpatient using the MDS–PAC, an IRF clinician must inform the Medicare inpatient of the following patient rights:

• The right to be informed of the purpose of the MDS–PAC data collection;

• The right to have the MDS–PAC information collected kept confidential and secure;

• The right to be informed that the MDS–PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

• The right to refuse to answer MDS–PAC questions; and

• The right to see, review, and request changes on his or her MDS–PAC assessment.

Under paragraph (b) of this section, the IRF must ensure that the authorized clinician document in the patient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

In accordance with paragraph (c) of this section, the patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

We anticipate adding the burden of disclosure to IRF patients and documenting that disclosure to the burden in § 412.13 on hospitals furnishing a patient rights statements. The hospitals would be able to easily give both statements to patients upon admission, along with other required notifications. The burden for the general patient rights statement has not yet been approved but is under development. We have estimated that it would take each hospital 5 minutes to disclose the general hospital statement to each patient on admission. The disclosure of the IRF patients' rights statement would increase that time by an estimated 2 minutes.

Section 412.610 Assessment Schedule

Paragraph (g), *MDS–PAC record retention,* of this section requires that an IRF maintain all MDS–PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

We estimate that, for facilities that choose to file a paper copy, it would

take the facility 5 minutes to print out, or copy, each assessment and file it in the patient's record. On average, each facility would need to obtain a copy of and file 882 assessments per year, equaling 74 hours. We cannot estimate how many facilities would choose to file paper copies. However, we are assuming that most facilities would choose to retain the assessments in an electronic format, which would not add to the paperwork burden. We request comments on the accuracy of this assumption concerning how many facilities will comply by retaining an electronic version.

Section 412.612 Coordination of MDS–PAC Data Collection.

Paragraph (b), *Certification,* of this section requires that the authorized clinician who has done at least part of the assessment certify the accuracy and completion date by signing and dating the appropriate lines of section AB of the MDS–PAC.

We estimate that it would take the authorized clinician approximately 10 minutes per assessment to determine to his or her satisfaction that the assessment is complete and to so certify. Eight hundred eighty-two assessments would equal 147 hours per year per facility, and 165,081 hours nationally.

Paragraph (c) of this section requires that any clinical who contributes data for an MDS–PAC item sign and date the appropriate lines of the MDS–PAC.

Under the definition of information in 5 CFR 1320.3(h)(1), ''information'' does not include such items as affidavits, oaths, affirmations, certifications, consents or acknowledgments, provided that they do not entail any burden other than that necessary to identify the respondent, the date, and the respondent's address. We believe that the signatures required by § 412.610(c) are acknowledgments identifying the signers (as persons furnishing a service) and are not information.

Section 412.614 Transmission of MDS–PAC Data

Paragraph (a), *Data format,* of this section requires that each IRF encode and transmit data—

- Using the computer program(s) available from HCFA; or
- Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS–PAC data set, and meets other HCFA specifications.

In accordance with paragraph (b), *How to transmit data,* of this section, each IRF must—

- Electronically transmit complete and encoded MDS–PAC data for each Medicare inpatient to the HCFA MDS–PAC system in accordance with the data format specified in paragraph (a) of this section; and
- Transmit data using electronic communications software that provides a direct telephone connection from the IRF to the HCFA MDS–PAC system.

IRFs would have to collect and transmit MDS–PAC data to the HCFA MDS—PAC system. The data may be entered by a IRF staff member from a paper document completed by a licensed clinical staff member, or by a data entry operator under contract to the IRF to key in data. IRFs would have to allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the HCFA MDS–PAC system.

We estimate that an average IRF with 320 admissions per year will require 3 minutes for data review and entry per assessment for up-front review and another 3 minutes for data entry review for a total of 6 minutes. The burden of transmitting the data is contained in that 6 minutes. The yearly burden would be 96 hours per facility. (This burden also includes recommended 15 minute monthly data entry audit for quality assurance purposes.)

Other Data Transmission Functions

In addition to the burden of managing the data transmission function, IRF staff will have to correct transmission problems and manage report logs and validation reports transmitted by the HCFA MDS–PAC system. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program.

We estimate that it will require a one-time burden of 5.5 hours per hospital to train the personnel to be able to complete data transmission tasks. With 1,123 facilities, the national burden would be 6177 hours.

Section 412.616 Release of Information Collected Using the MDS–PAC

Under paragraph (b) of this section, a facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and to the extent the facility itself is permitted to do so under § 412.616(a).

The burden associated with this ICR is the time required to include the necessary information in the contract. While this ICR is subject to the PRA, we believe the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 412.618 Interrupted Stay

Paragraph (a) of this section requires that if a patient has an interrupted stay the facility must record interrupted stay data on the MDS–PAC interrupted stay tracking form.

We currently have no data on the incidence of interrupted stays. We estimate, however, that it would take no more than 5 minutes to complete a form. We request comments on the burden that completion of this form might impose.

Submission to OMB

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 412.23, 412.29, 412.116, and 412.606 through 412.618. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Health Care Financing Administration, Office of Information Services, Standards and Security Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: Julie Brown HCFA–1069–P.

and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, HCFA Desk Officer.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is proposed to be amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. Section § 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in § 412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with § 413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of § 412.604.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after April 1, 2001.

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

A. Revising paragraph (a).

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising the introductory text of the redesignated paragraph (c).

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b) and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after April 1, 2001, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

* * * * *

4. Section 412.22 is amended by:

A. Revising paragraphs (a) and (b).

B. Revising the introductory text of paragraph (e).

C. Revising the introductory text of paragraph (h)(2).

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified

in § 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section and § 412.20(b), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

* * * * *

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(h) *Satellite facilities.* * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

5. Section 412.23 is amended by:

A. Revising the introductory text.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs (b)(2) introductory text, (b)(8), and (b)(9).

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2):

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) or is paid under the prospective payment system specified in § 412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, HCFA adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130.

* * * * *

6. In § 412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems specified in § 412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) *Satellite facilities.* * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

7. In § 412.29, the introductory text is revised to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

In order to be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

8. In § 412.116, paragraph (a) is revised to read as follows:

§ 412.116 Method of payment.

(a) *General rule.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before April 1, 2001) are made as described in § 413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after April 1, 2001, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of § 412.604 are made as described in § 412.632.

* * * * *

9. In § 412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* * * *

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system

specified in § 412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

* * * * *

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

(2) For cost reporting periods beginning on or after April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

Subparts N and O—[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§ 412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612, 412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632 is added to read as follows:

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

Sec.

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

§ 412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as ''inpatient rehabilitation facilities'').

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after April 1, 2001, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities is made on the basis of prospectively determined rates and applied on a per discharge basis.

§ 412.602 Definitions.

As used in this subpart—

Assessment reference date means the specific calendar day in the MDS–PAC assessment process that sets the designated endpoint of the common 3 day patient observation period, with most MDS–PAC assessment items usually referring back in time from this endpoint.

Authorized clinician means one of the following clinicians:

(1) An occupational therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(2) A physical therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(3) A physician who is a doctor of medicine or osteopathy and is licensed to practice medicine and surgery by the State in which the function or action is performed.

(4) A registered nurse as defined in § 484.4 of this chapter.

Discharge A Medicare patient in a inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released; or

(2) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized MDS–PAC software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means the period during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of discharge.

MDS–PAC stands for the Minimum Data Set for Post Acute Care, a patient clinical assessment instrument.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Rural area means an area as defined in § 412.62(f)(1)(iii).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means an area as defined in § 412.62(f)(1)(ii).

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) *General requirements.* (1) An inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, HCFA may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* An inpatient rehabilitation facility must meet the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment systems specified in § 412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare patient admitted or discharged on or after April 1, 2001, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606.

(d) *Limitation on charges to beneficiaries.* (1) *Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter.

(e) *Furnishing of inpatient hospital services directly or under arrangement.* (1) The applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter, other than physicians' services to individual patients reimbursable on a reasonable cost basis (in accordance with the criteria of § 415.102(a) of this subchapter).

(2) HCFA does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b) of this chapter and services of an anesthetist employed by a physician reimbursable under § 415.102(a) of this subchapter.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in § 409.3 of this subchapter).

(f) *Reporting and recordkeeping requirements.* All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

§ 412.606 Patient assessment.

(a) *Admission orders.* At the time that each Medicare patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the MDS–PAC instrument to assess Medicare inpatients who—

(1) Are admitted on or after April 1, 2001; or

(2) Were admitted before April 1, 2001, and are still inpatients as of April 1, 2001.

(c) *Comprehensive assessments.* (1) An inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS–PAC as part of his or her patient assessment in accordance with the schedule described in § 412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility must record appropriate and applicable data accurately and completely for each MDS–PAC item.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, the patient's clinical record, and other sources.

(4) The authorized clinician, must sign the MDS–PAC attesting to its completion and accuracy.

§ 412.608 Patient rights regarding MDS–PAC data collection.

(a) Before performing an assessment using the MDS–PAC, an authorized clinician must inform the Medicare inpatient of the following patient rights:

(1) The right to be informed of the purpose of the MDS–PAC data collection;

(2) The right to have the MDS–PAC information collected be kept confidential and secure;

(3) The right to be informed that the MDS–PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer MDS–PAC questions; and

(5) The right to see, review, and request changes on his or her MDS–PAC assessment.

(b) The inpatient rehabilitation facility must ensure that an authorized clinician documents in the Medicare inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13 of this chapter.

§ 412.610 Assessment schedule.

(a) *General.* For each Medicare inpatient an inpatient rehabilitation facility must submit MDS–PAC assessment data that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) *Starting the assessment schedule day count.* The first day that the inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the MDS–PAC assessment schedule.

(c) *Assessment reference dates.* With respect to the patient's current hospitalization, an inpatient rehabilitation facility must indicate on the MDS–PAC one of the following assessment reference dates:

(1) *Day 4 MDS–PAC assessment.* For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization, the date that is the 3rd calendar day after the patient started being furnished Medicare-covered Part A services.

(2) *Day 11 MDS–PAC assessment.* For the assessment that covers calendar days 8 through 10 of the patient's current hospitalization, the date that is the 10th calendar day after the patient started being furnished Medicare-covered Part A services.

(3) *Day 30 MDS–PAC assessment.* For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization, the date that is the 30th calendar day after the patient

started being furnished Medicare-covered Part A services.

(4) *Day 60 MDS–PAC assessment.* For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization, the date that is the 60th calendar day after the patient started being furnished Medicare-covered Part A services.

(5) *Discontinuation of Medicare-covered Part A services assessment.* For the assessment that is completed when the inpatient is not discharged from the inpatient rehabilitation facility but stops receiving Medicare-covered Part A services, the actual date that the inpatient stops receiving Medicare-covered Part A services.

(6) *Discharge assessment.* For the assessment that is completed when the Medicare inpatient is discharged from the inpatient rehabilitation facility, the actual date of discharge from the inpatient rehabilitation facility.

(d) *Late MDS–PAC assessment reference date.* If the MDS–PAC assessment reference date is entered later than the assessment reference date specified in paragraph (c)(1) of this section, the MDS–PAC assessment reference date is considered late.

(1) If the MDS–PAC assessment reference date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(2) If the MDS–PAC assessment reference date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

(e) *Completion and encoding dates.* (1) The Day 4, Day 11, Day 30, and Day 60 MDS–PAC assessments must be completed 1 calendar day after the MDS–PAC assessment reference date that is recorded on the MDS–PAC.

(2) The discharge MDS–PAC assessment must be completed on the 5th calendar day in the period beginning with the MDS–PAC assessment reference date.

(3) All MDS–PAC assessments must be encoded by the 7th calendar day in the period beginning with the MDS–PAC completion date that is recorded on the MDS–PAC.

(f) *Accuracy of the MDS–PAC data.* The encoded MDS–PAC assessment data must accurately reflect the patient's clinical status at the time of the MDS–PAC assessment.

(g) *MDS–PAC record retention.* An inpatient rehabilitation facility must maintain all MDS–PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

§ 412.612 Coordination of MDS–PAC data collection.

(a) *Responsibilities of the authorized clinician.* An inpatient rehabilitation facility's authorized clinician who has participated in performing an MDS–PAC patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the patient's MDS–PAC assessment; and

(2) The accuracy of the date inserted in the attestation section of the MDS–PAC.

(b) *Certification.* An inpatient rehabilitation facility's authorized clinician must certify the accuracy and completion date of the MDS–PAC assessment by signing and dating the appropriate lines of the MDS–PAC.

(c) *Signatures.* Any clinician who contributes data for an MDS–PAC item must sign and date the appropriate lines of the MDS–PAC.

(d) *Penalty for falsification.* (1) Under Medicare an individual who knowingly and willfully—

(i) Certifies a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§ 412.614 Transmission of MDS–PAC data.

(a) *Data format.* The inpatient rehabilitation facility must encode and transmit data for each Medicare inpatient—

(1) Using the computerized version of the MDS–PAC available from HCFA; or (2) Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS–PAC data set, and meets other HCFA specifications.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete and encoded MDS–PAC data for each Medicare inpatient to the HCFA MDS–PAC system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the HCFA MDS–PAC system.

(c) *Transmission dates.* All MDS–PAC assessments must be transmitted to HCFA MDS–PAC system by the 7th calendar day in the period beginning with the last permitted MDS–PAC encoding date.

(d) *Late transmission penalty.* (1) HCFA assesses a penalty when an inpatient rehabilitation facility does not transmit the required MDS–PAC data to the HCFA MDS–PAC system in accordance with the transmission timeframe in paragraph (c) of this section.

(2) If the actual MDS–PAC transmission date is later than the transmission date specified in paragraph (a) of this section the MDS–PAC data is considered late.

(i) If the MDS–PAC transmission date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(ii) If the MDS–PAC transmission date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

§ 412.616 Release of information collected using the MDS–PAC.

(a) *General.* An inpatient rehabilitation facility may release information from the MDS–PAC only as specified in § 482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§ 412.618 Interrupted stay.

For purposes of the MDS–PAC assessment process, if a Medicare patient has an interrupted stay the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the Day 4 MDS–PAC assessment remains in effect (that is, no new Day 4 MDS–PAC assessment is performed).

(2) The required scheduled MDS–PAC Day 11, Day 30, and Day 60 assessments must be performed.

(3) When the patient is discharged, a discharge MDS–PAC assessment must be performed.

(b) *Recording and encoding of data.* The authorized clinician must record

the interrupted stay data on the interrupted stay tracking form of the MDS–PAC.

(c) *Transmission of data.* The data recorded on the interrupted stay tracking form must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date that the Medicare patient returns to the inpatient rehabilitation facility.

(d) *Revised assessment schedule.* (1) If the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission dates for the Day 4 and Day 11 MDS–PAC assessments are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(2) If the interrupted stay occurs after the Day 4 assessment and before the Day 11 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 11 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(3) If the interrupted stay occurs after the Day 11 and before the Day 30 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 30 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(4) If the interrupted stay occurs after the Day 30 and before the Day 60 assessment then the assessment reference date, completion date, encoding date, and data transmission date for the Day 60 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

§ 412.620 Patient classification system.

(a) *Classification methodology.* (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For the purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from Day 4 assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(b) *Weighting factors.* (1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* HCFA will determine a weighting factor or factors for patients that are discharged and not transferred within a number of days from admission as specified by HCFA.

(3) *Patients who expire.* HCFA will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by HCFA.

(c) *Revision of case-mix group classifications and weighting factors.* HCFA may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following—

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter, and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities HCFA uses—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, used to estimate payments for inpatient operating and capital costs made under part 413 under this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2000.* HCFA determines the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2000 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2000.

(c) *Determining the Federal prospective payment rates*—(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments and other adjustments.

(2) *Update the cost per discharge.* (i) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2001. Based on the updated cost per discharge, HCFA estimates the payments that would have been made to the facility for fiscal year 2001 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(ii) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's fiscal year 2001 cost per discharge determined under paragraph (c)(2)(i) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, HCFA estimates the

payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the budget neutral conversion factor.* The budget neutral conversion factor is computed as follows:

(i) *For fiscal years 2001 and 2002.* Based on the updated costs per discharge and estimated payments for fiscal years 2001 and 2002 determined in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, HCFA computes a budget neutral conversion factor for fiscal years 2001 and 2002, as specified by HCFA, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section including adjustments, described in paragraph (d) of this section, as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the budget neutral conversion factor.* The budget neutral conversion factor described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* HCFA determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) *Budget neutrality.* HCFA adjusts the Federal prospective payment rates for fiscal years 2001 and 2002 so that aggregate payments under the prospective payment system are estimated to equal 98 percent of the amount that would have been made to inpatient rehabilitation facilities under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* HCFA adjusts the budget neutral conversion factor for a given year if HCFA determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate determined under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(2) *Adjustments for low income patients.* HCFA adjusts the Federal prospective payment, on a facility basis, for the proportion of low income patients that receive inpatient rehabilitation services as determined by HCFA.

(3) *Adjustments for rural areas.* HCFA adjusts the Federal prospective payment by a factor, as specified by HCFA, to account for the higher costs per patient in facilities located in rural areas as defined in § 412.602.

(4) *Adjustment for high cost outliers.* HCFA provides for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels, and factors to account for treating low income patients and for rural locations) as specified by HCFA. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount.

(5) *Adjustments related to the MDS–PAC.* An adjustment to a facility's Federal prospective payment amount for a given discharge will be made if—

(i) The assessment reference date identified on the MDS–PAC as described in § 412.610(d) is late; and

(ii) The transmission of MDS–PAC data as described in § 412.614(d) is late.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care,; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for non-transfer cases in the case-mix group to which the patient is classified.

(2) HCFA calculates the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for non-transfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the unadjusted payment amount.

(iii) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(ii) of this section.

§ 412.626 Transition period.

(a) *Duration of transition period and proportions of the blended transition rate.* (1) For cost reporting periods beginning on or after April 1, 2001 through fiscal year 2002, inpatient rehabilitation facilities receive a payment comprised of a blend of the adjusted Federal prospective payment, as determined in § 412.624(e) or § 412.624(f) and, a facility-specific payment as determined in paragraph (b) of this section.

(i) For cost reporting periods beginning on or after April 1, 2001 and before fiscal year 2002, payment is based on 66⅔ percent of the facility-specific payment and 33⅓ percent of the adjusted Federal prospective payment.

(ii) For cost reporting periods beginning in fiscal year 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted Federal prospective payment.

(2) For cost reporting periods beginning with fiscal year 2003 and after, payment is based entirely on the adjusted Federal prospective payment.

(b) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

§ 412.628 Publication of the Federal prospective payment rates.

HCFA publishes information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, inpatient rehabilitation facilities receive payment under this subpart for inpatient operating costs and capital costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.* (1) *Criteria for receiving periodic interim payments.* (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP*—(i) *Request by the inpatient rehabilitation facility.* Subject to paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and HCFA.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

2. Section 413.1 is amended by:

A. Revising paragraph (d)(2)(ii).

B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part 412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable

cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of § 412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C—Limits on Cost Reimbursement

3. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (a)(2)(i).

B. Adding a new paragraph (a)(2)(i)(C).

C. Revising paragraph (a)(2)(ii).

D. Adding paragraph (a)(2)(iii).

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction.* * * *

(2) *Applicability.* (i) This section is not applicable to—

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after October 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

(A) Hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in § 412.1(a)(1) of this chapter and in accordance with §§ 412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§ 412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before April 1, 2001, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter.

* * * * *

Subpart E—Payments to Providers

4. In § 413.64 paragraph (h)(2)(i) is revised to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement*—* * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in § 412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 18, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: September 29, 2000.

Donna E. Shalala,

Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations.

Appendix A—Technical Discussion of Cases and Providers Used in RAND Analysis

This Appendix explains the methodology used to create the data file used to develop the proposed IRF prospective payment system. A general description of the process to create this data file is contained in section II of this proposed rule. RAND has performed the following analysis to match UDSmr, COS, and HCFA data files.

Table A shows that for 1996 and 1997, the MEDPAR files had over 12 million records per year. We are interested in a subset of these records: cases paid by Medicare as rehabilitation stays that were exempt from the acute care hospital PPS.

TABLE A.—NUMBER OF MEDPAR CASES AND FACILITIES

Calendar year	No. of cases	No. of facilities
1996	12,231,275	6,339
1997	12,263,463	6,257

Table B shows total 1996 and 1997 rehabilitation stays by type of provider (free-standing rehabilitation facility versus excluded unit of an acute care hospital). This was the ''sampling'' frame. In order to describe the IRF prospective payment system case-mix, RAND attached information from FIM instruments to each record in this frame, thereby obtaining ''complete'' records. To the extent that RAND was unable to add information to some records, it was important to know both how to and whether to weight the complete records so they would reflect the composition of the frame.

TABLE B.—NUMBER OF REHABILITATION MEDPAR CASES AND FACILITIES

Calendar year/type	No. of cases	No. of facilities
1996:		
Excluded unit	229,193	877
Free-standing	114,933	204
Total	344,126	1,081
1997:		
Excluded unit	240,491	911
Free-standing	118,541	212
Total	359,032	1,123

Note: Free-standing facilities have characters 3–6 of the Medicare provider number in the range 3025–3099. Patients receiving rehabilitation care in excluded units of acute care hospitals have a ''provider code'' of T in their MEDPAR records.

Table C shows the number of facilities and the number of UDSmr and COS records for calendar years 1996 and 1997.

TABLE C.—NUMBER OF UDSMR/COS RECORDS AND FACILITIES

Calendar year	Source	No. of records	No. of facilities
1996	UDSmr	225,069	533
	COS	44,478	159
1997	UDSmr	258,915	595
	COS	67,350	164

Matching MEDPAR and UDSmr/COS Facilities

The first step in the matching process is to link MEDPAR facilities to UDSmr/COS facilities. For each of these combinations, RAND counted the number of exact matches of MEDPAR and UDSmr/COS records based on admission date, discharge date, and zip code. Table D summarizes the results of this stage of the linking process. The number of facilities represented in our UDSmr/COS datasets is slightly more than half of all IRFs.

TABLE D.—NUMBERS OF UDSMR/COS FACILITIES LINKED TO MEDPAR FACILITIES

Calendar year/source	MEDPAR Unique [1]	MEDPAR Multiple [2]	Non-Rehab [3]	Total
1996:				
UDSmr	501	10	22	533
COS	67	8	84	159
1997:				
UDSmr	557	15	23	595
COS	68	18	78	164

[1] UDSmr/COS IRFs that appear to have a single MEDPAR provider.
[2] UDSmr/COS IRFs that appear to have more than one MEDPAR provider.
[3] UDSmr/COS IRFs that appear to be SNFs or long term care hospitals.

The UDSmr/COS data do not contain the Medicare beneficiary identifier, and therefore it was necessary to use a probabilistic matching algorithm based on characteristics of the beneficiary and the hospitalization. The matching was accomplished in a series of four steps:

(1) Identify match variables;

(2) Recode certain UDSmr/COS variables to be consistent with MEDPAR, create additional records for UDSmr interrupted stays, and eliminate duplicate cases;

(3) Run a match algorithm to link UDSmr/COS and MEDPAR records; and

(4) Choose a single MEDPAR case if it matches multiple UDSmr or COS cases.

Step 1: Identify Match Variables

A further search for matches only within the provider number and facility identifier pairings was performed. For free-standing facilities, an attempt was made to match all MEDPAR records to a UDSmr record.

For MEDPAR, in addition to facility identity, 6 variables were used to link the records: Admission date, discharge date, zip code, age at admission, sex, and race. For UDSmr/COS, the same information in a slightly recoded form was available (for example, birth date). An indicator of whether Medicare was the primary payor was used to determine how to set certain parameters for the matching algorithm.

Step 2: Create Additional UDSmr/COS Files

COS's coding of interrupted stays is similar to Medicare's: One record per rehabilitation episode; therefore, these records did not require any additional processing. UDSmr, however, codes multiple stays via a series of ''transfer/return'' dates on a single UDSmr record. To facilitate matching UDSmr and MEDPAR records, multiple records for interrupted stays were created with admission and discharge dates corresponding to the beginning and ending of each stay. The additional records were then given the same chance of matching MEDPAR records as any non-interrupted stay. For both UDSmr and COS files, there were some duplicate cases.

Table E shows the number of records present at the various stages of processing. The last column shows the number of cases that would be matched to MEDPAR.

TABLE E.—NUMBER OF UDSMR/COS RECORDS AT VARIOUS STAGES OF PROCESSING

Calendar year/source	No. of records		
	Original	After expansion	After duplicate elimination
1996:			
UDSmr	225,069	232,076	231,003
COS	44,478	44,478	44,375
1997:			
UDSmr	258,915	267,444	266,288
COS	67,350	67,350	67,082

Step 3: Match Discharges from MEDPAR and UDSmr/CareData

A match algorithm similar to the one used in Carter, Relles, et al. (1997) was run assuming that links are imperfect—any variable can be in error. A scoring function is developed, based on Bayes' Theorem, which gives the odds of a match based on how consistent variables tend to be for true matching and non-matching cases. A score of 2.00 or above has a high probability of identifying a match. The match statistics reported below assume that cutoff.

Step 4: Choose a Single MEDPAR Case for Multiple UDSmr/COS Matches

While the matching was unique within a facility/provider pair, some MEDPAR providers were paired with different facilities, as shown in Table F. Also, some UDSmr and COS facilities were the same: 6 overlaps in 1996, 7 in 1997.

TABLE F.—MEDPAR FACILITIES PAIRED WITH MULTIPLE FACILITIES

Source	Calendar year	No. of facilities
UDSmr	1996	5
UDSmr	1997	8
COS	1996	5
COS	1997	10

First, MEDPAR duplicate links were eliminated within each file, and then duplicate links were eliminated between UDSmr and COS files all within the same years. In all cases, the highest scores were kept. Table G provides results for cutoff score 2.0.

TABLE G.—NUMBER OF LINKED RECORDS AFTER DUPLICATION ELIMINATION

Calendar year/source	No. of Records, Cutoff Source ≥2.0			
	Multiple paired providers (a)	Total records	Duplicates eliminated (b)	Overlap eliminated (c)
1996:				
UDSmr	5	163,509	162,850	162,692
COS	5	27,664	27,630	26,197
1997:				
UDSmr	8	185,567	184,431	183,960
COS	10	42,219	41,980	38,722

Note: (a) Number of MEDPAR providers paired with more than one UDSmr/COS facility. (b) Multiple pairings can link the same MEDPAR record to more than one UDSmr/COS case. This step eliminates those multiple links, keeping the link with the highest match score. (c) the same MEDPAR provider might show up in both UDSmr and COS, again allowing the same MEDPAR record to match more than one UDSmr/COS case.

Quality of the Match

There are two aspects to evaluating the quality of the match. The first is whether we actually matched all of the cases. To evaluate this, we computed match rates for each of our populations: UDSmr, COS, and MEDPAR. The second aspect is the representativeness of the match for the entire population. To evaluate this, we compared patient and facility characteristics to both linked and full population, and considered whether some form of weighting would make those populations look sufficiently the same.

Match Rates

Table H suggests overall match rates in these UDSmr/COS facilities for the eligible RPPS population to be almost 90 percent. This was slightly higher than expected—the Carter, Relles, *et al.* (1997) match rates were about 86 percent.

TABLE H.—MEDPAR MATCH RATES, PROVIDERS WITH A FULL YEAR OF DATA

Source	Calendar year	MEDPAR cases	Matched cases	Percent matched
UDSmr	1996	155,502	136,056	87.5
UDSmr	1997	175,807	156,520	89.0
COS	1996	7,157	6,354	88.8
COS	1997	36,774	33,549	91.2

Note: Tabulations are for patients eligible for IRFPPS.

The UDSmr/COS.com files contain many cases not paid by Medicare, but the files provide an indication of whether Medicare is the primary payer. Restricting our attention to just these cases, we obtain the percentages shown in Table I.

TABLE I.—UDSMR/COS MATCH RATES FOR MEDICARE AS THE PRIMARY PAYER

Source	Calendar year	UDS/COS cases	Matched cases	Percent matched
UDSmr	1996	160,125	153,926	96.1
UDSmr	1997	179,179	171,885	95.9
COS	1996	28,767	26,857	93.4
COS	1997	44,172	41,168	93.2

Note: UDSmr/COS cases matching any Medicare case.

These match rates are also slightly higher than reported in Carter and Relles (1997), where a 93.7 percent rate was achieved for 1994 UDSmr data. We consider these match rates to be acceptable, within the limitations of information available.

Representativeness of Linked MEDPAR

For analytical purposes, lack of representativeness is most important for characteristics that are related to outcomes we are trying to model. For example, if costs for treating a patient in free-standing facilities differed from costs in excluded units of acute care hospitals, we would consider re-weighting the sample of linked cases to adjust our total cost estimates.

Representativeness of Linked MEDPAR Hospital Characteristics

This section addresses the extent to which the facilities present in the UDSmr/COS file are representative of the set of all facilities that provide inpatient rehabilitation care to Medicare beneficiaries, and the extent to which UDSmr/COS patients are representative of all Medicare IRFPPS-eligible patients. This analysis reflects the effects of the partial-year sample available for some UDSmr/COS facilities as well as the sampling of MEDPAR facilities. The MEDPAR records contain data from over 1,000 IRFs in each year. Table J divides these facilities into free-standing rehabilitation facilities (free-standing rehab) and excluded rehabilitation units of acute-care hospitals (excluded units). It presents the number of facilities in the linked MEDPAR sample, along with the total MEDPAR counts of rehabilitation patients at these facilities.

TABLE J.—COMPARISON OF NUMBER OF UDSMR/COS AND MEDPAR REHABILITATION FACILITIES, BY TYPE

Type of facility	1996			1997		
	UDS/COS [1]	Total MEDPAR [2]	Percent UDS/COS	UDS/COS [1]	Total MEDPAR [2]	Percent UDS/COS
Number of rehab facilities:						
Free-standing rehab	130	204	64	142	212	67
Excluded unit	435	877	50	489	911	54
Total	565	1,081	42	631	1,123	56
Number of rehab patients:						
Free-standing rehab	86,301	114,933	75	94,327	118,541	80
Excluded unit	130,623	229,193	57	150,787	240,491	63
Total	216,924	344,126	63	245,114	359,032	68

[1] Hospitals with at least one linked MEDPAR/UDSmr/COS rehabilitation record.
[2] Total (matched and unmatched) rehabilitation cases.

As shown in Table J, UDSmr/COS slightly over-represents free-standing rehabilitation facilities and slightly under-represents excluded units. The table also indicates UDSmr/COS's tendency to include larger facilities. In 1997, UDSmr/COS facilities represented 47 percent of the facilities, but served almost 70 percent of all MEDPAR IRF cases. Based on data found in the table, in 1997, UDSmr/COS free-standing facilities had an average of 792 patients, 532 more than other-MEDPAR free-standing facilities, and UDSmr/COS excluded units had an average of 365 patients, 185 more than other-MEDPAR excluded units.

Table K shows the distribution of UDSmr/COS IRFs by size. This shows both that free-standing facilities are larger than excluded units, and that UDSmr/COS IRFs tend to be larger than other MEDPAR facilities within type of facility.

TABLE K.—COMPARISON OF SIZES OF UDSMR/COS AND MEDPAR FACILITIES, BY TYPE OF FACILITY

No. of MEDPAR patients	1996				1997			
	Free-standing		Excluded Unit		Free-standing		Excluded Unit	
	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR
1–100	2	23	30	97	4	24	33	105
101–200	14	9	139	140	14	7	143	126
201–300	14	2	105	102	11	5	123	103
301–400	14	10	59	48	17	9	65	40
401–500	8	8	38	27	12	7	52	29
501–1000	56	16	58	26	59	15	67	18
1001–2000	20	6	6	2	24	3	6	1
2001–3000	1	0	0	0	0	0	0	0
3001–4000	1	0	0	0	1	0	0	0
Total	130	74	435	442	142	70	489	422

Table L shows that there are some UDSmr/COS facilities in each region, although the southeast and mountain States appear to be slightly under represented.

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR UDSMR/COS SAMPLE HOSPITALS, BY STATE

State	1996			1997		
	Total		Percent UDS/COS	Total		Percent UDS/COS
	UDS/COS	MEDPAR		UDS/COS	MEDPAR	
AL	7,135	7,839	91	8,338	8,654	96
AK	136	247	55	153	302	51
AR	2,829	6,581	43	3,338	6,973	48
AZ	2,261	3,672	62	2,334	4,084	57
CA	8,108	15,294	53	7,899	15,559	51
CO	1,306	4,757	27	2,786	4,263	65
CT	1,521	2,217	69	2,024	2,290	88
DC	133	1,097	12	104	996	10
DE	1,061	1,399	76	985	1,361	72
FL	17,143	23,021	74	18,734	23,630	79
GA	6,115	9,615	64	7,014	10,716	65

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR UDSMR/COS SAMPLE HOSPITALS, BY STATE—Continued

State	1996			1997		
	Total		Percent UDS/COS	Total		Percent UDS/COS
	UDS/COS	MEDPAR		UDS/COS	MEDPAR	
HI	1,087	1,087	100	1,016	1,016	100
IA	1,264	1,264	100	1,404	1,404	100
ID	1,781	1,829	97	1,773	1,807	98
IL	8,044	14,953	54	9,191	14,894	62
IN	5,330	8,943	60	5,349	8,884	60
KS	874	3,224	27	786	3,333	24
KY	3,859	5,198	74	4,083	5,201	79
LA	3,338	9,206	36	5,071	10,061	50
MA	4,532	8,765	52	5,748	8,631	67
MD	667	867	77	574	715	80
ME	130	1,255	10	1,047	1,460	72
MI	13,470	16,523	82	14,090	17,255	82
MN	1,115	2,048	54	1,554	2,112	74
MO	3,349	9,788	34	4,414	10,513	42
MS	1,701	1,968	86	1,747	2,021	86
MT	878	878	100	766	766	100
NC	6,325	7,123	89	7,752	8,771	88
ND	1,564	1,821	86	1,356	1,636	83
NE	1,094	1,195	92	1,008	1,107	91
NH	1,320	2,310	57	1,442	2,505	58
NJ	10,010	11,234	89	10,637	11,083	96
NM	364	1,283	28	452	1,277	35
NV	0	2,230	0	0	2,303	0
NY	7,905	21,431	37	11,618	22,875	51
OH	8,992	11,837	76	10,175	13,888	73
OK	3,238	6,356	51	4,100	6,949	59
OR	824	1,179	70	728	1,184	61
PA	23,437	36,989	63	24,806	35,700	69
RI	1,379	2,247	61	1,517	2,307	66
SC	3,758	4,536	83	4,200	4,878	86
SD	1,684	2,096	80	1,702	2,101	81
TN	7,574	10,731	71	8,477	11,917	71
TX	19,498	33,619	58	22,551	36,616	62
UT	369	858	43	610	984	62
VA	4,924	6,738	73	5,628	7,235	78
VT	446	603	74	412	567	73
WA	3,726	3,753	99	3,584	3,608	99
WI	5,741	6,591	87	6,201	6,690	93
WV	3,480	3,497	100	3,553	3,574	99
WY	105	334	31	283	376	75
Total	216,924	344,126	63	245,114	359,032	68

Representativeness of Patient and Stay Characteristics

Table M compares demographic characteristics of all Medicare rehabilitation patients with the matched UDSmr/COS sample. Of all the characteristics examined, the UDSmr/COS sample of discharges appears very similar.

TABLE M.—PATIENT CHARACTERISTICS FOR MEDPAR REHABILITATION INPATIENTS, BY UDSMR/COS STATUS

Patient characteristic	1996			1997		
	UDS/COS	Other MEDPAR	Total MEDPAR	UDS/COS	Other MEDPAR	Total MEDPAR
Sample Size	171,626	172,500	344,126	206,032	153,000	359,032
Average Age	75.4	75.6	75.5	75.4	75.6	75.5
Age 0–50	2.6%	2.8%	2.7%	2.8%	3.0%	2.8%
Age 51–60	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%
Age 61–70	20.1%	19.3%	19.7%	19.5%	18.9%	19.2%
Age 71–80	44.2%	42.8%	43.5%	43.9%	42.8%	43.4%
Age 81–90	26.9%	28.1%	27.5%	27.4%	28.2%	27.7%
Age 91+	3.2%	3.9%	3.5%	3.2%	4.0%	3.6%
Male	37.9%	37.3%	37.6%	38.0%	37.6%	37.8%
White	86.7%	85.8%	86.3%	86.6%	85.3%	86.1%
Black	9.8%	10.6%	10.2%	10.1%	10.9%	10.4%
In-hospital death	0.2%	0.6%	0.4%	0.3%	0.7%	0.4%

Table N compares resources used for linked UDSmr/COS stays with those for other Medicare rehabilitation patients. Average length of stay for UDSmr/COS cases is the same as for non-UDSmr/COS patients. However, for cases in free-standing hospitals, UDSmr/COS stays consume fewer resources: LOS and total charges are about 10 percent less.

TABLE N.—COMPARISON OF RESOURCE USE FOR MEDICARE REHABILITATION INPATIENTS, BY UDSMR/COS STATUS

Hospitalization characteristic	1996			1997		
	UDS/COS	Other MEDPAR	Total MEDPAR	UDS/COS	Other MEDPAR	Total MEDPAR
All hospitals:						
Sample size	171,626	172,500	344,126	206,032	153,000	359,032
Length of Stay (days)	16.20	16.20	16.20	15.70	15.70	15.70
Daily therapy charges	$360.00	$351.00	$355.00	$379.00	$368.00	$374.00
Total therapy charges	$5,960.00	$5,829.00	$5,894.00	$6,064.00	$5,924.00	$6,004.00
Total charges	$18,013.00	$18,790.00	$18,403.00	$18,348.00	$19,287.00	$18,748.00
Freestanding hospitals:						
Sample size	65,349	49,584	114,933	82,393	36,148	118,541
Length of Stay (days)	18.0	18.9	18.4	17.8	19.2	18.2
Daily therapy charges	$360.00	$387.00	$371.00	$384.00	$406.00	$391.00
Total therapy charges	$6,652.00	$7,605.00	$7,063.00	$7,002.00	$8,064.00	$7,325.00
Total charges	$19,443.00	$21,214.00	$20,207.00	$20,202.00	$22,541.00	$20,915.00

Note: UDSmr/COS case totals count matched cases, hence differ from Table J which counts matched and unmatched cases.

Appendix B: Variables Suggested for Exclusion from the MDS–PAC Instrument

During the pilot and field testings of versions 7–9 of the MDS–PAC, a number of assessors (Registered Nurses, Physical Therapists, or Occupational Therapists) were asked to rate which items on the MDS–PAC they would suggest dropping. Based on these findings, the MDS–PAC no longer includes 104 items that were originally field tested in Version 8 of the instrument. The table below describes the percentage of assessors by facility type (rehabilitation hospital or skilled nursing facility) who recommended dropping each of the MDS–PAC items displayed in the table. The table is broken down by the type of facility in which the assessor was employed. The items in the table below are the majority of the items that are now in the version of the MDS–PAC found in Appendix BB.

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
A1A	First Name	0	8.3
A1B	Middle Initial	0	8.3
A1C	Last Name	0	8.3
A1D	Jr/Sr	0	8.3
A3	Reason for Assessment	5.9	2.0
A5A	Medical Stabilization	5.8	10.0
A5B	Rehab/Functional Improvement	4.7	4.0
A5C	Recuperation	12.8	18.0
A5D	Monitor to Avoid Clinical Complication	9.2	6.0
A5E	Palliative Care	18.6	6.0
A6	Admitted from	6.5	4.8
A7A	Time of Onset of Precipitating Event	15.4	33.3
A7B	Reason Most Recent Acute Care Hospitalization	8.6	10.0
A8A	Primary Payment Source for Stay	2.3	4.0
A8B	Secondary Payment Source for Stay	5.7	8.2
A9	Marital Status	4.7	4.2
AA10	Gender	0	2.0
AA11	Birthdate	0	8.3
AA12A	American Indian/Alaskan Native	12.0	16.7
AA12B	Asian	12.0	16.7
AA12C	Black or African-American	12.0	16.7
AA12D	Native Hawaiian or Other Pacific Islander	12.0	16.7
AA12E	White	12.0	16.7
AA12F	Hispanic or Latino	15.4	16.7
AA13	Date of Reentry	12.9	14.3
A10	Education	10.3	6.0
A11A	Primary Language	1.2	2.0
A11B	Other Language	2.4	2.0
A12	Dominant Hand	9.2	50.0
A13	Mental Health History	12.3	4.9
A14	Conditions Related to MR/DD Status	12.5	25.0
A15A	Legal Guardian	7.5	5.0
A15B	Other Legal Oversight	7.5	5.0
A15C	Durable Power of Attorney/Health	7.5	5.0
A15D	Patient Responsible for Self	7.5	5.0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
A16A	Living Will	11.5	2.0
A16B	Do Not Resuscitate	13.8	0
A16C	Do Not Hospitalize	16.1	4.1
A16D	Other Treatment Restrictions	13.8	2.0
A16E	None of the above	12.6	2.0
AA2A	Date of Entry	3.1	0
AA4	Assessment Reference Date	0	0
AA6A	Social Security #	3.4	0
AA6B	Medicare #	0	0
AA7	Medical Record &num	2.3	0
AA8A	State #	6.9	2.0
AA8B	Federal #	4.7	0
AA9	Medicaid #	1.2	0
B1	Comatose	14.8	0
B2A	Short-term Memory Ok	0	2.0
B2B	Long-term Memory Ok	0	2.0
B2C	Situational Memory Ok	8.2	0
B2D	Procedural Memory Ok	5.9	0
B3A	Decisions Regarding Tasks of Daily Life	2.3	0
B3B	Status Compared to 30 Days Ago	6.9	24.5
B4A	Easily Distracted	5.7	0
B4B	Periods of Altered Perception	5.7	2.0
B4C	Episodes of Disorganized Speech	5.7	4.1
B4D	Periods of Restlessness	5.7	2.0
B4E	Periods of Lethargy	6.1	0
B4F	Mental Function Varies over Course of Day	7.4	0
C1	Hearing	3.4	0
C2A	Hearing Aid	4.5	0
C2B	Lip Reading	4.9	0
C2C	Signs/Gestures/Jokes	5.7	0
C2D	Message to Express Needs	4.5	0
C2E	None of the Above	4.5	0
C3A	Expressing Information Content	1.1	22.4
C3B	Status Compared to 30 Days Ago	8.0	2.0
C2	Speech Clarity	0	0
C5A	Verbal Content	0	0
C5B	Status Compared to 30 Days Ago	7.0	22.4
C6A	See in Adequate Light W/Glasses	1.2	0
C6B	More Impaired in Vision	7.4	22.5
D1A	Patient Made Negative Statements	3.8	0
D1B	Persistent Anger W/Self or Others	3.8	0
D1C	Expressions of Unrealistic Fears	11.5	0
D1D	Repetitive Anxious Complaints	7.7	0
D1E	Repetitive Health Complaints	11.5	0
D1F	Sad, Pained, Facial Expressions	7.7	0
D1G	Crying, Tearfulness	3.8	0
D1H	Repetitive Physical Movements	11.5	0
D1IS	Insomnia/change in Sleep Patterns	3.8	0
D1J	W/draw from Activities of Interest	11.5	0
D1K	Reduced Social Interaction	7.7	0
D2	Mood Persistence	4.8	5.0
D3A	Wandering—Freq	3.4	0
D3B	Verbal Abuse Behavior—Freq	4.6	0
D3C	Physical Abuse Behavior—Freq	3.4	2.1
D3D	Social Inappropriate Behavior—Freq	3.4	2.1
D3E	Resists Care—Freq	3.4	0
E10AA	Leg—Joint	4.7	4.2
E10AB	Voluntary Motor Control Leg	5.1	2.6
E10AC	Intact Touch Leg	7.6	10.3
E10BA	Arm-Joint	4.7	4.2
E10BB	Voluntary Motor Control Arm	5.1	2.6
E10BC	Intact Touch Arm	7.6	10.3
E10CA	Trunk & Neck—Joint	7.0	4.2
E10CB	Vol. Motor Control—Trunk & Arm	7.6	2.6
E10CC	Intact Touch Trunk & Arm	8.9	10.3
E1A	Bed Mobility—3 Days	2.4	0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
E1B	Transfer Bed/Chair—3 Days	2.4	2.0
E1C	Locomotion—3 Days	2.4	2.0
E1D	Walk in Corridor—3 Days	4.7	4.1
E1E	Dressing Upper Body—3 Days	2.4	0
E1F	Dressing Lower Body—3 Days	2.4	0
E1G	Eating—3 Days	2.4	0
E1H	Toilet Use—3 Days	2.4	0
E1I	Transfer Toilet—3 Days	2.3	4.1
E1J	Personal Hygiene—3 Days	2.3	0
E1K	Bathing—3 Days	2.4	0
E1L	Transfer Tub/shower—3 Days	4.7	4.1
E3	ADL Areas Now More Impaired	4.0	16.7
E4A	Meal Preparation—Now	4.5	23.4
E4C	Phone Use—Now	10.2	25.5
E4D	Medication Management—Now	4.5	31.9
E4E	Stairs—Now	4.5	23.4
E4F	Car Transfer—Now	5.7	23.4
E5	IADL Areas Now More Impaired	3.8	16.7
E6A	Cane/Crutch	0	0
E6B	Walker	2.3	0
E6C	Wheeled—Not Motorized	2.5	0
E6D	Adaptive Eating Utensil	0	9.1
E6E	Mechanical Lift	3.4	2.2
E6F	Orthotics/Prosthesis	0	18.2
E6G	Postural Support	3.4	2.2
E6H	Slide Board	3.4	2.2
E6I	Other Adaptive Device	2.3	2.2
E6J	None of Above	2.5	2.7
E7A	Hours of Physical Activity—past 24 Hrs	6.5	45.0
E7B	Hours of Physical Activity—30 Days Ago	29.4	50.0
E8A	Distance Walk W/o Sit Down—Consistently	4.6	6.3
E8B	Walking Support Provided	11.1	25.6
E9A	Moved from Seated to Standing	8.0	2.1
E9B	Turned Around Face Opposite Direction	14.8	8.3
F1A	Control of Urinary Bladder	0	0
F1B	Continence Compared to 30 Days Ago	4.5	22.4
F2A	External Catheter	1.1	0
F2B	Indwelling Catheter	2.3	4.1
F2C	Intermittent Cath	2.5	0
F2F	Pads, Briefs	3.7	0
F4	Bowel Continence	1.1	2.0
F5	Bowel Appliances	2.5	0
G2A	Diabetes Mellitus	0	8.3
G2AA	A Multiple Sclerosis	0	8.3
G2AB	Parkinson's Disease	0	8.3
G2AC	Quadriplegia	0	8.3
G2AD	Seizure Disorder	0	8.3
G2AE	Spinal Cord Dysfunction—Nontraumatic	0	8.3
G2AF	Spinal Cord Dysfunction—Traumatic	0	8.3
G2AG	Stroke	0	8.3
G2AH	Anxiety Disorder	0	8.3
G2AI	Depression	0	8.3
G2AJ	Other Psychiatric Disorder	0	8.3
G2AK	Asthma	0	8.3
G2AL	COPD	0	8.3
G2AM	Emphysema	0	8.3
G2AN	Cancer	4.2	8.3
G2AO	Post Surgery—Non Orthopedic	4.2	8.3
G2AP	Renal Failure	0	8.3
G2AQ	None of Above	0	8.3
G2B	Hypothyroidism	0	8.3
G2C	Cardiac Arrhythmias	0	8.3
G2D	Congestive Heart Failure	0	8.3
G2E	Coronary Artery Disease	0	8.3
G2F	Deep Vein Thrombosis	0	8.3
G2G	Hypertension	0	8.3

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
G2H	Hypotension	0	8.3
G2I	Peripheral Vascular Disease	0	8.3
G2J	Post Acute MI	0	8.3
G2K	Post Heart Surgery	0	8.3
G2L	Pulmonary Embolism	0	8.3
G2M	Pulmonary Failure	0	8.3
G2N	Other Cardiovascular Disease	0	8.3
G2O	Fracture—Hip	0	8.3
G2P	Fracture—Lower Extremity	0	8.3
G2Q	Fracture(s)—Other	0	8.3
G2R	Osteoarthritis	0	8.3
G2S	Osteoporosis	0	8.3
G2T	Rheumatoid Arthritis	0	8.3
G2U	Alzheimer's Disease	0	8.3
G2V	Aphasia or Apraxia	0	8.3
G2W	Cerebral Palsy	0	8.3
G2X	Dementia Other than Alzheimer's	0	8.3
G2Y	Hemiplegia/Hemiparesis	0	8.3
G3A	Antibiotic Resistant Infection	0	2.0
G3B	Cellulitis	0	2.5
G3C	Hepatitis	1.2	2.0
G3D	HIV/AIDS	1.2	2.0
G3E	Pneumonia	0	2.0
G3F	Osteomyelitis	0	2.0
G3G	Septicemia	1.2	2.0
G3H	Staphylococcus Infection	1.2	4.1
G3I	Tuberculosis (Active)	1.2	2.0
G3J	Urinary Tract Infection	0	2.0
G3K	Wound Infection	0	2.0
G3L	None of Above	0	2.0
G4AA	ICD–9–CM Diagnosis Code #1	10.8	4.2
G4AB	ICD–9–CM Code #1	8.4	4.2
G4BA	ICD–9–CM Diagnosis Code #2	10.8	4.2
G4BB	ICD–9–CM Code #2	8.4	4.2
G4CA	ICD–9–CM Diagnosis Code #3	11.0	4.2
G4CB	ICD–9–CM Code #3	8.5	4.2
G4DA	ICD–9–CM Diagnosis Code #4	11.0	4.2
G4DB	ICD–9–CM Code #4	8.5	4.2
G4EA	ICD–9–CM Diagnosis Code #5	12.2	4.2
G4EB	ICD–9–CM Code #5	9.8	4.2
H1	Vital Signs	4.6	12.5
H2A	Dizziness/Vertigo/Lightheaded	1.1	0
H2B	Fell in past 7 Days	1.1	4.1
H2C	Fell in past 8 to 180 Days	7.7	0
H3D	Advanced Cardiac Failure	9.1	10.2
H2E	Chest Pain/Pressure on Exertion	1.1	2.0
H2F	Chest Pain/Pressure at Rest	1.1	2.0
H2G	Edema—Generalized	1.1	2.0
H2H	Edema—Localized	2.3	2.0
H2I	Edema—pitting	3.4	2.1
H2J	Impaired Aerobic Capacity	3.4	2.0
H2K	Constipation	1.1	0
H2L	Dehydrated	3.4	0
H2M	Diarrhea	1.1	0
H2N	Internal Bleeding	3.8	0
H2O	Recurrent Nausea/Vomiting	2.3	0
H2P	Refuse/Inability to Take Liquids Orally	6.8	0
H2R	Fever	4.5	0
H2S	Hemi-neglect	4.5	0
H2T	Cachexia (Severe Malnutrition)	6.8	0
H2U	Morbid Obesity	3.4	0
H2V	End-stage Disease	4.5	0
H2W	None of Above	0	0
H3A	Inability to Lie Flat—Loss of Breath	2.3	0
H3B	Shortness of Breath—Exertion	3.4	0
H3C	Shortness of Breath—Rest	3.4	0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
H3D	Oxygen Saturation	3.4	2.0
H3E	Diff Cough/clearing Airway	3.4	0
H3F	Recurrent Aspiration	2.3	0
H3G	Recurrent Aspiration Infection	4.9	0
H3H	None of Above	3.5	0
H4A	Highest Pressure Ulcer Stage	2.3	0
H4B	# of Current Pressure Ulcers	2.4	0
H4C	Length Multiplied by Width	4.7	12.2
H4D	Exudate Amount	4.7	12.2
H4E	Predominant Tissue	4.7	12.2
H4F	Total Push Score	4.7	10.4
H5A	# of Stasis Ulcers	3.4	0
H5B	# of Surgical Wounds	3.4	0
H5C	Ulcer Resolved/Healed	8.4	6.1
H6A	Burns	2.3	2.0
H6B	Open Lesions Excluding Foot	2.3	0
H6C	Rashes	1.1	0
H6D	Skin Tears or Cuts	1.1	0
H6E	None of Above	1.1	0
I1A	Freq Patient Complains of Pain	0	0
I1B	Intensity of Pain	0	0
I1C	Current Pain Status	7.3	26.8
J1A	Chewing Problem	1.2	0
J1B	Dental Problems	1.2	0
J2	Swallowing	1.2	0
J3A	Height in Inches	5.8	0
J3B	Weight in Pounds	7.0	0
J4A	Weight Loss	8.1	4.2
J4B	Weight Gain	8.2	4.2
J5A	Total Calories	3.5	0
J5B	Fluid Intake	4.6	0
K1A	Total # Physician Visits	21.6	22.4
K1B	# Times Phys/nurse Practitioner Called to Bedside	17.2	40.0
K1C	# Nurse Practitioner Visits	20.7	27.1
K1D	# Phys Asst Visits	20.7	29.2
K1E	# New or Changed Orders	14.9	22.4
K2AA	Diabetic Management	3.5	8.3
K2AB	At Dis—insulin Management	7.7	33.3
K2BA	Injections	7.7	8.3
K2BB	Injections at Discharge	8.3	20.0
K2CA	IV Antibiotics/meds	7.7	8.3
K2CB	At Dis—Iv Antibiotics/meds	7.7	33.3
K2DA	Application of Dressings	7.7	8.3
K2DB	Application of Dressings at Dis.	8.3	20.0
K2EA	Application of Ointments	7.7	8.3
K2EB	At Dis—Application of Ointments	7.7	33.3
K2GA	Nutrition/dehydration Intervention	7.7	8.3
K2GB	At Dis—nutrition/hydration Intervention	7.7	33.3
K2HA	Pressure Relieving Bed/Chair	3.8	8.3
K2HB	At Dis—Pressure Relieving Bed/Chair	7.7	33.3
K2IA	Turning and Repositioning	3.8	8.3
K2IB	At Dis—Turning and Repositioning	7.7	33.3
K2JA	Ulcer Care	7.7	8.3
K2JB	At Discharge—Ulcer Care	7.7	33.3
K2KA	Wound Care—Surgical	7.7	8.3
K2KB	At Dis—Wound Care Surgical	7.7	33.3
K2LA	Bladder Training	3.8	8.3
K2LB	At Dis—Bladder Training	8.3	20.0
K2MA	Scheduled Toileting	3.8	8.3
K2MB	At Dis—Scheduled Toileting	8.3	20.0
K2NA	Bowel Program	3.8	8.3
K2NB	At Dis—Bowel Program	8.3	20.0
K2OA	Cardiac Monitoring/Rehab	11.5	8.3
K2OB	At Dis—Cardiac Monitoring	7.7	33.3
K2PA	Cast(s)	11.5	8.3
K2PB	At Dis—Cast(s)	7.7	33.3

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
K2QA	Continuous Positive Airway Pressure	11.5	8.3
K2QB	At Dis—Continuous Positive Airway Pressure	9.0	33.3
K2RA	Drains	3.8	0
K2RB	At Dis—Drains	7.7	31.7
K2SA	Dialysis	0	0
K2SB	At Dis—Dialysis	4.2	16.7
K2TA	Enteral Tube Feeding	0	0
K2TB	At Dis—Enteral Tube Feeding	6.5	31.7
K2UA	IV Line—Central	3.8	0
K2UB	At Dis—Central Iv Line	7.7	31.7
K2VA	IV Line—Peripheral	3.8	0
K2VB	At Dis—Peripheral Iv Line	7.7	31.7
K2WA	Ng Feeding Tube	0	0
K2WB	At Dis—NG Feeding Tube	6.4	31.7
K2XA	Oxygen	0	0
K2XB	At Dis—Oxygen	6.4	31.7
K2YA	Pain Management—Other than Drugs	7.7	0
K2YB	At Dis—Pain Management	7.7	31.7
K2ZA	Suctioning—Oral	0	0
K2ZB	At Dis—Suctioning—Oral	7.7	31.7
K2AAA	Suctioning—Tracheal	0	0
K2AAB	At Dis—Suctioning Tracheal	7.7	31.7
K2ABA	Tracheostomy Care	0	0
K2ABB	At Dis—Tracheostomy Care	6.4	31.7
K2ACA	Transfusion(s)	7.7	0
K2ACB	At Dis—Transfusion(s)	7.7	31.7
K2ADA	Ventilator or Respirator	7.7	0
K2ADB	At Dis—Vent. Or Resp.	9.0	31.7
K2AEA	Ventilator Weaning	7.7	0
K2AEB	At Dis—Ventilator Weaning	9.0	31.7
K2AFA	Train Family to Assist Patient	3.8	0
K2AFB	At Dis-Train Family to Assist Patient	6.4	31.7
K2AGA	Training in Health Maint	3.8	0
K2AGB	At Dis—Pat Train Skills Required after Discharge	6.4	31.7
K2AHA	Design and Implementation	3.8	0
K2AHB	At Dis—Social Service Design	7.7	31.7
K3AIA	None of Above	0	0
K3AIB	At Dis—None of Above	7.7	31.7
K3A	Range of Motion—Passive	4.5	8.2
K3B	Range of Motion—Active	4.5	8.2
K3C	Splint/Orthotic Assistance	4.5	8.2
K3D	Bed Mobility	4.5	8.2
K3E	Bladder/Bowel	3.4	8.2
K3F	Transfer	4.5	8.2
K3G	Walking	4.5	8.2
K3H	Dressing or Grooming	3.4	8.2
K3I	Eating or Swallowing	3.4	8.2
K3K	Communication	3.4	8.2
K4AA	Speech—Days Ordered	16.0	26.2
K4AB	Speech—Days Delivered	2.4	4.8
K4AC	Speech—Min Delivered	3.7	2.4
K4AD	Post Dis—Speech	4.0	18.0
K4BA	Ot—Days Ordered	17.3	26.2
K4BB	Ot—Days Delivered	2.4	4.8
K4BC	Ot—Min Delivered	2.5	2.4
K4BD	Post Dis—Ot	5.3	18.2
K4CA	Pt—Days Ordered	17.3	26.2
K4CB	Pt—Days Delivered	1.2	4.8
K4CC	Pt—Min Delivered	3.7	2.4
K4CD	Pt—Post Dis—Pt	5.3	18.2
K4DA	Resp. Therapy—Days Ordered	16.0	26.2
K4DB	Resp. Therapy—Days Delievered	2.4	4.8
K4DC	Resp. Therapy—Min. Delivered	3.7	2.4
K4DD	Post Dis—Resp.Therapy	4.0	18.2
K4EA	Psych Therapy—Days Ordered	18.5	26.2
K4EB	Psych Therapy—Days Delivered	3.7	4.8

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
K4EC	Psych Therapy—Min Delivered	3.7	2.4
K4ED	Post Dis—Psych Therapy	6.7	18.2
K4FA	Therapeutic Recreation—Days Ordered	18.7	24.2
K3FB	Therapeutic Recreation—Days Delivered	1.3	3.0
K3FC	Therapeutic Recreation—Min Delivered	5.3	0
K3FD	Post Dis—Therapeutic Recreation	6.7	18.2
K5A	Full Bed Rails on Both Sides	5.1	0
K5B	Other Types of Side Rails Used	6.4	4.9
K5C	Trunk Restraint	6.4	0
K5D	Chair Prevents Rising	7.7	2.4
L1A	Bed Mobility/Transfer	6.9	10.2
L1B	Dressing	6.9	10.2
L1C	Eating	6.9	10.2
L1D	Locomotion	6.9	10.2
L1F	Medication Managment	6.8	14.3
L1G	Pain Management	6.8	10.2
L2A	Believe Is Capable of Incr Indep.	5.7	10.4
L2B	Unable to Recognize New Limits	8.0	10.4
L2C	Fails to Initiate/Continue Adls	9.2	10.4
L3A	Functional Status—Last 3 Days	9.2	12.2
L3B	Health Status—Last 3 Days	9.3	12.2
L4	Estimated Length of Stay	2.3	6.0
M1A	Emotional Support	0	8.3
M1B	Intermit Phys Support—less than Daily	0	8.3
M1C	Intermit Phys Support—Daily	0	8.3
M1D	Full Time Physical Support	0	8.3
M1E	All or Most of Nec Transportation	0	9.1
M2A	Family Overwhelmed by Pat. Illness	4.2	16.7
M2B	Family Relationship Require Great Deal of Staff Time	4.2	8.3
M3AA	Type of Residence—Pre	2.3	10.2
M3AB	Type of Residence—Discharge	0	10.0
M3AC	Temp. Type of Residence	5.0	12.5
M3BA	Lived With—Pre	2.5	10.6
M3BB	Live With—Disch	0	10.4
M3BC	Temp Live(d) With	5.3	13.2
N1C	Date Assessment Coord Signed	0	0

BILLING CODE 4120–03–P

APPENDIX BB Patient_____Numeric Identifier_____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
INTERRUPTED STAY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	**LEGAL NAME OF PATIENT**	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	**ADMISSION DATE**	a. *Date the stay began (date of initial admission)* Month Day Year b. *Date Medicare covered Part A stay began — If different than* ***AA2a*** Month Day Year
6.	**SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]**	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
7.	**MEDICAL RECORD NO.**	
8.	**FACILITY PROVIDER NO.**	a. State No. b. Federal No.
9.	**MEDICAID NO.**	***["+" if pending, "N" if not a Medicaid recipient]***
10.	**GENDER**	1. Male 2. Female
11.	**BIRTHDATE**	Month Day Year
12.	**ETHNICITY/ RACE**	(***CHECK all that apply***) ***ETHNICITY*** Hispanic or Latino ***RACE*** American Indian/Alaskan Native a. Asian b. Black or African American c. Native Hawaiian or other Pacific Islander d. White
13.	**INTERRUPTED STAY**	a. *Date/time departed from the rehabilitation unit/hospital* Month Day Year Hours Minutes AM/PM b. *Date/time returned to the rehabilitation unit/hospital* Month Day Year Hours Minutes AM/PM
14.	**CLINICIAN COMPLETING ASSESSMENT**	a. **SIGNATURE OF CLINICIAN ATTESTING TO THE ACCURACY OF THE DATES THE PATIENT DEPARTED FROM AND RETURNED TO THE REHABILITATION UNIT/HOSPITAL** Printed Name b. (First) c. (Middle Initial) d. (Last) e. (Suffix) f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist

APPENDIX BB Patient_____Numeric Identifier_____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*

• Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	LEGAL NAME OF PATIENT	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	ADMISSION DATE	a. *Date the stay began (date of initial admission)* Month — Day — Year b. *Date Medicare covered Part A stay began — If different than **AA2a*** Month — Day — Year
3.	REASON FOR ASSESSMENT	1. Admission (covers first 3 days, completed on day 4) 2. Reassessment completed on day 11 3. Reassessment completed on day 30 4. Reassessment completed on day 60 5. Discharge assessment completed day 5 after discharge
4.	ASSESSMENT REFERENCE DATE	*Assessment reference date—last day of the 3-day MDS-PAC observation period* Month — Day — Year
5.	DISCHARGE STATUS	a. *Last day of stay* Month — Day — Year b. *If discharged, status at discharge* 0. Rehabilitation program complete for this stay and return not anticipated 1. Patient left, against medical advice, prior to completion of plan of care 2. Acute problem, discharge to acute hospital 3. Patient died
6.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]	a. Social Security Number — — b. Medicare number (or comparable railroad insurance number)
7.	MEDICAL RECORD NO.	
8.	FACILITY PROVIDER NO.	a. State No. b. Federal No.
9.	MEDICAID NO.	*["+" if pending, "N" if not a Medicaid recipient]*
10.	GENDER	1. Male 2. Female
11.	BIRTHDATE	Month — Day — Year
12.	ETHNICITY/ RACE	(*CHECK all that apply*) ***ETHNICITY*** Hispanic or Latino (a.) ***RACE*** American Indian/Alaskan Native (b.) Asian (c.) Black or African American (d.) Native Hawaiian or other Pacific Islander (e.) White (f.)

SECTION AB. ASSESSMENT ATTESTATION

1.	PERSON COMPLETING ASSESSMENT	a. SIGNATURE OF CLINICIAN ATTESTING TO COMPLETION OF ASSESSMENT: Printed Name b. (First) c. (Middle Initial) d. (Last) e. (Suffix) f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist g. Date MDS-PAC signed as complete Month — Day — Year

2a. Signatures of staff completing part of the assessment	Credentials	Sections	Date
b.			Date
c.			Date
d.			Date
e.			Date
f.			Date

APPENDIX BB Patient _____ Numeric Identifier _____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
FULL ASSESSMENT FORM (ASSESSMENT, REASSESSMENT, DISCHARGE)

SECTION A. DEMOGRAPHIC/ADMISSION INFORMATION HISTORY

- **Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated**

1.	LEGAL NAME OF PATIENT	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	ADMISSION DATE	a. *Date the stay began (date of initial admission)* Month — Day — Year b. *Date Medicare covered Part A stay began — If different than* ***A2a*** Month — Day — Year
3.	REASON FOR ASSESSMENT	1. Admission (covers first 3 days, completed on day 4) 2. Reassessment completed on day 11 3. Reassessment completed on day 30 4. Reassessment completed on day 60 5. Discharge assessment completed day 5 after discharge
4.	ADMISSION STATUS	0. First admission to inpatient rehabilitation services 1. Readmission to rehabilitation but not directly from other rehabilitation 2. Readmission directly from other rehabilitation
5.	GOALS FOR STAY	***CODE indicate all that apply:*** 0. No 1. Yes a. Medical stabilization b. Rehabilitation/Functional improvement c. Recuperation d. Monitoring to avoid clinical complication e. Palliative care
6.	ADMITTED FROM (At date of admission—A2)	1. Private home 2. Private apartment 3. Rented room 4. Board and care/group home 5. Assisted living 6. Homeless shelter 7. Transitional living 8. Long term care facility (nursing home) 9. Post acute care SNF 10. Acute care hospital—not rehabilitation unit 11. Rehabilitation unit (in acute hospital) 12. Rehabilitation hospital 13. Long term care hospital 14. Psychiatric hospital/unit 15. MR/DD facility (exclude group home) 16. Other hospital 17. Outpatient surgery center 18. Other
7.	PRECIPITATING EVENT PRIOR TO ADMISSION	a. ***Time of the onset of the precipitating event/problem*** *that directly preceded admission into this facility (time from date of admission—**item A2**)* 0. Within last week 1. Within last 8 to 14 days 2. 15 to 30 days ago 3. 31 to 60 days ago 4. More than 60 days ago b. *Date of admission of most recent acute hospitalization (**within last 90 days**)* Month — Day — Year c. *Reason for most recent acute care hospitalization (**within last 90 days**)* 0. Not hospitalized at any time in **last 90 days** 1. New problem 2. Exacerbation 3. Both
8.	PRIMARY AND SECONDARY PAYMENT SOURCE FOR STAY	0. None - No insurance coverage, no private pay 1. Medicare 2. Medicaid 3. CHAMPUS 4. Department of Veterans Affairs 5. Managed care/HMO—Medicare 6. Managed care/HMO—non-Medicare 7. Private insurance 8. Private pay—self or family 9. Workers' compensation 10. Other payment A Prim B Sec
9.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
10.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9th-11th grade 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
11.	LANGUAGE	a. *Primary Language* 0. English 1. Spanish 2. French 3. Other, specify in **A11b** b. ***If other, specify***
12.	DOMINANT HAND	1. Right 2. Left 3. Unable to determine
13.	MENTAL HEALTH HISTORY	*Patient's RECORD indicates history of mental retardation, mental illness, or developmental disability problem* 0. No 1. Yes
14.	CONDITIONS RELATED TO MR/DD STATUS	1. Not applicable—no MR/DD 2. MR/DD with no organic condition 3. MR/DD with organic condition
15.	RESPONSIBILITY/ LEGAL GUARDIAN	(***CHECK all that apply***) Legal guardian [a.] Other legal oversight [b.] Durable power of attorney/health care proxy [c.] Patient responsible for self [d.] *NONE OF ABOVE* [e.]
16.	ADVANCE DIRECTIVES	(***CHECK all that apply*** *that have supporting* ***documentation***) Living will [a.] Do not resuscitate [b.] Do not hospitalize [c.] Treatment restrictions [d.] *NONE OF ABOVE* [e.]

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*Persistent vegetative state/no discernible consciousness* 0. No 1. Yes (**IF YES, SKIP TO SECTION E**)
2.	MEMORY/ RECALL ABILITY (Over last 3 days)	(***CODE for recall of what was learned or known***) 0. Memory OK 1. Memory problem a. Short-term memory OK—Seems/appears to recall after 5 minutes b. Long-term memory OK—Seems/appears to recall long past c. Situational memory OK—**Both**: recognizes staff names/faces frequently encountered **AND** knows location of places regularly visited (bedroom, dining room, activity room, therapy room) d. Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation
3.	COGNITIVE SKILLS FOR DAILY DECISION MAKING (Over last 3 days)	a. *Making decisions regarding tasks of daily life* 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times* 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions b. ***Is now more impaired*** *in decision making than prior to precipitating event (item **A7a**)* 0. No or unsure 1. Yes, more impaired today
4.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (Over last 7 days)	(***CODE for behavior in the last 7 days.***) [***Note: Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time***]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from patient's usual functioning (e.g., new onset or worsening) a. **EASILY DISTRACTED**—(e.g., difficulty paying attention; gets sidetracked) b. **PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS**—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. **EPISODES OF DISORGANIZED SPEECH**—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. **PERIODS OF RESTLESSNESS**—(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out) e. **PERIODS OF LETHARGY**—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. **MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY**—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

SECTION C. COMMUNICATION/VISION PATTERNS (Over last 3 days)

1.	HEARING	*With hearing appliance, if used* 0. *HEARS ADEQUATELY*—No difficulty in normal conversation, social interaction, TV, phone 1. *MINIMAL DIFFICULTY*—Requires quiet setting to hear well 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to increase volume and speak distinctly 3. *HIGHLY IMPAIRED*—Absence of useful hearing
2.	MODES OF COMMUNICATION	(***CHECK all used by patient to make needs known***) Hearing aid [a.] Lip reading [b.] Signs/gestures/sounds [c.] Writing messages to express or clarify needs [d.] *NONE OF ABOVE* [e.]
3.	MAKING SELF UNDERSTOOD (Expression)	a. *Expressing information content—however able* 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts *BUT* if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to concrete requests 4. *RARELY/NEVER UNDERSTOOD* b. ***Is now more impaired*** *in making self understood by others than was prior to precipitating event (item **A7a**)* 0. No or unsure 1. Yes, more impaired today

APPENDIX BB Patient_____ Numeric Identifier_____

4.	SPEECH CLARITY	0. *CLEAR SPEECH*—Distinct, intelligible words 1. *UNCLEAR SPEECH*—Slurred, mumbled words 2. *NO SPEECH*—Absence of spoken words	
5.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	**a.** *Understanding verbal information content (however able) with hearing appliance, if used* 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message *BUT* comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message, with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication only 4. *RARELY/NEVER UNDERSTANDS* **b.** *Is* ***now more impaired*** *in understanding others than was prior to precipitating event (item* ***A7a****)* 0. No or unsure 1. Yes, more impaired today	
6.	VISION	**a.** *Ability to see in adequate light and with glasses, if used* 0. *ADEQUATE*—Sees fine detail, including regular print, in newspaper/books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision, eyes do not appear to follow objects BUT may report seeing light or colors only **b.** *Is* ***now more impaired*** *in vision than was prior to precipitating event (item* ***A7a****)* 0. No or unsure 1. Yes, more impaired today	

SECTION D. MOOD AND BEHAVIOR PATTERN

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (Over last 3 days)	(***CODE for indicators observed in last 3 days, irrespective of the assumed cause***) 0. Indicator not exhibited in last 3 days 2. Exhibited on each of last 3 days 1. Exhibited on 1-2 of last 3 days	
		VERBAL EXPRESSIONS OF DISTRESS **a. PATIENT MADE NEGATIVE STATEMENTS**—(e.g., "*Nothing matters; Would rather be dead than live this way; What's the use; Let me die*") **b. PERSISTENT ANGER WITH SELF OR OTHERS**—(e.g., easily annoyed, anger at presence in post acute care, anger at care received) **c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS**—(e.g., fear of being abandoned, left alone, being with others, afraid of nighttime) **d. REPETITIVE ANXIOUS COMPLAINTS/CONCERNS** (non-health related)—(e.g., persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit) **e. REPETITIVE HEALTH COMPLAINTS**—(e.g., persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs) ***SAD, APATHETIC, ANXIOUS APPEARANCE*** **f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS**—(e.g., furrowed brows) **g. CRYING, TEARFULNESS** **h. REPETITIVE PHYSICAL MOVEMENTS**—(e.g., pacing, hand wringing, restlessness, fidgeting, picking) ***SLEEP CYCLE ISSUES*** **i. INSOMNIA/CHANGE IN USUAL SLEEP PATTERNS** ***LOSS OF INTEREST*** **j. WITHDRAWAL FROM ACTIVITIES OF INTEREST**—(e.g., no interest in long standing activities or being with family/friends) **k. REDUCED SOCIAL INTERACTION**—(e.g., less talkative, more isolated)	
2.	MOOD PERSISTENCE (Over last 3 days)	***One or more indicators*** *of depressed, sad or anxious mood* ***were not easily altered by attempts to "cheer up," console, or reassure the patient over last 3 days*** 0. No mood indicators or always easily altered 1. Partially altered or easily altered on only some occasions 2. All aspects of mood not easily altered	
3.	BEHAVIORAL SYMPTOMS (Over last 3 days)	(***CODE*** *for behavioral symptom* ***frequency over the last 3 days***) 0. Behavior not exhibited in last 3 days 1. Behavior of this type occurred on 1 day 2. Behavior of this type occurred on 2 days 3. Behavior of this type occurred daily	
		a. WANDERING—Moved (locomotion) with no rational purpose, seemingly oblivious to needs or safety	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were threatened, screamed at, cursed at	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were hit, shoved, scratched, sexually abused	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS—Made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings	
		e. RESISTS CARE—Resisted taking medications/injections, ADL assistance, eating, or changes in position	

SECTION E. FUNCTIONAL STATUS

1.	**3 DAY ADL SELF-PERFORMANCE**—(***CODE for Performance Over All Shifts, for All Episodes, OVER LAST 3 DAYS***) [NOTE - for *Bathing and Tub Transfer*, code for most dependent single episode in this period] 0. *INDEPENDENT*—No help, setup, or supervision —OR— Help, setup, or supervision provided only 1 or 2 times during period (with any task or subtask) 1. *SETUP HELP ONLY*—Article or device provided or placed within reach of patient 3 or more times 2. *SUPERVISION*—Oversight, encouragement or cuing provided 3 or more times during period —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision) 3. *MINIMAL ASSISTANCE* (*LIMITED ASSISTANCE*)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. *MODERATE ASSISTANCE* (*EXTENSIVE ASSISTANCE*)—Patient performed part of activity on own (50% or more of subtasks) *BUT* help of following type(s) provided 3 or more times: — Weight-bearing support (e.g., holding weight of limb, trunk) — Full staff performance of a task (some of time) or discrete subtask 5. *MAXIMAL ASSISTANCE*—Patient involved but completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. *TOTAL ASSISTANCE* (*TOTAL DEPENDENCE*)—Full staff performance of activity during entire period 8. *ACTIVITY DID NOT OCCUR*—During entire period	
		a. BED MOBILITY—How patient moves to and from lying position, turns side to side, and positions body while in bed	
		b. TRANSFER BED/CHAIR—How patient moves between surfaces—to or from: bed, chair, wheelchair, standing position (**EXCLUDE** to/from bath/toilet)	
		c. LOCOMOTION—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how moves once in wheelchair	
		d. WALK IN FACILITY—How patient walks in room, corridor, or other place in facility	
		e. DRESSING UPPER BODY—How patient dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
		f. DRESSING LOWER BODY—How patient dresses and undresses (**street clothes, underwear**) from the waist down, includes protheses, orthotics, belts, pants, skirts, shoes, and fasteners	
		g. EATING—How patient eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
		h. TOILET USE—How patient uses the toilet room (or commode, bedpan, urinal); cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (**EXCLUDE** transfer toilet)	
		i. TRANSFER TOILET—How patient moves on and off toilet or commode	
		j. GROOMING/PERSONAL HYGIENE—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**EXCLUDE** baths and showers)	
		k. BATHING—How patient takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair and TRANSFER). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode***	
		l. TRANSFER TUB/SHOWER—How patient transfers in/out of tub/shower ***Code for most dependent episode***	
2.	ADL ASSIST CODES (Code for most help in last 3 days)	0. Neither code applies 2. 2+ person physical assist 1. Weight bearing support with 1 limb **a.** Bed mobility **b.** Transfer bed/chair **c.** Locomotion **d.** Walk in facility **e.** Dressing upper body **f.** Dressing lower body **g.** Eating **h.** Toilet use **i.** Transfer **j.** Grooming/personal hygiene **k.** Bathing **l.** Transfer tub/shower	
3.	ADL CHANGES	**a.** ***NUMBER*** *of ADL areas (from* ***E1*** *above) in which patient is now more limited in self performance than was prior to precipitating event (item* ***A7a****)* **b.** ***NUMBER*** *of ADL areas (from* ***E1*** *above) in which patient was independent prior to precipitating event (item* ***A7a****)*	

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4. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (In last 24 hours of 3-day assessment period)

CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—if the patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you consider the patient's capacity (ability) would have been to perform the activity

0. *INDEPENDENT*—Would have required no help, setup, or supervision
1. *SETUP HELP ONLY*—Would have only needed article/device placed within reach; patient could have performed on own
2. *SUPERVISION*—Would have required oversight, encouragement, or cuing
3. *LIMITED ASSISTANCE*—On some occasion(s) could have done on own, other times would have required help
4. *MODERATE ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own
5. *MAXIMAL ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of subtask on own
6. *TOTAL DEPENDENCE*—Full performance by other of activity would have been required at all times (no residual capacity exists)

a. **MEAL PREPARATION**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)

b. **MANAGING FINANCES**—Paying for newspaper or TV service, using cafeteria

c. **PHONE USE**—How telephone calls are made or received (using assistive devices such as large numbers or voice amplification as needed)

d. **MEDICATION MANAGEMENT**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments)

e. **STAIRS**—How moves up and down stairs (e.g., one flight of steps, using hand rails as needed)

f. **CAR TRANSFER**—How moves in and out of a car, opening door, sitting, and rising from seat

5. IADL AREAS NOW MORE LIMITED

***NUMBER** of IADL areas (from **E4** above) in which patient is now more limited in self performance than was prior to precipitating event (item **A7a**)*

0. None
1. Some (1-3 IADL areas)
2. All or most (4-6 IADL areas)

6. DEVICES/ AIDS

(***CHECK all that apply***)

LOCOMOTION DEVICES		Mechanical lift	e.
Cane/Crutch	a.	Orthotics/prosthesis	f.
Walker	b.	Postural support (while sitting)	g.
Wheelchair/scooter	c.	Slide board	h.
OTHER AIDS		Other adaptive devices	i.
Adaptive eating utensil	d.	*NONE OF ABOVE*	j.

7. STAMINA

CODE:
0. None
1. Less than 1 hour per day
2. 1 to 2 hours per day
3. 2+ to 3 hours per day
4. 3+ to 4 hours per day
5. More then 4 hours per day

	A Last 24 hours	B Prior
Hours of physical activity at two points in time—examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping **(A) *in last 24 hours*** *and* **(B) *immediately prior*** *to precipitating event (item **A7a**)*		

8. WALKING AND STAIR CLIMBING (Note time frame)

a. Farthest distance walked without sitting down **Code for most consistent in last 24 hours**
0. 150+ feet
1. 51-149 feet
2. 25-50 feet
3. 10-24 feet
4. Less than 10 feet
8. *ACTIVITY DID NOT OCCUR*

b. Walking support provided **Code for most consistent in last 24 hours**
0. None
1. Setup help only
2. Supervision
3. One person physical assistance
4. Two+ person physical assistance
8. *ACTIVITY DID NOT OCCUR*

8. WALKING AND STAIR CLIMBING (Note time frame) (cont)

c. **Stair climbing—Code for most dependent episode when activity attempted in last 24 hours** [full flight = 12-14 stairs; partial flight = 4-6 stairs] *There are only three possible codes when patient does 4-6 stairs only (code = 2,5,6)*

0. *COMPLETE INDEPENDENCE*—Up and down **full** flight of stairs with NEITHER *physical help* NOR *support device*
1. *MODIFIED INDEPENDENCE*—Up and down **full** flight of stairs with NO *physical help and any of following:*
Use of one or more supportive devices [*support devices* includes the **required** use of hand rails]
OR Use of an appliance (i.e., cane, brace, prosthesis, walker)
OR Excessive time to climb the stairs (3 or more times normal)
2. *SUPERVISION*—Up/down **full** flight of stairs with supervision or cuing -OR- up and down partial flight with NO physical help (device may or may not be used)
3. *MINIMAL ASSISTANCE*—Contact guard/steadying/assistance to go up/down **full** flight of stairs
4. *MODERATE ASSISTANCE*—Some weight bearing help to go up/down **full** flight of stairs, patient does most on own
5. *MAXIMAL ASSISTANCE*—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort -OR- receives physical help on partial flight of stairs
6. *TOTAL ASSISTANCE*—Did not go up/down 4-6 stairs (OR has 2-person assist) OR totally dependent
8. *ACTIVITY DID NOT OCCUR **IN LAST 24 HOURS***

9. BALANCE RELATED TO TRANSITIONS (Code for most dependent in last 24 hours)

CODE:
0. Smooth transition; stabilizes without assistance
1. Transition not smooth, but able to stabilize without assistance
2. Transition not smooth; unable to stabilize without assistance
8. *ACTIVITY DID NOT OCCUR*

a. Moved from seated to standing position

b. Turned around and faced the opposite direction

10. NEURO-MUSCULO-SKELETAL IMPAIRMENT (Code for most limited in last 24 hours)

A. (***CODE** for joint mobility/range of motion at joints listed* **(*code for most impaired joint*)**)
0. No impairment
1. Impairment on one side
2. Impairment on both sides

B. (***CODE** for voluntary motor control (active, coordinated, purposeful movement - **code for most dependent joint***)**)
0. No loss
1. Partial loss one side
2. Partial loss both sides
3. Full loss one side
4. Full loss both sides

C. (***CODE** for Intact touch/sensation on extremity, i.e., tactile sense* **(use same codes as E10B)**)

	A	B	C
a. Leg (hip, knee, ankle, foot)			
b. Arm (shoulder, elbow, wrist, hand)			
c. Trunk and neck			

SECTION F. BLADDER/BOWEL MANAGEMENT

1. BLADDER CONTINENCE (Code for last 7-14 days)

a. *Control of urinary bladder function (if dribbles, volume insufficient to soak through undergarments)*

0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily
5. *FREQUENTLY INCONTINENT*—Tended to be incontinent daily, but some control present (i.e., on day shift)
6. *INCONTINENT*—Has inadequate control of bladder, multiple daily episodes all or almost all of time
8. *DID NOT OCCUR*—No urine output from bladder

b. *Is now more impaired in bladder continence than was prior to precipitating event (item **A7a**)*
0. No or unsure
1. Yes, more impaired today

2. BLADDER APPLIANCE (Code for last 24 hours)

CODE:
0. No
1. Yes

a. External catheter		e. Ostomy	
b. Indwelling catheter		f. Pads, briefs	
c. Intermittent catheterization		g. Urinal, bedpan	
d. Medications for control			

3. BLADDER APPLIANCE SUPPORT (Code for last 24 hours)

0. No appliances **(in item F2)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of sub-tasks involved in using equipment
5. Maximal assistance; patient able to do 25-49% of all sub-tasks involved in using the equipment
6. Total dependence

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4. BOWEL CONTINENCE (Code for last 7-14 days)
0. *CONTINENT*— Complete control, does not use ostomy device
1. *CONTINENT WITH OSTOMY*—Complete control with use of an ostomy device that does not leak stool
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—2-3 times a week
5. *FREQUENTLY INCONTINENT*—4+ times a week but not all of time
6. *INCONTINENT*—All of time
8. *DID NOT OCCUR*— No bowel movement during the entire 14 day assessment period

5. BOWEL APPLIANCES (Code for last 3 days)
CODE: 0. No 1. Yes
a. Bedpan
b. Enema
c. Medication for control
d. Ostomy

6. BOWEL APPLIANCE SUPPORT (Code for last 24 hours)
0. No appliances **(in item F5)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of tasks
5. Maximal assistance; patient able to do 25-49% of all sub-tasks
6. Total dependence

SECTION G. DIAGNOSES

1. IMPAIRMENT GROUP *Refer to manual for coding of impairment group*

2. OTHER DISEASES
CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
[If no disease in list, check **G2aq *None of Above*** item]

ENDOCRINE
a. Diabetes mellitus (250.00)
b. Hypothyroidism (244.9)
HEART/CIRCULATION
c. Cardiac arrythmias (427.9)
d. Congestive heart failure (428.0)
e. Coronary artery disease (746.85)
f. Deep vein thrombosis (451.1)
g. Hypertension (401.9)
h. Hypotension (458.9)
i. Peripheral vascular disease (arteries) (443.9)
j. Post acute MI (within 30 days) (410.92)
k. Post heart surgery (e.g., valve, CABG) (V45.81)
l. Pulmonary embolism (415.1)
m. Pulmonary failure (518.8)
n. Other cardiovascular disease (429.2)
MUSCULOSKELETAL
o. Fracture - hip (V43.64)
p. Fracture - lower extremity (812.40)
q. Fracture(s) - other (829.0)
r. Osteoarthritis (715.90)
s. Osteoporosis (733.00)
t. Rheumatoid arthritis (714.0)
NEUROLOGICAL
u. Alzheimer's disease (331.0)
v. Aphasia or Apraxia (784.3,784.69)
w. Cerebral palsy (343.9)
x. Dementia other than Alzheimer's disease (290.0)
y. Hemiplegia/hemiparesis — left side (342.90)
z. Hemiplegia/hemiparesis — right side (342.90)
aa. Multiple sclerosis (340)
ab. Parkinson's disease (332.0)
ac. Quadriplegia (344.00 - 344.09)
ad. Seizure disorder (780.39)
ae. Spinal cord dysfunction—non-traumatic (336.9)
af. Spinal cord dysfunction—traumatic (952.9)
ag. Stroke (CVA) (436)
PSYCHIATRIC/MOOD
ah. Anxiety disorder (300.00)
ai. Depression (311)
aj. Other psychiatric disorder (300.9)
PULMONARY
ak. Asthma (493.9)
al. COPD (496)
am. Emphysema (492.8)
OTHER
an. Cancer (199.1)
ao. Post surgery - non-orthopedic, non-cardiac (V90.9)
ap. Renal failure (586)
aq. *NONE OF ABOVE*

3. INFECTIONS
CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
(If no infections, check *NONE OF ABOVE item G3l*)

a. Antibiotic resistant infection (e.g., methicillin resistant staph - (041.11), VRE - (041.9))
b. Cellulitis (682.9)
c. Hepatitis (070.9)
d. HIV/AIDS (042)
e. Pneumonia (486)
f. Osteomyelitis (730.2)
g. Septicemia (038.9)
h. Staphylococcus infection (other than item "G3a") (041.10)
i. Tuberculosis (active) (011.90)
j. Urinary tract infection (599.0)
k. Wound infection (958.3, 998.59,136.9)
l. *NONE OF ABOVE*

4. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9-CM CODES (Any new diagnosis at reassessment or discharge is to be recorded here)
A. ***CODE ICD-9-CM diagnosis code***
B. ***CODE***:
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

	A. ICD-9-CM	B
a.		
b.		
c.		
d.		
e.		

5. COMPLICATIONS/COMORBIDITIES *Code the **ICD-9-CM** diagnostic code. Refer to manual to code comorbidities.*

DIAGNOSIS	ICD-9-CM
a.	
b.	
c.	
d.	

SECTION H. MEDICAL COMPLEXITIES

1. VITAL SIGNS *Vital signs (pulse, BP, respiratory rate, temperature)* ***Score for the most abnormal vital sign***
0. All vital signs were normal/standard (i.e., when compared to standard values)
1. Vital signs abnormal, but not on all days during assessment period
2. Vital signs consistently abnormal (on all days)

2. PROBLEM CONDITIONS (In last 3 days)
(***CHECK** all problems present in the **last 3 days** unless otherwise noted*)
FALLS/BALANCE
Dizziness/vertigo/light-headedness a.
Fell (since admission or last assessment) b.
Fell in **180 days** prior to admission c.
CARDIAC/PULMONARY
Advanced cardiac failure (ejection fraction < 25%) d.
Chest pain/pressure on exertion e.
Chest pain/pressure at rest f.
Edema - generalized g.
Edema - localized h.
Edema - pitting i.
Impaired aerobic capacity/endurance (tires easily, poor task endurance) j.
FLUID STATUS
Constipation k.
Dehydrated; output exceeds input; or BUN/Creat ratio > 25 l.
Diarrhea m.
Internal bleeding n.
Recurrent nausea/vomiting o.
Refusal/inability to take liquids orally p.
OTHER
Delusions/hallucinations q.
Fever r.
Hemi-neglect (inattention to one side) s.
Cachexia (severe malnutrition) t.
Morbid obesity u.
End-stage disease, life expectancy of **6 or fewer months** v.
NONE OF ABOVE w.

3. RESPIRATORY CONDITIONS (In last 3 days)
(***CHECK** all problems present in the **last 3 days***)
Inability to lie flat due to shortness of breath a.
Shortness of breath with exertion (e.g., taking a bath) b.
Shortness of breath at rest c.
Oxygen saturation < 90% d.
Difficulty coughing and clearing airway secretions e.
Recurrent aspiration f.
Recurrent respiratory infection g.
NONE OF ABOVE h.

4. PRESSURE ULCERS (Code for last 24 hours)
a. *Highest current pressure ulcer stage*
0. No pressure ulcer **(if no, skip to H5)**
1. Any area of persistent skin redness **(Stage 1)**
2. Partial loss of skin layers **(Stage 2)**
3. Deep craters in the skin **(Stage 3)**
4. Breaks in skin exposing muscle or bone **(Stage 4)**
5. Not stageable (necrotic eschar predominant; no prior staging available)

b. *Number of current pressure ulcers*

SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING—calculate three components (**c** through **e**) and code total score in **f**

c. Length multiplied by width (open wound surface area)
0. 0 cm^2
1. <0.3 cm^2
2. 0.3–0.6 cm^2
3. 0.7–1.0 cm^2
4. 1.1–2.0 cm^2
5. 2.1–3.0 cm^2
6. 3.1–4.0 cm^2
7. 4.1–8.0 cm^2
8. 8.1–12.0 cm^2
9. 12.1–24.0 cm^2
10. > 24 cm^2

d. Exudate amount
0. None 1. Light 2. Moderate 3. Heavy

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4.	**PRESSURE ULCERS** (Code for last 24 hours) (cont)	**e.** Tissue type 0. Closed/resurfaced: The wound is completely covered with epithelium (new skin) 1. Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface 2. Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance 3. Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous 4. Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges	
		f. TOTAL PUSH SCORE (sum of above three items—**c**, **d**, and **e**)	
5.	**OTHER SKIN INTEGRITY**	**a.** Number of stasis ulcers **in last 24 hours**	
		b. Number of surgical wounds **in last 24 hours**	
		c. Ulcer resolved or healed **in last 90 days** 0. No or never had ulcer 1. Yes	
6.	**OTHER SKIN PROBLEMS OR LESIONS PRESENT** (Code for last 24 hours)	(***CHECK all that apply***)	
		Burns (second or third degree)	a.
		Open lesions other than rashes, cuts (e.g., cancer lesions, ulcers)	b.
		Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)	c.
		Skin tears or cuts (other than surgery)	d.
		NONE OF ABOVE	e.

SECTION I. PAIN STATUS

1.	**PAIN SYMPTOMS** (In last 3 days)	(***CODE the highest level of pain present in the last 3 days, even with treatments*** [Note - At minimum, patient must be asked about frequency and intensity])	
		a. FREQUENCY with which patient complains or shows evidence of pain 0. No pain 2. Daily - single shift 1. Less than daily 3. Daily - multiple shifts	
		b. INTENSITY of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating	
		c. Current pain status as compared to pain status prior to precipitating event (item **A7a**) 0. Same 1. Better 2. Worse 8. UNKNOWN	

SECTION J. ORAL/NUTRITIONAL STATUS (In last 3 days)

1.	**ORAL PROBLEMS**	***CODE***: 0. No 1. Yes	
		a. Chewing problem (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control)	
		b. Dental problems (e.g., ill-fitting or lack of dentures, painful tooth, poor dental hygiene)	
2.	**SWALLOWING**	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE (NPO)*	
3.	**HEIGHT AND WEIGHT**	*Record* ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 3 days****; measure weight consistently in accordance with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* **a.** HT (inches) **b.** WT (pounds)	
4.	**WEIGHT CHANGE**	**a. Weight loss**—5 % or more in **last 30 days** 0. No or unknown 1. Yes, planned loss 2. Yes, unplanned loss	
		b. Weight gain—5 % or more in **last 30 days** 0. No or unknown 1. Yes, planned gain 2. Yes, unplanned gain	
5.	**PARENTERAL OR ENTERAL INTAKE**	**a.** The proportion of **total calories** the patient received through parenteral or tube feedings in the **last 3 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%	
		b. The average **fluid intake** per day by IV or tube in **last 3 days** 0. None 3. 1001 to 1500 cc/day 1. to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION K. PROCEDURES/SERVICES (In last 3 days)

1.	**CLINICAL VISITS AND ORDERS**	*Services in* ***last 3 days***	
		a. Total number of physician visits (by attending, consultant, etc.) in which patient was examined and MD notes written	
		b. Number of times **physician or nurse practitioner** called to bedside for emergency—e.g., cardiorespiratory arrest, hemorrhaging, to evaluate change in condition	
		c. Number of **nurse practitioner** visits in which patient examined and notes written	
		d. Number of **physician assistant** visits in which patient examined and notes written	
		e. Number of **new or changed orders**	

2.	**TREATMENTS AND SERVICES**	**A. Over the last 3 days**, code for *treatment frequency* [*either daily* (*code 3*) *or less than daily* (*code 2*) or ordered, not yet implemented (code 1)] **(If no treatments provided or ordered, check *NONE OF ABOVE item K2ai*)** [*Blank*] Did not occur, not ordered 2. Less than daily 1. Ordered, not yet implemented 3. Daily **B.** ***RECORD AT DISCHARGE ASSESSMENT ONLY*** **(A3 = 5)**, *record whether patient will receive service after discharge* [*Blank*] No 1. Yes					
			A	**B**		**A**	**B**
		MEDICATION RELATED			r. Drains (cutaneous drains and other drains)		
		a. Diabetic management			s. Dialysis		
		b. Injections			t. Enteral feeding tube		
		c. IV antibiotics/meds			u. IV line - central		
		SKIN TREATMENT			v. IV line - peripheral		
		d. Application of dressings			w. NG feeding tube		
		e. Application of ointments, topical medications			x. Oxygen		
		f. Debridement (chemical or surgical)			y. Pain management - other than drugs		
		g. Nutrition/hydration intervention to manage skin problems			z. Suctioning - oral/nasopharyngeal		
		h. Pressure relieving bed/chair			aa. Suctioning - tracheal		
		i. Turning and repositioning			ab. Tracheostomy care		
		j. Ulcer care			ac. Transfusion(s)		
		k. Wound care - surgical			ad. Ventilator or respirator		
		MANAGEMENT OF HEALTH PROBLEMS			ae. Ventilator weaning		
		l. Bladder training			**OTHER**		
		m. Scheduled toileting			af. Family training in assistance to patient in health measures or skills required after return to community		
		n. Bowel program			ag. Patient training in health maintenance or skills required after return to community		
		o. Cardiac monitoring/rehabilitation			ah. Design and implementation of discharge plan		
		p. Cast(s)					
		q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)			ai. *NONE OF ABOVE*	ai.	ai.
3.	**NURSING PRACTICE OR RESTORATIVE CARE**	*Record the NUMBER OF DAYS each of the following restorative or practice techniques was* ***provided to the patient for more than or equal to a total of at least 15 minutes per day in the last 3 days*** *(Enter 0 if none or less than 15 min. daily)*					
		a. Range of motion (passive)			f. Transfer		
		b. Range of motion (active)			g. Walking		
		c. Splint/orthotic assistance			h. Dressing or grooming		
		TRAINING AND SKILL PRACTICE IN			i. Eating or swallowing		
		d. Bed mobility			j. Amputation/prosthesis care		
		e. Bladder/bowel			k. Communication		
4.	**THERAPY SERVICES** (By qualified therapist or therapy assistant under direction of therapist)	*Over the* ***last 3 days****, record the number of days and total minutes each of the following therapies was ordered* **[A]** *administered* **[B]** *(for at least 15 minutes a day) (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]** **A. # of days** treatment ordered during the **last 3 days [MAX=3]** **B. # of days** administered for **15 minutes or more [MAX=3]** **C. total # of minutes** provided in **last 3 days** (or *ordered* if days administered = 0 and days ordered > 0)					
		D. ***RECORD AT DISCHARGE ASSESSMENT*** ***(A3 = 5)****, record whether patient will receive service after discharge* 0. No 1. Yes	**DAYS Ordered**	**DAYS Administered**	**Minutes Delivered**		**Post Discharge**
			A	**B**	**C**		**D**
		a. Speech - language pathology and audiology services					
		b. Occupational therapy					
		c. Physical therapy					
		d. Respiratory therapy					
		e. Psychological therapy (by any licensed mental health professional)					
		f. Therapeutic recreation					

APPENDIX BB Patient_____ Numeric Identifier_____

5.	**DEVICES AND RESTRAINTS**	(*USE THE FOLLOWING* ***CODES FOR LAST 3 DAYS***) 0. Not used 3. Daily use - days only 1. Used less than daily 4. Night and day, but not constant 2. Daily use - night only 5. Constant use for full 24 hours (with periodic release)	
		a. Full bed rails on BOTH open sides of bed	
		b. Other types of side rails used (e.g., half rail, one side)	
		c. Trunk restraint	
		d. Chair prevents rising	

SECTION L. FUNCTIONAL PROGNOSIS

1.	**FUNCTIONAL IMPROVEMENT GOALS** **(Code for last 24 hours)**	*For* ***all but discharge assessment****—code for clinical staff expectations of patient goals in the areas listed below by time of discharge.* *For* ***discharge assessment****, code for staff expectation of patient functional goal in the post discharge period.* 0. No goal exists 1. Goal-improvement, full recovery to premorbid status anticipated 2. Goal-improvement, partial recovery anticipated 3. Goal-improvement, recovery uncertain 4. Goal-maintenance, prevention of further decline			
		ADLs		**e.** Toileting	
		a. Bed mobility/transfer		**OTHER**	
		b. Dressing		**f.** Medication management	
		c. Eating		**g.** Pain control	
		d. Locomotion		**h.** Managing finances	
2.	**ATTRIBUTES RELEVANT TO REHABILITATION**	*CODE*: 0. No 1. Yes 8. UNKNOWN			
		a. Patient believes he/she is capable of increased independence			
		b. Patient unable to recognize new limitations			
		c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability			
3.	**CHANGE OVER LAST 3 DAYS**	*CODE*: 0. Improved 1. About the same as at admission (or last assessment if this is not an admission assessment) 2. Worse			
		a. Change in overall **functional status** over **last 3 days**			
		b. Change in overall **health status** over **last 3 days**			
4.	**ESTIMATED LENGTH OF STAY FROM DATE OF ADMISSION**	*How long patient is expected to stay in current setting prior to return to community* (***count from date of admission in item A2, including that day***) 0. 1-6 days 4. 91 or more days 1. 7-13 days 5. Discharge to community not expected 2. 14-30 days 6. Expected discharge will be to another health care setting - prior to return to community 3. 31-90 days			

SECTION M. RESOURCES FOR DISCHARGE

1.	**AVAILABLE SOCIAL SUPPORTS** **(Family/close friends)**	*CODE*: 0. No 1. Possibly yes 2. Definitely yes *Presence of one or more family members (or close friends) who are* ***willing and able*** *to provide support after discharge*	
		a. Emotional support	
		b. Intermittent physical support with ADLs or IADLs — less than daily	
		c. Intermittent physical support with ADLs or IADLs — daily	
		d. Full time physical support (as needed) with ADLs or IADLs	
		e. All or most of necessary transportation	
2.	**CAREGIVER STATUS**	*CODE*: 0. No 1. Yes	
		a. Family (or close friend) overwhelmed by patient's illness	
		b. Family relationship(s) require unusual amounts of staff time	

			A Prior to adm	B Perm disch	C Temp disch
3.	**LIVING ARRANGEMENT**	**A.** ***CODE*** *for* ***permanent*** *living arrangement* ***prior to admission*** **B.** ***CODE*** *for* ***permanent*** *arrangement expected* ***at discharge*** *or actual discharge site if this is a discharge assessment* (**A3=5**) **C.** ***CODE*** *for* ***initial*** *arrangement expected at discharge—if different than column* ***M3B*** (otherwise, leave blank) or actual discharge site if this is a discharge assessment (**A3=5**)			
		a. Type of residence 0. UNKNOWN 1. Private home 2. Private apartment 3. Rented room 4. Board and care/assisted living/group home 5. Homeless (with or without shelter) 6. Long-term care facility (nursing home) 7. Post acute care SNF 8. Hospice 9. Acute unit/hospital 10. Other			
		b. Live(d) with 0. UNKNOWN 1. Alone 2. Spouse only 3. Spouse and other(s) 4. Child (not spouse) 5. Other relative(s) (not spouse or children) 6. Friends 7. Group setting 8. Personal care attendant 9. Other			

BILLING CODE 4120–03–P

Appendix BBB—Item-by-Item Guide to the Minimum Data Set for Post Acute Care (MDS–PAC)

1.1 Required Assessments and Associated Forms

The following rules apply to HCFA's MDS–PAC to be used by rehabilitation hospitals and rehabilitation units in acute care hospitals.

The content of the MDS–PAC patient assessment instrument is recorded on the following required forms:

The Minimum Data Set-Post Acute (MDS–PAC) is designed to be used for admission assessments, reassessments, and discharge assessments. These forms contain Section AA (Identification Information) through M (Resources for Discharge). There are three separate forms which are entitled ''Basic Assessment Tracking Form'', ''Interrupted Stay Tracking Form'', and ''Full Assessment Form''. Whenever an item is on all three forms, there will be no distinguishing notation. However, if an item(s) is (are) to be asked only on a particular form, there will be a statement in the ''coding'' section.

1.2 Overview to the Item-by-Item Guide to MDS–PAC

This Manual is to be used in conjunction with the MDS–PAC forms.

It provides information to facilitate completion of an accurate and uniform patient assessment. Item-by-item instructions focus on:

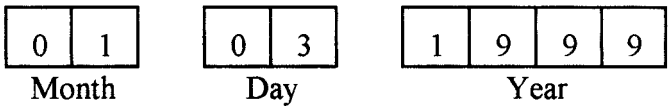
- The intent of items included on the MDS–PAC.
- Supplemental definitions and instructions for completing MDS–PAC items.
- Reminders of which MDS–PAC items require a different observation and information about the patient other than the standard 3-day observation period.
- Sources of information to be consulted in completing specific MDS–PAC items.
- Examples to illustrate MDS–PAC coding responses.

1.3 How Can This Manual Be Used?

Use this manual alongside the MDS–PAC forms, keeping the forms in front of you at all times. The MDS–PAC form itself contains a wealth of information. Learn to rely on it as a resource for many of the definitions and procedural instructions necessary for proper assessment. The amplifying information in this manual should facilitate successful use of the MDS–PAC forms.

Coding Conventions

- Dates—Where recording month, day, and year, enter two digits for the month and the day, but four digits for the year. For example, the third day of January in the year 1999 is recorded as:



- The standard no-information code is either a ''circled'' dash or an ''NA''. This code indicates that all available sources of information have been exhausted; that is the information is *not available*, and despite exhaustive probing, it remains unavailable. The use of NA code is very limited. For example, ''NA'' cannot be used in Section E. If an activity has not occurred in the last 3 days, a code of ''8'' must be used.
- NONE OF THE ABOVE is a response item to several items (for example., G3, Infections, box l). Check this item where none of the responses apply; it should not be used to signify lack of information about the item.
- ''Skip'' Patterns—There are a few instances where scoring on one item will govern how scoring is completed for one or more additional items. The instructions direct the assessor to ''skip'' over the next item (or several items) and go on to another (for example, B1, Comatose, directs the assessor to ''skip'' to Section E. if B1 is answered ''1''—Yes''. The intervening items from B2–D3 would not be scored. If B1 was recorded as ''0''—''No'', then the assessor would continue with item B2.).

A useful technique for visually checking the proper use of the ''skip'' pattern instructions is to circle the ''skip'' instructions before going to the next appropriate item.

- The ''8'' code is for use in Section E., Functional Status. The use of this code is limited to situations where the ADL activity was not performed and therefore an objective assessment of the resident's performance is not possible. Its primary use is with bed-bound residents who neither transferred from bed nor moved between locations over the entire 3 day period of observation.

The items from the MDS–PAC forms are presented in a sequential basis in this manual. Each item is accompanied by a statement of intent (rationale for assessment), definitions, assessment processes, and coding instructions. Many items are accompanied by patient examples to illustrate coding concepts.

The chart that follows summarizes the recommended approach to assist you in becoming familiar with the MDS–PAC. The initial time investment in this multi-step review process will have a major payback on the quality of your patient assessments using the MDS–PAC.

Carefully review these item-by-item instructions. The time-frame of the assessment, the processes, the coding options and items have been developed to reflect the needs of post-acute patients.

Recommended Approach for Becoming Familiar With the MDS–PAC

(A) First, review the MDS–PAC forms.

- Notice how sections are organized and where information is to be recorded.
- Work through one section at a time.
- Examine item definitions and response categories.
- Review procedural instructions, time frames, and general coding conventions. Note that the assessment reflects activities over the last 3 days unless otherwise indicated.
- Are the definitions and instructions clear? Do they differ from current practice at your facility? What areas require further clarification?
- Complete the MDS–PAC assessment for a patient at your facility. Draw only on your knowledge of this individual. Enter the appropriate codes on the MDS–PAC form. Where your review could benefit from additional information, make note of that fact. Where might you secure additional information?

(B) Complete the initial pass through this manual.

- Go on to this step only after first reviewing the MDS–PAC form and trying to complete as many items as possible for a patient known to you.
- As you read this manual, clarify questions that arose as you used the MDS–PAC for the first time to assess a patient. Note sections of this manual that help to clarify coding and procedural questions you may have had.
- Once again, read the instructions that apply to a single section of the MDS–PAC. Make sure you understand this information before going on to another section. Review the test case you completed. Would you still code it the same way? It will take time to go through all this material. Do it slowly. Do not rush. Work through the Manual one section at a time.
- Are you surprised by any MDS–PAC definitions, instructions, or case examples? For example, do you understand how to code ADLs? Or Mood?
- Do any definitions or instructions differ from what you thought you learned when you reviewed the MDS–PAC form?
- Would you now complete your initial case differently?
- Are there definitions or instructions that differ from current practice patterns in your facility?
- Make notations next to any section(s) of this Manual you have questions about.

In a second pass through this manual, focus on issues that were more difficult or problematic in the first pass.

- Further familiarize yourself with definitions and procedures that differ from current practice patterns or seem to raise questions.
- Reread each of the case examples presented throughout this chapter.
- (D) The third pass through this manual will provide you with another opportunity to review the material in this manual.
- (E) Future use of information in this manual:

• Keep this manual at hand during the assessment process.

• Where necessary, review the intent of each item in question.

• This manual is a source of information. Use it to increase the accuracy of your assessments.

1.4 What Is the Standard Format Used in This Manual?

To facilitate completion of the MDS–PAC assessment and to ensure consistent interpretation of items, this manual presents the following types of information for many (but not all) items:

Intent: Reason(s) for including the item (or set of items) in the MDS–PAC, including discussions of how the information will be used by clinical staff to identify patient problems and develop the plan of care.

Definition: Explanation of key terms.

Process: Sources of information and methods for determining the correct response for an item. Sources include:

• Patient interview, observation, and examination.

• Clinical records, facility records, transmittal records (at admission), physician orders, laboratory data, medication records, treatment sheets, flow sheets (for example, vital signs, weights, intake and output), care plans, and any similar documents in the facility record system.

• Discussion with multidisciplinary facility staff—licensed and nonlicensed staff caregivers.

• Discussion with the patient's family, particularly during the admission assessment period, when available.

• Attending physician.

Coding: Proper method of recording each response, with explanations of individual response categories.

1.5 Item-by-Item Instructions for the MDS–PAC Forms

The item-by-item instructions follow the sequence of items on the HCFA MDS–PAC. This will facilitate your use of this guide as a reference tool.

Basic Assessment Tracking Form

Section AA. Identification Information

Intent: This section provides the key information to uniquely identify each patient as well as the reason for assessment.

1. Legal Name of Patient

Definition: Legal name in the clinical record. This must be the same as the patient's Medicare record legal name.

Coding: Use printed letters. Enter in the following order:

a. First Name.

b. Middle initial (leave blank if no middle name).

c. Last/Family Name.

d. Suffix—meaning Jr., Sr., III, etc.

2. Admission Date

a. Date the stay began.

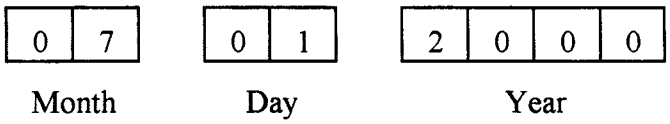
Intent and Definition: For the current precipitating event/problem, this is the date when the patient first became a rehabilitation patient in your facility.

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the person was first admitted to receive rehabilitative care for the current precipitating event/problem. This admission date should correspond with the admission date used by the billing office to initially begin this stay.

Process: Review the clinical record. If it is unclear on what date the stay for the current precipitating event/problem began, clarify with the admissions/business or medical record departments.

Coding: For a one digit month or day, place a zero in the box. For example: July 1, 2000, should be entered as follows:



b. Date Medicare-covered Part A stay began.

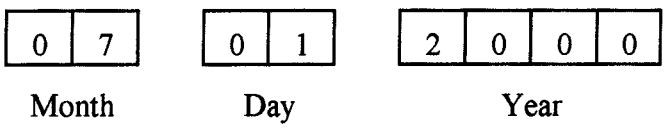
Intent and Definition: For the current precipitating event/problem, this is the date of the current stay when the patient first started receiving Medicare-covered Part-A services in your facility. Complete this date only if this date is different than the date in item AA2A ''Date the stay began.''

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the patient first started to be furnished Medicare-covered Part A services in your rehabilitation facility for the current precipitating event/problem. This date should correspond with the date used by the billing office to initially start billing Medicare for this stay.

Process: Review the clinical record. If it is unclear what date the person first started being furnished Medicare-covered Part A services for the current stay and for the current precipitating event/problem, clarify with the admissions/business or medical record departments.

Coding: For a one digit month or day, place a zero in the first box. For example: July 1, 2000, should be entered as follows:



3. Reason for Assessment

Intent and Definition: To document the key reason for completing the MDS–PAC assessment.

Process: Calculate the length of time the patient has been receiving Medicare-covered Part A services during the current stay. Then determine the type of assessment for which the data must be collected and recorded on the MDS–PAC.

Coding: Code for appropriate assessment.

1. Admission assessment (covers first 3 days)—Completed on day 4.

2. Reassessment—Completed on day 11.

3. Reassessment—Completed on day 31.

4. Reassessment—Completed on day 61.

5. Discharge assessment—After the assessment reference date for the discharge MDS–PAC assessment is determined, the completion date for the discharge MDS–PAC assessment must be set. The completion date

for the discharge MDS–PAC assessment must be the fifth calendar day following the discharge MDS–PAC assessment reference date. To count the 5 calendar days following the discharge MDS–PAC assessment reference date count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The following tables illustrate the relationship between the type of MDS–PAC assessment (the Day 4, Day 11, Day 30, Day 60, and discharge assessment), and the observation time period, the assessment reference date, and the MDS–PAC completion date. In addition, for each type of MDS–PAC assessment the tables depict the associated encoding date and by when the data for that type of assessment must be transmitted.

TABLE 1.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16.
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23.
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43.
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73.

Table 1 above represents the generic assessment schedule and other associated MDS–PAC dates. The term ''day'' refers to the number of calendar days during the patient's current hospitalization that the patient has been hospitalized as a Medicare Part-A patient.

Table 2 below is an example of how Table 1 would be applied using actual calendar dates. In Table 2 it is assumed that the patient was admitted on April 3, 2001.

TABLE 2.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	4/5/01	4/6/01	4/12/01	4/18/01
Day 11	Days 8 to 10	4/12/01	4/13/01	4/19/01	4/25/01
Day 30	Days 28 to 30	5/2/01	5/3/01	5/9/01	5/15/01
Day 60	Days 58 to 60	6/1/01	6/2/01	6/8/01	6/14/01

TABLE 3.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date*	MDS–PAC assessment reference date	MDS–PAC must Be completed on:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/1/00	5/1/00	5/5/00	5/11/00	5/17/00

*This is either when the first of the following occurs: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services.

4. Assessment Reference Date

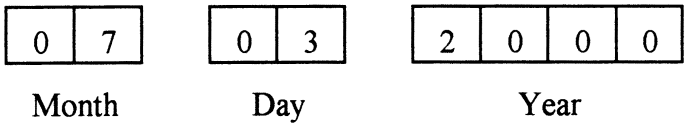
Intent: To establish a common reference point for all staff participating in the patient's assessment. Although staff members may work on completing a patient's MDS–PAC on different days (for example, begin entering demographics on day 1 of admission, and complete functional assessment on day 3), establishment of the assessment reference date ensures the commonality of the assessment period. It starts the ''clock'' so that all assessment items refer to the patient's status, treatment regimen, and resource utilization during the same period of time. Many items require the ''counting'' of the number of treatments, visits, or procedures, making a common temporal reference point crucial for accuracy.

Definition: This is the last day in the MDS–PAC assessment process, that is, the last day of the 3-day MDS–PAC observation period. It is the designated endpoint of the observation period. In order to gain accurate information for the interdisciplinary team, it is essential for everyone to focus on the same time period (that is, for most items, this day and the two that preceded it.) It is from this date that all time references are measured. For a discharge assessment, including an unexpected discharge, see the explanation under ''Process'' below.

For instance, if an item indicates ''in the past 3 days'' this 3 day period is calculated from the last day of the MDS–PAC observation period (that is, the third day and the two days that preceded it.)

Process: Refer to item AA2—''Admission Date''. The date entered in AA2b or if no date is entered in AA2b then the date entered in AA2a must be used to calculate the assessment reference date that must be used for the Day 4, Day 11, Day 30, or Day 60 assessments. The assessment reference date for the discharge assessment is the day when one of either of these two events occurs first: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services. The MDS–PAC discharge assessment process is started only at the first point in time either of these events occur. There may be cases when a patient ceases receiving inpatient rehabilitation Medicare-covered services, but is not discharged from the IRF.

Coding: Beginning with the left-most box enter the month, day, and year of the assessment reference date. Do not leave any boxes blank. If the month or day contains only a single digit, place a ''0'' in the first box. For example: July 3, 2000, should be entered as follows:



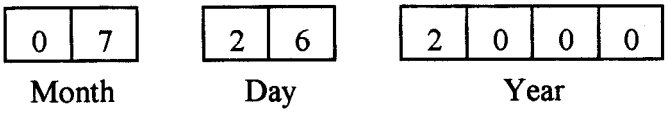
5. Discharge Status

a. Last day of stay.

Intent and Definition: To establish the date when either of these two events occurs first: (1) The individual is discharged as an inpatient from the IRF and physically leaves the facility, or (2) the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services whether or not the patient physically leaves the facility.

Process: Consult the physician's orders. In cases when the patient is discharged ''Against Medical Advice'' (AMA) refer to the documentation in the clinical record progress notes and the physician's orders.

Coding: Beginning with the left-most box enter the month, day, and year of discharge. Do not leave any boxes blank. If the month or day contains only a single digit, place a ''0'' in the first box. For example July 26, 2000, should be entered as:



b. If discharged, status at discharge.

Intent: The intent of this item is to determine the patient's status upon discharge.

Definition: This is the patient's clinical and rehabilitation program status at discharge.

Process: Consult with members of the interdisciplinary team. Examine the documentation in the patient's clinical record. Talk to the patient and family if necessary.

Coding

0. Rehabilitation program complete for this stay and return not anticipated.

1. Patient left, against medical advice, prior to completion of plan of care.

2. Acute problem, discharge to acute hospital.

3. Patient died.

6. Social Security and Medicare Numbers

Intent: To record patient identifier numbers.

Process: Review the patient's medical record face sheet (usually at the front of the chart). To ensure accuracy, review a copy of the patient's Social Security (SS) card and Medicare card, if possible. In rare cases, the patient will have neither a Social Security number nor a Medicare number. When this occurs, another type of identification number may be used (for example, a railroad insurance number).

Coding: Begin printing one number per box starting with the left-most box. Recheck each number to be sure you have entered the digits in the correct order.

a. Enter the Social Security number as specified in the medical record or on the Social Security card.

b. Enter the Medicare number as indicated in the medical record. However, if the patient does not have a Medicare number but instead has a comparable railroad insurance number, then enter that number in these boxes and indicate that this is not a Medicare number by placing the letter ''C'' in first box of the ''b'' boxes.

7. Medical Record Number

Definition: A patient's identification number designated by the facility.

Process: Review the patient's medical record ''face sheet'' (usually at the front of the chart) for the medical record number. If the number is missing, obtain the number from the facility's Medical Records Department.

Coding: Begin printing one number per box starting with the left-most box. Recheck the number to be sure you have entered the digits in the correct order.

8. Facility Provider Number

Intent: To record the facility identifier numbers.

Definition: The identification numbers assigned to health care facilities by the Medicare and Medicaid programs. Some facilities will have only a Federal (Medicare) identification number; others will have Federal (Medicare) and State (Medicaid) identification numbers. ''Medicaid only'' facilities have a Federal as well as a State number. The Medicaid Federal number has a ''letter'' in the third box.

Process: Obtain the facility's Medicare and Medicaid numbers from the facility's business office. Once you have these numbers, they apply to all patients of that facility.

Coding: Begin printing one number per box starting with the left-most box. Recheck each number to be sure you have entered the digits in the correct order. Remember, there must be at least one provider number indicated, and there may be two, one for the state, one for the federal.

9. Medicaid Number

Intent: An identifying number for tracking purposes.

Process: Review the patient's medical record face sheet (usually at the front of the chart). Review a copy of the patient's Medicaid card to ensure accuracy, if possible.

Coding: Begin printing one number per box starting with the left-most box. Recheck the number to be sure you have entered the digits in the correct order.

- If the Medicaid application is pending, place a ''+'' in the first box.
- If the patient does not receive Medicaid benefits, place an ''N'' in the first box.

10. Gender

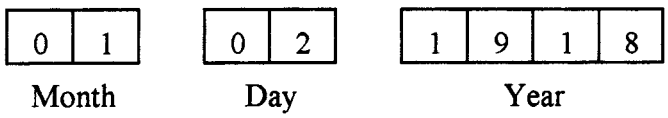
Coding

1. Male.

2. Female.

11. Birthdate

Coding: Beginning with the left-most box enter the month, day, and year of birth. If you do not know the patient's full birthdate you may enter a partial birthdate, but the partial birthdate must at least include the patient's year of birth. If the month or day contains only a single digit, place a ''0'' in the first box. For example: January 2, 1918 should be entered as:



Note: It's not unheard of to mistakenly enter today's date in this location. Make sure you have entered the date of birth.

12. Ethnicity/Race

Intent: The documentation of ethnicity and race per nationally established standards.

Process: Ask the patient and/or family member what best describes their race and ethnic background.

Coding: Check all that apply.

Ethnicity

a. Hispanic or Latino.

Race

b. American Indian/Alaskan Native.
c. Asian.
d. Black or African American.
e. Native Hawaiian or other Pacific Islander.
f. White.

13. Interrupted Stay

Note: This item only appears on the interrupted stay tracking form.

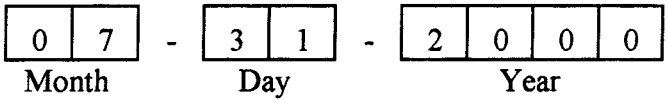
Intent and Definition: To track patients that have an interruption in their stay. An interrupted stay is one in which a patient is discharged from a rehabilitation facility and returns to the same rehabilitation facility in 3 calendar days or less. For purposes of the MDS–PAC assessment process, if a patient has an interrupted stay, then—(1) No new Day 4 MDS–PAC assessment would be performed; and (2) The required scheduled MDS–PAC update assessments must still be performed. Note: A patient that returns to the same rehabilitation facility more than 3 calendar days after being discharged is considered a ''new'' patient in terms of the MDS–PAC assessment schedule process.

In counting the 3 calendar day time period to determine the length of the interrupted stay, the first day of the start of the interrupted stay is counted as ''day 1,'' with midnight of that day serving as the end of that calendar day. The next 2 calendar days that immediately follow would be days two and three. If the patient returns to the rehabilitation facility by midnight of the third calendar day, then it would be determined that the patient had an interrupted stay of 3 calendar days or less.

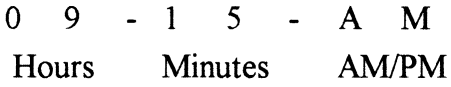
a. Date/time departed from the rehabilitation unit/hospital.

Process: Consult the clinical record, talk to physician and nursing staff.

Coding: If the patient has not had an interrupted stay, the boxes will remain blank. Otherwise, use all boxes. For a one-digit month or day, place a zero in the first box. July 31, 2000, should be entered as follows:



A time of 9:15 am should be entered as follows:

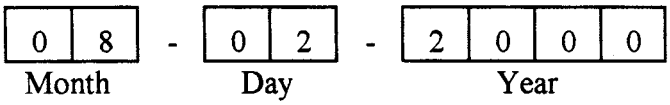


b. Date/time returned to the rehabilitation unit/hospital.

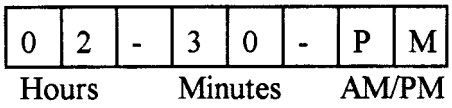
Process: Review the clinical record. If dates are unclear or unavailable, ask the admissions office or medical record department.

Coding: If patient has not had an interrupted stay, leave the boxes blank. Otherwise, use all the boxes. For a one-digit month or day, place a zero in the first box.

August 2, 2000, should be entered as follows:



A time of 2:30 pm should be entered as follows:



14. Clinician Completing Assessment

Note: This item only appears on the interrupted stay tracking form. This is NOT the same as Section AB ''Assessment Attestation''.

Intent: To ensure that the data recorded on the Interrupted Stay Tracking Form is accurate and submitted to the HCFA MDS–PAC system within 7 calendar days of the date recorded in item AA13b. The date recorded in item AA13b is ''day 1'' when starting to count the 7 calendar days in order to determine the 7 calendar day time period.

Definition: The clinician who signs item AA14a must be a physician, registered nurse, physical therapist, or occupational therapist.

Process: As necessary examine the clinical record, and consult with other members of the interdisciplinary care team to obtain the data needed prior to completing this item.

Coding: After signing your name print your name at AA14b to AA14e. Indicate your credentials in the box at AA14f.

Section AB. Assessment Attestation

1. Person Completing the Assessment

Intent and Definition: A licensed clinician who is a physician, registered nurse, physical therapist, or occupational therapist must sign and certify that—(1) The assessment is complete; and (2) The data recorded for the assessment items are to the best of his or her belief accurately recorded and accurately depict the patient's clinical status.

Process: Examine the MDS–PAC to determine if according to the instructions that the required data for each item has been accurately recorded.

Coding: The physician, registered nurse, physical therapist, or occupational therapist signs his/her name on line AB1a. The date that he or she signed the assessment as complete and accurate is entered in the boxes of AB1g and his/her name must be printed on the line that starts at AB1b. In the box for item AB1f enter the code number that identifies the type of licensed clinician signing item AB1a.

2. Signatures of Staff Completing Part of the Assessment

Intent: Each individual who completes a portion of the assessment must sign and certify to the accuracy of the items he or she has completed.

Coding: On lines AB2a–AB2f each person who has completed any MDS–PAC item signs their name, writes their credentials, indicates what section(s) or item(s) he or she completed, and writes the date of his or her signature.

Section A. Demographic/Admission Information History

Intent: This section provides the key information to uniquely identify each patient as well as the reason for assessment.

1. Legal Name of Patient

Definition: Legal name in the clinical record. This must be the same as the patient's Medicare record legal name.

Coding: Use printed letters. Enter in the following order:

a. First Name.

b. Middle initial (leave blank if no middle name).

c. Last/Family Name.

d. Suffix—meaning Jr., Sr., III, etc.

2. Admission Date

a. Date the stay began.

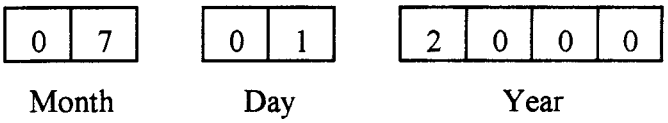
Intent and Definition: For the current precipitating event/problem, this is the date when the patient first became a rehabilitation patient in your facility.

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the person was first admitted to receive rehabilitative care for the current precipitating event/problem. This admission date should correspond with the admission date used by the billing office to initially begin this stay.

Process: Review the clinical record. If it is unclear what date the stay for the current precipitating event/problem began, clarify with the admissions/ business or medical record departments.

Coding: For a one digit month or day, place a zero in the box. For example: July 1, 2000, should be entered as follows:



b. Date Medicare-covered Part-A stay began.

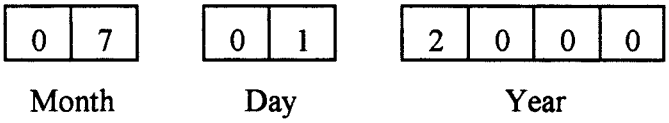
Intent and Definition: For the current precipitating event/problem, this is the date of the current stay when the patient first started receiving Medicare-covered Part-A services in your facility. Complete this date only if this date is different than the date in item A2a ''Date the stay began.''

It is possible that a patient in a rehabilitative phase of care may be discharged from the rehabilitation facility and then admitted to an acute care hospital or unit. Admissions and ''bed-hold'' policies vary in different settings. A rehabilitation facility may choose to follow a facility specific policy and ''close'' the medical record of a patient that has an overnight stay in an acute care hospital, or to keep the chart ''open'' during this period of time. However, to be in compliance with Medicare regulations, if a patient has an overnight stay in an acute care hospital or unit, then for Medicare payment purposes the rehabilitation facility must discharge the patient.

For the purpose of the MDS–PAC, enter the date the patient first started to be furnished Medicare-covered Part-A services in your rehabilitation facility for the current precipitating event/problem. This date should correspond with the date used by the billing office to initially start billing Medicare for this stay.

Process: Review the clinical record. If it is unclear what date the person first started being furnished Medicare-covered Part A services for the current stay and for the current precipitating event/problem, clarify with the admissions/ business or medical record departments.

Coding: For a one digit month or day, place a zero in the first box. For example: July 1, 2000, should be entered as follows:



3. Reason for Assessment

Intent and Definition: To document the key reason for completing the MDS–PAC assessment.

Process: Calculate the length of time the patient has been receiving Medicare-covered Part-A services during the current stay. Then determine the type of assessment for which the data must be collected and recorded on the MDS–PAC.

Coding: Code for appropriate assessment.

1. Admission assessment (covers first 3 days)—Completed on day 4.

2. Reassessment—Completed on day 11.

3. Reassessment—Completed on day 31.

4. Reassessment—Completed on day 61.

5. Discharge assessment—After the assessment reference date for the discharge MDS–PAC assessment is determined, the completion date for the discharge MDS–PAC assessment must be set. The completion date for the discharge MDS–PAC assessment must be the fifth calendar day following the discharge MDS–PAC assessment reference date. To count the 5 calendar days following the discharge MDS–PAC assessment reference date count the discharge MDS–PAC assessment reference date as day 1 of the 5 calendar days. For example, if the MDS–PAC assessment reference date is May 1, 2000, then the MDS–PAC completion date would be May 5, 2000.

The following tables illustrate the relationship between the type of MDS–PAC assessment (the Day 4, Day 11, Day 30, Day 60, and discharge assessment), and the observation time period, the assessment reference date, and the MDS–PAC completion date. In addition, for each type of MDS–PAC assessment the tables depict the associated encoding date and by when the data for that type of assessment must be transmitted.

TABLE 1.—MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed on:	Hospitalization episode covered by this assessment:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	Day 3	Day 4	Entire Hospitalization Time Period.	Day 10	Day 16.
Day 11	Days 8 to 10	Day 10	Day 11		Day 17	Day 23.
Day 30	Days 28 to 30	Day 30	Day 31		Day 37	Day 43.
Day 60	Days 58 to 60	Day 60	Day 61		Day 67	Day 73.

Table 1 above represents the generic assessment schedule and other associated MDS—PAC dates. The term ''day'' refers to the number of calendar days during the patient's current hospitalization that the patient has been hospitalized as a Medicare Part A patient.

Table 2 below is an example of how Table 1 would be applied using actual calendar dates. In Table 2 it is assumed that the patient was admitted on April 3, 2001.

TABLE 2.—EXAMPLE APPLYING THE MDS–PAC ASSESSMENT SCHEDULE AND ASSOCIATED DATES

MDS–PAC assessment type	Hospitalization time period and observation time period	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Day 4	First 3 Days	04/05/01	04/06/01	04/12/01	04/18/01
Day 11	Days 8 to 10	04/12/01	04/13/01	04/19/01	04/25/01
Day 30	Days 28 to 30	05/02/01	05/03/01	05/09/01	05/15/01
Day 60	Days 58 to 60	06/01/01	06/02/01	06/08/01	06/14/01

TABLE 3.—EXAMPLE APPLYING THE MDS–PAC DISCHARGE ASSESSMENT DATES

MDS–PAC assessment type	Discharge date	MDS–PAC assessment reference date	MDS–PAC must be completed by:	MDS–PAC must be encoded by:	MDS–PAC must be transmitted by:
Discharge Assessment	5/01/00	5/01/00	5/05/00	5/11/00	5/17/00

*This is either when the first of the following occurs: (1) The day the patient is discharged from the IRF, or (2) the day the patient ceases receiving Medicare-covered Part-A inpatient rehabilitation services.

4. Admission Status

Intent: The purpose of this item is to determine if the patient has been previously admitted for rehabilitation of this problem.

Process: Talk to the patient and family if necessary. Review the medical record to determine what type of facility this patient has been admitted from.

Coding: Place the number of the most appropriate code in the box.

0. First admission to inpatient rehabilitation services.

1. Readmission to rehabilitation but not directly from other rehabilitation.

2. Readmission directly from other rehabilitation.

5. Goals for Stay

Intent: To document the expected outcomes of the patient's post acute care stay. It is possible and common to have more than one goal for the stay.

Definition: a. Medical stabilization—Patient's condition is unstable and requires frequent medical and nursing monitoring (for example, vital signs; drug levels; laboratory evaluation) and interventions (for example, titrating drug dosages; transfusions) in an effort to achieve a steady state/program of care.

b. Rehabilitation/Functional Improvement—Care is directed towards the attainment of baseline (or prior to the precipitating event) level of function in a selected area or areas, for example, activities of daily living, instrumental activities of daily living, cognitive status, communication status, or psychosocial functioning.

c. Recuperation—Care directed towards recovery from an illness by regaining health or strength. Often includes patient or family caregiver teaching to prepare for different level of care (for example, medication management; energy conservation; ostomy care).

d. Monitoring to avoid clinical complication—For a medically stable patient, care directed at systematic monitoring of the patient's condition through observation (that is, clinical signs and symptoms) and measurement of physical parameters (that is, lab values; respiratory function tests) with the intent of preventing complications associated with the patient's clinical condition.

e. Palliative care—A primary goal of care is to provide comfort and quality of life through the prevention and control of symptoms near the end of life. Palliative care often includes active treatment of associated conditions in an effort to promote a sense of well-being at the end of life (for example, antidepressant drugs/psychotherapy for depression; physical therapy as an adjunct to pain management and prevention of pressure ulcers; nutritional counseling).

Coding: Code each possible goal with one of the following responses, as appropriate:

0. No.

1. Yes.

6. Admitted From (At admission date A2)

Intent: To facilitate care planning by documenting the place from which the patient was admitted to the facility on the date recorded in item A2.

Definition: 1. Private home—Any house or condominium in the community whether owned by the patient or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.

2. Private apartment—Any apartment in the community whether owned by the patient or another person.

3. Rented room—A rented room in a private house, boarding house, or hotel.

4. Board and care/group home—A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home

health, homemaker, personal care, meal service, transportation, etc.

5. Assisted living—A housing option for older adults who need some assistance with activities of daily living (ADLs) but do not require 24-hour nursing care.

6. Homeless shelter—A community-based shelter for individuals who do not have a place to reside.

7. Transitional living—A community based supervised setting where individuals are taught skills so that they can live independently in the community.

8. Long term care facility (nursing home)—A licensed health facility that provides 24-hour skilled or intermediate nursing care.

9. Post acute care SNF—Facility (or designated beds within a SNF) dedicated to the care of patients with intense rehabilitative or clinically complex needs. Most patients are admitted to the post acute care facility from an acute hospital, or rehabilitation hospital. These patients will have a short, intense stay in the post acute care SNF.

10. Acute care hospital (not rehabilitation unit)—A facility licensed as an acute care hospital which focuses primarily on the diagnosis and treatment of acute medical (and in some cases psychiatric) disorders.

11. Rehabilitation unit (in acute care hospital)—A unit within an acute care hospital that focuses on the acute rehabilitation of individuals who have been functionally affected by disease or injury.

12. Rehabilitation hospital—A facility licensed as a rehabilitation hospital that focuses on the physical rehabilitation of individuals who have been functionally affected by disease or injury.

13. Long term care hospital—A facility licensed as a long-term care hospital. Included are hospitals that focus on the management of clinically complex patients, chronic medical needs, chronic disease, etc. (includes chronic disease hospitals, and long term acute care hospitals).

14. Psychiatric hospital/unit—A facility licensed as a psychiatric hospital or unit which focuses on the diagnosis and treatment of psychiatric disorders.

15. MR/DD facility (exclude group home)—A facility which specializes in the management and rehabilitation of individuals with mental retardation or developmental disorders. Examples include mental retardation or developmental disabilities facility (including MR/DD institutions) and intermediate care facilities for the mentally retarded (ICF/MRs).

16. Other hospital—Any other hospital not categorized above (may include in-patient hospice programs).

17. Outpatient surgery center—A stand-alone or hospital-affiliated outpatient surgery center designated to provide perioperative care (no inpatient beds). Includes same-day surgery units.

18. Other—Any other setting not categorized above.

Process: Review the medical record. If unavailable in medical record, ask patient or family.

Coding: Choose only one answer and enter the appropriate code in the box provided.

7. Precipitating Event Prior to Admission

a. Time of onset of the precipitating event or problem that directly preceded admission into this facility (time from admission date—item A2).

Intent: This item seeks to provide the care team with some perspective on the event that caused the admission.

Process: Review medical record for history of the event or problem using admission date to the facility (item A2) as a reference point. If necessary, clarify with patient or family.

Coding: Enter the number that best represents the time period in which the precipitating event occurred. This information is obtained only on admission, but must be coded and submitted to the HCFA MDS–PAC system for each subsequent (for example, the Day 11) assessment.

0. Within last week.

1. Within last 8–14 days.

2. 15–30 days ago.

3. 31–60 days ago.

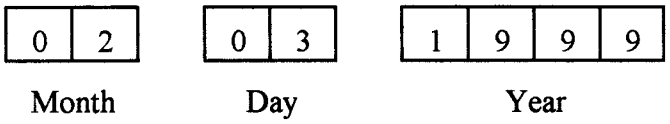
4. More than 60 days ago.

b. Date of admission of most recent acute care hospitalization (within last 90 days).

Intent: This item (in addition to the next) gives perspective on the amount of time the patient spent in the hospital. If there was NO hospitalization in the last 90 days, leave this section blank and move on to item A8.

Process: Review the medical record. Hospital discharge summaries are the most efficient means to gather this information, if available. If unavailable, consult with patient or family.

Code: Enter the date of admission to the hospital in space provided. For a one-digit month or day, place a zero in the first box. For example: February 3, 1999, should be entered as:



c. Reason for most recent acute care hospitalization (within last 90 days).

Definition: Hospitalization—The patient was formally admitted to an acute care hospital by a physician as an inpatient with an overnight stay. This category does not include day surgery or outpatient services.

New problem—A condition that is distinctly different or unrelated to any previously identified disease or condition of the patient.

Exacerbation—Recurrence or aggravation of symptoms or increase in the severity of a previously identified disease or condition.

Process: Review medical record. If necessary, clarify with patient or family.

Coding: Using the following codes, enter the number that best represents the reason the patient was most recently hospitalized.

0. Not Hospitalized at any time in last 90 days.

1. New problem.

2. Exacerbation.

3. Both (New Problem and Exacerbation).

8. Primary and Secondary Payment Sources for Stay (Per diem)

Intent: To document the payment source(s) that covers the daily per diem services for this post acute stay.

Definition: Per diem—Room, board, nursing services and other services included in the routine daily charge.

Process: Consult with the business or billing office to review current payment sources. Do not rely exclusively on information recorded in the patient's medical record (usually the face sheet at the front of the chart) as the patient's clinical condition may trigger different sources of payment during the stay. It's important to capture all methods of payment; usually business offices track such information.

Coding: Using the following list, enter the code which best indicates the primary and secondary payment sources in the appropriate boxes. In Column A, code for the primary payment source for the stay. In Column B, code for the secondary payment source for the stay.

Note: The code for Column B can't be the same as the code in Column A.

0. None—no insurance coverage, no private pay.

1. Medicare.

2. Medicaid.

3. CHAMPUS.

4. Department of Veterans Affairs.

5. Managed Care/HMO—Medicare.

6. Managed Care/HMO—non-Medicare.

7. Private insurance.

8. Private pay—self or family pays, includes private pay by patient or family.

9. Worker's Compensation.

10. Other payment—examples include Commission for the Blind, Alzheimer's Association.

9. Marital Status

Process: Ask patient or family member.

Coding: Choose the code that best describes the patient's current marital status. If the patient is in a ''Common Law'' marriage, enter code ''2'', Married. Common Law marriage—a couple who have been co-habitating and who consider themselves as being married, even though not legally married.

1. Never married.

2. Married.

3. Widowed.
4. Separated.
5. Divorced.

10. Education (Highest Level Completed)

Intent: To record the highest level of education the patient attained. Knowing this information is useful for assessment (for example, interpreting cognitive patterns or language skills), care planning (for example, deciding how to focus a planned recovery program), and planning for patient education in self-care skills.

Definition: The highest level of education attained.

1. No schooling: Patient/family state that patient received no formal schooling at all.
2. 8th grade or less: Patient attended school through 8th grade level or less.
3. 9th–11th grade: Patient completed school at 9th, 10th, or 11th grade.
4. High School: Patient obtained high school diploma—completed school through the twelfth grade or GED.
5. Technical or Trade School: Include schooling in which the patient received a non-degree certificate in any technical occupation or trade (for example, carpentry, plumbing, acupuncture, baking, secretarial, practical/vocational nursing, computer programming, etc.).
6. Some College: Includes completion of some college courses at a junior (community) college, associate's degree, or incomplete bachelor's degree.
7. Bachelor's degree: Includes any undergraduate bachelor's level college degree.
8. Graduate Degree: Master's degree or higher (M.S., Ph.D., M.D., J.D., etc.).

Note: If assessor has been unsuccessful in determining educational information, the assessor may use a ''dash'' symbol to indicate information not available.

Process: Ask the patient or family. If a part of your facility's standard intake record, review the patient's record.

Coding: Code for the best response. For MR/DD patients who have received special education services, code ''2'' (8th grade/less).

11. Language

Definition: (a.) Primary language—The language the patient primarily speaks or understands. If patient is unable to speak at the present time, code for language familiar to patient prior to the precipitating event.

Process: Determine patient's primary language by asking the patient or family. If a part of your facility's standard intake record, review the patient's record.

Coding: Given the choices provided, indicate what the patient identifies as their primary language.

0. English.
1. Spanish.
2. French.
3. Other, specify in A11b.

(b.) If the patient's primary language is other than English, Spanish, or French, enter 3 for Other in item A11a, and print the primary language in item A11b beginning in the left-most box.

12. Dominant Hand

Intent: To document which hand the patient considers to be the ''dominant'' hand. Knowing the patient's ''handedness'' can facilitate rehabilitation and assist in the detection of neurological and functional diagnoses.

Definition: The dominant hand describes what is usually referred to as ''handedness'' and reflects the area of the brain that is most dominant.

Process: Ask patient, family, or therapy staff.

Coding: Indicate which hand the individual has considered to be dominant since childhood. If an individual feels that both hands are equal (ambidextrous), enter code ''3'', unable to determine. Also use code ''3'' if you are unable to obtain this information from the patient, family or medical record.

If Right handed, code ''1''.
If Left handed, code ''2''.
If Unable to determine, code ''3''.

13. Mental Health History

Intent: To document a primary or secondary diagnosis of psychiatric illness or developmental disability.

Definition: Patient has one of the following:

- A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder, personality disorder; other psychotic disorder; or another mental disorder that may lead to chronic disability; but
- Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder;

AND

- The disorder results in functional limitations in major life activities that would be appropriate within the past 3 to 6 months for the individual's developmental stage;

AND

- The treatment history indicates that the individual has experienced either: (a) Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (for example, partial hospitalization or inpatient hospitalization); or (b) within the last 2 years due to the mental disorder, experienced an episode of significant disruption to the normal living situation, for which formal supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

Process: Review the patient's record *only.* For a ''Yes'' response to be entered, there must be written documentation (that is, verbal reports from the patient or patient's family are not sufficient).

Coding: Enter ''0'' for No or ''1'' for Yes.
0. No.
1. Yes.

14. Conditions Related to MR/DD Status (Mental Retardation/Developmental Disabilities)

Intent: To document presence of mental retardation or developmental disabilities with and without organic conditions.

Process: Review the patient's record only. Condition must be documented in the clinical record. Examples of organic conditions related to MR/DD are rubella, prenatal infection, congenital syphilis, maternal intoxication, mechanical injury at birth, prenatal hypoxia, neuronal lipid storage diseases, phenylketonuria (PKU), neurofibromatosis, microcephalus, macroencephaly, meningomyelocele, congenital hydrocephalus, etc.

Coding: If organic condition is present, check if condition is related to MR/DD status present before age 22. When age of onset is not specified, assume that the condition meets this criterion AND is likely to continue indefinitely.

1. Not applicable—No MR/DD.
2. MR/DD with no organic condition.
3. MR/DD with organic condition.

15. Responsibility/Legal Guardian

Intent: To record who has responsibility for participating in decisions about the patient's health care, treatment, financial affairs, and legal affairs. Depending on the patient's condition, multiple options may apply. For example, a patient with moderate dementia may be competent to make decisions in certain areas, although in other areas a family member will assume decision-making responsibility. Or a patient may have executed a limited power of attorney to someone responsible only for legal affairs.

Definition: a. Legal guardian—Someone who has been appointed after a court hearing and is authorized to make decisions for the patient, including giving and withholding consent for medical treatment. Once appointed, the decision-making authority of the guardian may be revoked only by another court hearing.

b. Other legal oversight—Use this category for any other program in your State whereby someone other than the patient participates in or makes decisions about the patient's health care and treatment.

c. Durable power of attorney/health care—Documentation that someone other than the patient is legally responsible for health care decisions if the patient becomes unable to make decisions. This document may also provide guidelines for the agent or proxy decision-maker, and may include instructions concerning the patient's wishes for care. Unlike a guardianship, durable power of attorney/health care proxy terms can be revoked by the patient at any time.

d. Patient responsible for self—Patient retains responsibility for decisions. In the absence of guardianship or legal documents indicating that decision-making has been delegated to others, always assume that the patient is the responsible party.

e. NONE OF THE ABOVE.

Process: Legal oversight such as guardianship, durable power of attorney, and living wills are generally governed by state law. The descriptions provided here are for general information only. Refer to the law in your State and to the facility's legal counsel, as appropriate, for additional clarification.

Consult the patient and the patient's family. Review records. Where the legal oversight or guardianship is court ordered, a copy of the legal document must be included in the patient's record in order for the item to be checked on the MDS–PAC form.

Coding: Check all that apply.

16. Advance Directives

Intent: To document the existence of any legal directives to guide the health care team in making treatment decisions, whether made by the patient him/herself or a legal proxy. This documentation must be in the medical record to be considered current and binding. The absence of pre-existing directives for the patient provides an opportunity for a discussion by the clinical team with the patient and family regarding the patient's wishes. Any discrepancies between the patient's current stated wishes and what is said in legal documents in the patient's file should be resolved immediately.

Definition: a. Living will—A document specifying the patient's preferences regarding measures used to prolong life when there is a terminal prognosis.

b. Do not resuscitate—In the event of respiratory or cardiac failure, the patient, family or legal guardian has directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods will be used to attempt to restore the patient's respiratory or circulatory function.

c. Do not hospitalize—A document specifying that the patient is not to be hospitalized even after developing a medical condition that usually requires hospitalization.

d. Treatment restrictions—The patient or responsible party (family or legal guardian) does not wish the patient to receive certain medical treatments. Examples include, but are not limited to: blood transfusion, tracheotomy, respiratory intubation, and restraints. Such restrictions may not be appropriate to treatments given for palliative reasons (for example, reducing pain or distressing physical symptoms such as nausea or vomiting). In these cases, the directive should be reviewed with the responsible party. Treatment restrictions could also include:

• *Feeding restrictions*—The patient or responsible party (family or legal guardian) does not wish the patient to be fed by artificial means (for example, tube, intravenous nutrition) if unable to be nourished by oral means.

• *Medication restrictions*—The patient or responsible party (family or legal guardian) does not wish the patient to receive life-sustaining medications (for example, antibiotics, chemotherapy).

e. NONE OF THE ABOVE.

Process: You will need to familiarize yourself with the legal status of each type of directive in your State. In some states only a health care proxy is formally recognized; other jurisdictions allow for the formulation of living wills and the appointment of individuals with durable power of attorney for health care decisions. Facilities should develop a policy regarding documents drawn in other states, respecting them as important expressions of the patient's wishes until their legal status is determined.

Review the patient's record for documentation of the patient's advance directives. Documentation must be available in the record for a directive to be considered current and binding.

Some patients at the time of admission may be unable to participate in decision-making. Staff should make a reasonable attempt to determine whether the new patient has ever created an advance directive (for example, ask family members, check with the primary physician). Lacking any directive, treatment decisions will likely be made in concert with the patient's closest family members or, in their absence or in case of conflict, through legal guardianship proceedings.

Coding: The following comments provide further guidance on how to code these directives. You will also need to consider State law, legal interpretations, and facility policy.

• The patient (or proxy) should always be involved in the discussion to ensure informed decision-making. If the patient's preference is known and the attending physician is aware of the preference, but the preference is not recorded in the record, check the MDS–PAC item only after the preference has been documented.

• If the patient's preference is in areas that require supporting orders by the attending physician (for example, do not resuscitate, do not hospitalize, feeding restrictions, other treatment restrictions), check the MDS–PAC item only if the document has been recorded or after the physician provides the necessary order. Where a physician's current order is recorded but patient's or proxy's preference is not indicated, discuss with the patient's physician and check the MDS–PAC item only after documentation confirming that the patient's or proxy's wishes have been entered into the record.

• If your facility has a standard protocol for withholding particular treatments from all patients (for example, no facility staff member may resuscitate or perform CPR on any patient; facility does not use feeding tubes), check the MDS–PAC item only if the advanced directive is the individual preference of the patient (or legal proxy), regardless of the facility's policy or protocol.

Coding: Check all that apply. If none of the directives are verified by documentation in the medical records, check NONE OF ABOVE.

Section B. Cognitive Patterns

Intent: To assess the patient's ability to think coherently, remember and organize thoughts into actions, including daily self-care activities. These items focus on the patient's functional performance, including demonstration of ability to remember recent and past events, to perform key decision making skills. This information can significantly contribute to the development of a post acute plan of care, including the discharge plan.

Questions about cognitive function and memory can be threatening or sensitive for some patients. Some may react defensively or get agitated and emotional if unable to remember or answer the questions. These are not uncommon reactions to ''performance anxiety'' and feelings of being exposed, embarrassed, or frustrated if the patient is aware that he or she cannot respond cogently. It is important to recognize these feelings and to be as supportive as possible.

It is important to establish an environment that enables the patient to function at their optimal level. The first few days of admission to a post acute setting can be overwhelming. Be sure to interview the patient in a private, quiet area (for example, limit distractions and interruptions as much as possible), and not in the presence of other patients or family, unless the patient would prefer that they stay. Using a non-judgmental approach to questioning will help create a needed sense of trust between the assessor and the patient. Clarify and validate your findings with the patient's family or other clinicians as needed. This input is especially important for those patients with limited communication skills or language barriers.

Engage the patient in general conversation to help establish rapport.

• Actively listen and observe for clues to help you structure your assessment. Remember that repetitiveness, inattention, rambling speech, defensiveness, or agitation may be challenging to deal with during an interview, but they provide important information about cognitive function.

• Be open, supportive, and reassuring during your conversation with the patient (for example, ''Do you sometimes have trouble remembering things? Tell me what happens. We will try to help you'').

If the patient becomes really agitated, sympathetically respond to his or her feelings of agitation and STOP discussing cognitive function. The information-gathering process does not need to be completed in one sitting during the three-day observation/assessment period but may be ongoing during the entire assessment period. Say to the agitated patient, for example, ''Let's talk about something else now,'' or ''We don't need to talk about that now. We can do it later''. Observe the patient's cognitive performance over the next few hours and days and come back to ask more questions when he or she is feeling more comfortable.

1. Comatose

Intent: To record whether the patient's clinical record includes a documented neurological diagnosis of coma or persistent vegetative state.

Process: Review medical record for documentation.

Coding: Enter the appropriate number in the box.

If the patient has been diagnosed as comatose or in a persistent vegetative state, code ''1'' (Yes) and Skip to Section E. If the patient is not comatose, or is semi-comatose, code ''0'' (No) and proceed to the next item (B2).

2. Memory/Recall Ability

Intent: To determine a patient's ability to remember recent and past events (that is, short-term, long-term, situational and procedural memory).

Process: a. Short-term memory OK: Ask the patient to describe a recent event that both of you have had the opportunity to remember (you should be able to validate that patient's memory with your knowledge of such events). Examples include what the patient had for breakfast, when the last pain medication dosage was received, (you can validate the patient's recollection with information from the medical record). For persons with verbal communication deficits,

non-verbal responses are acceptable (for example, when asked how many children visited today, they can correctly tap out a response of the appropriate number). If there is no positive indication of memory ability, code ''1'', Memory problem.

b. Long-term memory OK: Engage in conversation about past events that are meaningful to the patient (for example, family, hospitalization, work experience). Ask questions for which you can validate the answers (from your review of the medical record, general knowledge, the patient's family). For patients with limited communication skills, ask family members about their perception of the patient's memory. If the patient demonstrates difficulty remembering key events of long ago, code ''1'', Memory problem.

c. Situational memory OK: This item refers to two abilities that can be demonstrated by the patient within the facility: (1) The patient's ability to recognize the names and faces of staff whom they frequently encounter, AND (2) the patient's ability to remember the location of places regularly visited (for example, bedroom, meal room/dining area, activity room, therapy room). IMPORTANT: For coding purposes, the patient must demonstrate positive abilities in BOTH types of situations to be coded as ''0'', Memory OK. If she/he demonstrates difficulty in one or both areas code as ''1'', Memory problem.

• Recognize staff names and faces—The patient distinguishes staff caregivers from family members, strangers, visitors, and other patients. It is not necessary that the patient remembers all staff members' names, but to recognize them as staff caregivers (that is, nurse, therapist) vs. others.

• Remember the location of places regularly visited—The patient is able to locate or recognize key areas of the facility that they frequent regularly. It is not necessary for the patient to know his/her room number but he/she should be able to find the way to his room, recognize the purposes of particular rooms, etc.

d. Procedural Memory OK: This MDS–PAC item refers to the ability to perform sequential activities. Dressing is an example of such a task as it requires multiple steps to complete the entire task. The patient must be able to perform or remember to perform all or most all of the steps in order to be scored a ''0'' Memory O.K. If the patient demonstrates difficulty in two or more steps, code as ''1'' Memory Problem.

Coding: For each type of memory:

Code ''0'' in the box provided, if memory OK.

Code ''1'' in the box provided, if memory problem is demonstrated.

3. Cognitive Skills for Daily Decision Making

Intent: To record the patient's ability and actual performance in making every day decisions about tasks or activities of daily living. This item is especially important for assessment and care planning for 2 reasons: (1) The information can alert health care providers to new changes (decline or improvement) in the patient's cognitive function, and (2) the information can alert staff to a discrepancy between a patient's capacity for decision-making and their current level of performance, which may indicate that caregivers or family may be inadvertently fostering the patient's dependence. It may have an impact on the course of treatment outcomes and discharge plan.

For persons who have been acutely ill, it is important to determine the patient's ''baseline'' cognitive skills from some point prior to the current admission (Note: this instrument uses a time period prior to the assessment reference date [item AA4]), as well as his/her current skills (Note: the last 3 days, and the time immediately prior to precipitating event), so that the clinician can make a comparison for diagnostic and care planning purposes. Even slight deviations (decline) from baseline may be secondary to a variety of causes including: (1) The outcome of a recent acute event (for example, a primary neurological event such as a CVA; post anesthesia), (2) an evolving acute illness or exacerbation of disease (for example, infection; congestive heart failure; dehydration; drug effects or interactions; depression), or (3) a progression of a chronic neurological condition (for example, Alzheimer's disease; Huntington's disease). Detecting change is the first step in determining whether the change is due to a remediable condition or chronic decline. Likewise, follow-up measurements can provide an indication of success of treatment programs, prognosis for independent living, etc.

(a) Making decisions regarding tasks of daily life.

Process: This assessment should be conducted through conversation with direct care staff, a review of the clinical record (chart), in addition to personally observing and interacting with the patient [Note—this personal interaction can occur in the course of regular ongoing care activities; or it can be a part of a planned MDS–PAC interview/observation where a series of issues are reviewed—cognition, mood, ADLs, activities]. Your inquiry should focus on whether the patient is actively making choices, plans, and decisions, and not whether staff believe the patient might be capable of doing so. Remember, the intent of this item is to record what the patient is doing (performance). Where a health care provider or family member takes decision-making responsibilities away from the patient regarding tasks of everyday living or the patient does not participate in decision-making (which may happen when patients take on the ''sick'' role), consider the patient to have impaired performance in decision making. In this case document how they function now rather than your supposition of their capacity to function. Consult with family and health care providers where necessary to clarify patient decision making.

Coding: Enter the number that most accurately characterizes the patient's cognitive performance in making decisions regarding the tasks of daily life over the last three days.

0. Independent—The patient's decisions in planning and executing daily routines and making decisions were consistent, reasonable, safe, and organized reflecting lifestyle, culture, values.

1. Modified Independence—The patient was organized in daily routines and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.

2. Minimally Impaired—For the most part, the patient was organized in daily routines and made safe decisions, but in specific situations the patient demonstrated poor decision-making skills requiring directions or cues or supervision at those times.

3. Moderately Impaired—The patient demonstrated poor decision making skills that could place his/her safety at risk. The patient needs reminders, cues and supervision in planning, organizing, correcting, and carrying out daily routines. Cues and supervision are required at all times.

4. Severely Impaired—The patient's decision making was severely impaired: the patient never (or rarely) makes decisions.

(b) Is now more impaired in decision making than prior to precipitating event (item A7a).

Intent: To record whether the patient is now more impaired than she/he was at a specified period in time prior to the precipitating event (that is, the current score to item B3a is higher that it would have been prior to the precipitating event).

Process: Through patient interview, family reports, or review of earlier clinical record, compare the patient's current skills in daily decision making with their skills immediately prior to the precipitating event [Item A7a].

Coding: Enter the number corresponding to the most appropriate response.

0. No or unsure.

1. Yes, more impaired today.

4. Indicators of Delirium—Periodic Disordered Thinking/Awareness

Intent: To assess and record behavioral signs that may indicate that delirium is present. The characteristics of delirium are usually manifested behaviorally, and therefore can be observed. For example, disordered thinking, a typical characteristic of delirium, may be first observed as rambling, irrelevant, or incoherent speech. Other typical behaviors are described in the definitions below.

Many acute conditions (for example, infections; congestive heart failure) and treatment (for example, polypharmacy; anesthesia; anticholinergic drugs) can have a deleterious effect on cognitive performance and the development of delirium, particularly in persons with the following risk factors: over age 80 years, prior history of cognitive impairment, recent hip fractures, complex medical conditions and drug regimens, recent hospitalization, and history or signs/symptoms of depression. The incidence rate of delirium among acute care hospital patients is as high as 41% and often occurs by day 2 through 6 of the hospitalization. Approximately 48–96% of patients continue to have some behavioral and cognitive symptoms by discharge. With the shortening of hospital stays, and the shift towards earlier discharge to post acute environments it is crucial for clinicians to identify and monitor for behavioral

manifestations of delirium for two reasons: (1) to identify new or worsening signs that herald the onset of a treatable acute condition, and (2) to document the progression of changes over time for discharge planning.

Definition: a. Easily distracted—(for example, has difficulty paying attention, does not complete tasks or conversations without getting sidetracked)

b. Periods of altered perception or awareness of surroundings—(for example, moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)

c. Episodes of disorganized speech—(for example, speech is incoherent, nonsensical, irrelevant, rambling from subject to subject; loses train of thought)

d. Periods of restlessness—(for example, fidgeting or picking at skin, clothing, napkins, etc.; frequently changing positions; repetitive physical movements or calling out)

e. Periods of lethargy—(for example, sluggishness, staring into space; difficult to arouse; little body movement)

f. Mental function varies over the course of the day—(for example, alertness and behaviors vary during the course of the day, sometimes better, sometimes worse; sometimes present, sometimes not)

Process: Observe patient and interview staff.

Coding: Code for the patient's behavior in the last seven days regardless of what you believe the cause to be—focus on when the manifested behavior first occurred. Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time.

0. Behavior not present.

1. Behavior present, not of recent onset.

2. Behavior present over last 7 days appears different from the patient's usual functioning (for example, new onset or worsening).

Section C. Communication/Vision Patterns

Intent: To document the patient's sensory function (for example, ability to hear and see with assistive devices, if used, and/or environmental adjustments, if necessary) and ability to understand and communicate with others.

Communication—There are many possible causes for communication problems experienced by elderly and post acute patients. Some can be attributed to the aging process; others are associated with progressive physical and neurological disorders. Usually the communication problem is caused by more than one factor. For example, a patient might have aphasia as well as long standing hearing loss; or he might have dementia with word finding difficulties and a hearing loss. The patient's physical, emotional, and social situation may also complicate communication problems. Additionally, a noisy or isolating environment can inhibit opportunities for effective communication.

Deficits in ability to make one's self understood (expressive communication deficits) can include reduced voice volume and difficulty in producing sounds, or difficulty in finding the right word, making sentences, writing, and gesturing. Deficits in one's ability to understand (receptive communication deficits) can involve declines in hearing, comprehension (spoken or written), or recognition of facial expressions.

Vision—Visual limitations or difficulties may be related to the aging process as well as to diseases common in aged and chronically ill persons (for example, cataracts, glaucoma, macular degeneration, diabetic retinopathy, neurologic diseases). It is important to identify visual impairment. Some conditions may be treatable and reversible; others, though not reversible, may be managed by interventions aimed at maintaining or improving the patient's residual visual abilities. In the post acute setting, identifying and addressing visual impairment is an important part of preparing the patient for tasks related to self-care upon potential discharge to a more independent care setting (for example, reading medication and food labels; safely negotiating a living environment; using the stove).

1. Hearing

Intent: To evaluate the patient's ability to hear (with hearing appliance, if used, and/or environmental adjustments, if necessary) during the last 3-day period. Identifying impairments early in the post acute stay can facilitate the development of necessary adaptions for discharge. Often the environment can have an impact on the patient's ability to hear and must be considered in the assessment.

Process: If the patient has an adaptive hearing device/aid/appliance, evaluate hearing ability with the working device in place. Interview the patient (ask about hearing function) and observe for hearing function during your verbal interactions. Use a variety of observations to make your assessment (for example, one-on-one vs. group situations). Always be mindful of environmental factors that may influence your assessment (for example, call bells; vacuum cleaners; suctioning equipment; roommate's conversations; outside noises, etc.). If necessary to clarify exact hearing level, consult with the patient's family, primary caregivers, or speech or hearing specialists.

Be alert to what you have to do to communicate with the patient. For example, if you have to speak more clearly, use a louder tone, speak more slowly, or use more gestures, or if the patient needs to see your face to know what you are saying, or if you have to take the patient to a more quiet area to conduct the interview—all of these are cues that there is a hearing problem, and should be indicated in coding this section.

Coding: Enter the number that corresponds to the most correct response.

0. Hears adequately—The patient hears all normal conversational speech, social interaction, including when using the phone, and watching TV.

1. Minimal difficulty—The patient hears speech at conversational levels but has difficulty hearing when the environment is not quiet or when he/she is in group situations. Background noise affects hearing.

2. Hears in special situations only—The patient is hearing deficient but compensates and hears better when the speaker increases volume, adjusts his voice tone, and/or speaks distinctly; or the patient can hear only when the speaker's face is clearly visible.

3. Highly impaired/absence of useful hearing—The patient hears only some sounds and frequently fails to respond even when speaker adjusts tone and volume, speaks slowly and distinctly, or is positioned face-to-face with the patient. There is no comprehension of conversational speech, even when the speaker makes maximum adjustments.

2. Modes of Communication

Intent: To record the types of communication techniques (for example, alternative verbal or non-verbal techniques) used by the patient to make his or her needs or wishes known.

Definition: a. Hearing aid—An apparatus used by those with impaired hearing for amplifying sound.

b. Lip reading—Understanding spoken word by means of visualization of the speaker's mouth and lips.

c. Signs/gestures/sounds—This category includes non-verbal expressions used by the patient to communicate with others.

- Actions may include pointing to words, objects, people; facial expressions; using physical gestures such as nodding head twice for ''yes'' and once for ''no'' or squeezing another's hand in the same manner.
- Sounds may include grunting, banging, ringing a bell, etc.

d. Writing messages to express or clarify needs—Patient writes notes to communicate with others.

e. NONE OF THE ABOVE.

Process: Interact with the patient and observe for any reliance on non-verbal expression (physical gestures, such as pointing to objects), either in one-on-one communication or in group situations. Consult with the direct care staff from all shifts. For patient with limited communication skills, have staff ask patient's family if there are additional effective means of communication.

Coding: Check the boxes for each method used by the patient to communicate his or her needs. If the patient does not use any of the listed items, check NONE OF THE ABOVE.

3. Making Self Understood (Expression)

Intent: To document the patient's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these. In order to monitor the patient's progress, the assessment reflects the patient's status at 2 points in time: over the last 3 days, and immediately prior to the precipitating event (A7a).

(a) Expressing information content—however able.

Process: Interact with the patient. Observe and listen to the patient's efforts to communicate with you using the assistive devices/modes of expression they would normally use to communicate. Consult with the primary caregivers (over all shifts), and speech-language pathologist, if possible, who will be able to report on observations of patient's interactions with others in different

settings (for example, one-on-one, groups) and different circumstances (for example, when calm, when agitated) and different times of day. If direct care staff are uncertain and you require further clarification, consult with family members who frequently visit the patient (if such a person is present).

Coding: Enter the number corresponding to the patient's ability to make self understood over the last 3 days.

0. Understood—The patient expresses ideas clearly, without difficulty.

1. Usually Understood—The patient may have difficulty expressing ideas (finding words or finishing thoughts) but is able to make him/herself understood if the listener is patient and gives him/her time to express himself. Little or no prompting required by the listener.

2. Often Understood—The patient has difficulty finding the right words or finishing thoughts, resulting in delayed or incomplete responses. The patient usually requires some prompting/cuing by the listener to complete or clarify the message (make self understood).

3. Sometimes Understood—The patient has limited ability, but expresses simple, concrete requests regarding at least basic needs that would be generally understood (for example, food, drink, sleep, toilet, pain).

4. Rarely or Never Understood—The patient is not able to communicate effectively. At best, this communication is such that it required staff to interpret the meaning of highly individual, patient-specific sounds or body language (for example, indicated presence of pain or need to use the toilet).

(b) Is now more impaired in making self understood by others than was prior to precipitating event (item A7a).

Process: Through patient interview, family reports, or review of earlier clinical record compare patient's current ability to make self understood (last 3 days) with their ability prior to the precipitating event [Item A7a]).

Coding: Enter the number corresponding to the most appropriate response.

0. No, or unsure.

1. Yes, more impaired today.

4. Speech Clarity

Intent: To document the quality/intelligibility of the patient's speech (not the content or appropriateness).

Definition: Speech—the expression of articulate words.

Process: Throughout the course of the assessment the patient will have many opportunities to talk with you. Listen to the clarity of speech. To assess speech quality over the last 3 days also confer with primary caregivers.

Coding: Enter the number corresponding to the response which best describes the clarity and quality of the patient's speech in the last 3 days.

0. Clear speech—utters distinct, intelligible words.

1. Unclear speech—utters slurred or mumbled words.

2. No speech—absence of spoken words.

5. Ability to Understand Others (Comprehension)

Intent: To describe the patient's ability to comprehend information whether communicated to the patient orally, in writing, or in sign language or Braille. This item measures not only the patient's ability to hear messages but also to process and understand language. In order to monitor the patient's progress, the assessment reflects the patient's status at 2 points in time: the last 3 days, and immediately prior to a more distant precipitating event (A7a).

(a) Understanding verbal information content (however able) with hearing appliance, if used.

Process: Assess the patient using whatever assistive devices/methods (for example, hearing aids) that the patient would usually use in communicating with others. Interact with the patient. Throughout the assessment process and at other times observe the patient and determine his/her ability to comprehend your questions and statements. Try to observe the patient's interactions with others, in different situations and times of day. Consult with primary staff caregivers (over all shifts), and speech-language pathologist (if present) to clarify patient understanding at different times and in different settings. If direct care staff are uncertain and you require further clarification, consult with family member who frequently visits the patient (if such person is present).

Coding: Enter the number corresponding to the patient's ability to comprehend (understand others) over the last 3 days.

0. Understands—The patient clearly comprehends the speaker's message(s) and demonstrates this understanding through words or actions/behaviors.

1. Usually Understands—The patient may miss some part or intent of the message but comprehends most of it. The patient may have periodic difficulties integrating information but generally demonstrates comprehension, by responding in words or actions. Little or no prompting required.

2. Often Understands—The patient may miss some part or intent of the message. When the messenger(s) (staff or family) rephrase or simplify the message(s) or use gestures, and specifically inquires as to the patient's understanding of what is being communicated, the patient's comprehension is enhanced. This type of prompting occurs often.

3. Sometimes Understands—The patient demonstrates frequent difficulties integrating information and responds adequately only to simple and direct questions or directions/cues (for example, one-step commands such as ''close your eyes'')

4. Rarely/Never Understands—The patient demonstrates very limited ability to understand communication. Based on the patient's verbal and nonverbal responses, staff have difficulty determining whether the patient comprehends messages, or the patient can hear sounds but does not understand messages.

(b) Is now more impaired in understanding others than was prior to precipitating event (Item A7a).

Process: Through patient interview, family reports, or review of earlier clinical record compare patient's current ability to understand others (last 3 days) with their ability immediately prior to the precipitating event [Item A7a].

Coding: Enter the number corresponding to the most appropriate response.

0. No or unsure.

1. Yes, more impaired today.

6. Vision

Intent: To evaluate the patient's ability to see close objects in adequate lighting, using the patient's customary visual appliances for close vision (for example, glasses; contact lenses; magnifying glass). Adequate lighting is defined as the amount of light that is sufficient or comfortable for a person with normal vision.

Process: • Ask the patient about his or her visual abilities for close vision (for example, to see newsprint, menus, greeting cards), use of glasses, contact lenses, etc.

• To validate the patient's reported vision, ask the patient to look at regular-size print in a book or newspaper using whatever visual appliance he or she customarily uses for close vision (for example, glasses, magnifying glass). Then ask the patient to read a few words aloud, starting with larger headlines and ending with the finest, smallest print.

• Be sensitive to the fact that some patients are not literate or are unable to read English. In such cases, ask the patient to read aloud individual letters of different size print or numbers, such as dates or page numbers, or to name items in small pictures.

• If the patient is unable to communicate or follow your directions for testing vision, observe the patient's eye movements to see if his or her eyes seem to follow movement and objects. Though these are gross measurements of visual acuity, they may assist you in assessing whether the patient has any visual ability.

(a) Ability to see in adequate light and with glasses, if used.

Coding: Enter the code that best describes the patient's visual ability given adequate light and use of his/her customary visual aids.

0. Adequate—The patient sees fine detail, including regular print in newspapers/books.

1. Impaired—The patient sees large print, but not regular print in newspapers/books.

2. Moderately Impaired—The patient has limited vision, is not able to see newspaper headlines, but can identify objects in his or her environment.

3. Highly Impaired—The patient's ability to identify objects in his or her environment is in question, but eye movements appear to follow objects (for example, people walking by).

Note: Many patients with severe cognitive impairment are unable to participate in vision screening because they are unable to follow directions or are unable to tell you what they see. However, many such patients appear to ''track'' or follow moving objects in their environment with their eyes. For patients who appear to do this, use code ''3'', Highly Impaired. Even though these are gross measures, with our current limited technology, this is the best general assessment you can do under the circumstances.

4. Severely Impaired—The patient has no vision; reports seeing only light or colors, but eyes do not appear to follow objects (for example, people walking by).

(b) Is now more impaired in vision than was prior to precipitating event (Item A7a).

0. No or unsure.

1. Yes, more impaired today.

Section D. Mood and Behavior Patterns

Mood distress is a serious condition that is associated with significant morbidity and mortality. It may be precipitated by acute illness, loss of independence (whether temporary or permanent), a new diagnosis (possibly terminal), pain, effects of medications, etc. Although changes in mood and behavior can happen to anyone, persons at particular risk for disorders such as depression are those with prior history of mood disorders, mild to moderate cognitive impairment, pain, and unstable health conditions. Many clinicians and patients perceive changes in mood and behavior to be normal, expected reactions to crisis (for example, deteriorating health). Although such reactions are common, it is crucial to identify the particular signs of distress, assess the frequency of their occurrence, and determine whether they are easily altered. Then clinicians can develop an appropriate treatment plan based on the impact of the mood or behavioral indicators on the patient's quality of life and well-being, ability to participate in the post acute treatment and discharge plans, etc.

1. Indicators of Depression, Anxiety, Sad Mood

Intent: To record the frequency of indicators observed in the last 3 days, irrespective of the assumed cause of the indicator (behavior).

Definition: Feelings of psychic distress may be expressed directly by the patient who is depressed, anxious, or sad. However, direct statements such as ''I'm so depressed'' are often rare; signs must be often ''teased'' out by clinicians through observation and interview. Distress may be more commonly expressed in the following ways:

VERBAL EXPRESSIONS OF DISTRESS

a. Patient made negative statements—for example, ''Nothing matters; Would rather be dead than live this way; What's the use; Let me die.''

b. Persistent anger with self or others—for example, easily annoyed, anger at presence in post acute care, anger at care received.

c. Expressions of what appear to be unrealistic fears—for example, fear of being abandoned, left alone, being with others, afraid of nighttime.

d. Repetitive anxious complaints/concerns (non-health related)—for example, persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit.

e. Repetitive health complaints—for example, persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs.

Distress may also be expressed non-verbally and identified through observation of the patient in the following areas during usual daily routines:

SAD, APATHETIC ANXIOUS APPEARANCE

f. Sad, pained, worried facial expressions—for example, furrowed brows.

g. Crying, tearfulness.

h. Repetitive physical movements—for example, pacing, hand wringing, restlessness, fidgeting, picking.

SLEEP CYCLE ISSUES

Distress can also be manifested in disturbed sleep patterns.

i. Insomnia/change in usual sleep patterns—for example, difficulty falling asleep, fewer or more hours of sleep than usual, waking up too early and unable to fall back to sleep.

LOSS OF INTEREST

These items refer to a change in the patient's usual pattern of behavior.

j. Withdrawal from activities of interest—for example, no interest in long standing activities or being with family/friends.

k. Reduced social interaction—for example, less talkative, more isolated.

Process: Initiate a conversation with the patient, being cognizant of earlier statements by (or observations of) the patient. Some patients are more verbal about their feelings than others and will either tell someone about their distress, or tell someone only when asked directly how they feel. For patients who verbalize their feelings, ask how long these conditions have been present. Other patients may be unable to articulate their feelings (that is, cannot find the words to describe how they feel, or lack insight or cognitive capacity). Observe the patient carefully for any indicator, both at the time of the planned assessment and in any direct contacts you may have with the patient during the three days covered by this assessment. Consult with direct-care staff over all shifts, if possible, or other clinicians who work with the patient, or family who have direct knowledge of the patient's typical and current behavior. Relevant information may also be found in the clinical record, although this can vary.

Coding: For each indicator apply one of the following codes based on interactions with and observations of the patient in the last 3 days. Remember, code regardless of what you believe the cause to be.

0. Indicator not exhibited in last 3 days.

1. Exhibited on 1–2 of last 3 days.

2. Exhibited on each of last 3 days.

2. Mood Persistence

Intent: To identify if one or more indicators of depressed, sad or anxious mood [Item D1] were easily altered by attempts to ''cheer up'', console, or reassure the patient over the last three days.

Process: The information on which to base this judgement is gathered as part of the conversations, observation, and record reviews for D1 (the individual indicators of mood state). The key factor here is the need to assess whether (when aggregated across the several mood indicators) the patient cannot be easily consoled, reassured or cheered up.

Coding: One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to cheer up, console, or reassure the patient over last 3 days.

0. No mood indicators or always easily altered.

1. Partially altered or easily altered on only some occasions.

2. All aspects of mood not easily altered.

3. Behavioral Symptoms

Intent: To identify the frequency of behavioral symptoms over the last 3 days that cause distress to the patient, or are distressing or disruptive to other patients or staff members. Such behaviors include those that are potentially harmful to the patient, or disruptive in the environment, even if staff or other patients appear to understand or have adjusted to them (for example, ''Mrs. R. doesn't mean anything by calling out. She does it because she's confused right now.'')

Behavioral symptoms can be associated with an acute illness, a change in medication, or simply a response to or change in the environment. Acknowledging and documenting behavioral symptoms provides a basis for further evaluation, care planning, and delivery of consistent, appropriate care.

Note: Documentation of the patient's behavioral status in the medical record may not be accurate, valid, or complete, and it is not intended to be the only source of information. (See Process below). However, once the frequency and alterability of behavioral symptoms is determined, subsequent documentation should more accurately reflect the patient's status and response to interventions.

Definition: a. Wandering—Locomotion with no discernible, rational purpose. A wandering patient may be oblivious to his or her physical or safety needs. Wandering behavior should be differentiated from purposeful movement (for example, a hungry person moving about the unit in search of food). Wandering may be manifested by walking or by wheelchair use.

Do not include pacing back and forth as wandering behavior. If it occurs, it should be documented in Item D1h, ''Repetitive physical movements''.

b. Verbally Abusive Behavioral Symptoms—Other patients or staff were threatened, screamed at, or cursed at.

c. Physically Abusive Behavioral Symptoms—Other patients or staff were hit, shoved, scratched, or sexually abused.

d. Socially Inappropriate/Disruptive Behavioral Symptoms—Includes disruptive sounds, excessive noise, screams, self-abusive acts, sexual behavior or disrobing in public, smearing or throwing food or feces, hoarding, rummaging through others' belongings.

e. Resists care—Resists taking medications/injections, ADL assistance, help with eating, or changes in position. This category does not include instances where the patient has made an informed choice not to follow a course of care (for example, patient has exercised his or her right to refuse treatment, and reacts negatively if staff try to reinstate treatment).

Signs of resistance may be verbal or physical (for example, verbally refusing care, pushing caregiver away, scratching caregiver). These behaviors are not necessarily positive or negative, and their presence should prompt further investigation of their cause (for example, fear of pain, fear of falling, poor comprehension, anger, poor

relationships, eagerness for greater participation in care decisions, past experience with medication errors and unacceptable care, desire to modify care being provided).

Process: Take an objective view of the patient's behavioral symptoms. The coding for this item focuses on the patient's actions, not intent. It is often difficult to determine the meaning behind a particular behavioral symptom. Therefore, it is important to record all behavioral symptoms. The fact that staff have become used to the behavior and minimize the patient's presumed intent (''He doesn't really mean to hurt anyone. He's just frightened.'') is not pertinent to this coding. Does the patient manifest the behavioral symptom or not?

Observe the patient and how he/she responds to caregiver attempts to deliver care to him or her. Consult with staff who provide direct care on all three shifts. A symptomatic behavior may be present and might not be seen because it occurs during intimate care on another shift. Therefore, it is especially important to solicit input from direct caregivers (including nurse assistants) who have contact with the patient.

Simply relying on written notes in the patient record is not sufficient. You must be alert to the possibility that staff might not think to report a behavioral symptom if it is part of the unit norm (for example, staff are working with severely cognitively and functionally impaired patients (for example, in a head trauma unit) and are used to patients' wandering, noisiness, etc.). Focus staff attention on what has been the individual patient's actual behavior over the last three days. Finally, although it may not be complete, review the clinical record for documentation of behaviors you may not have seen, nor staff reported. When such a note is found, review the patient's status with staff. Is the note correct? Is it within the appropriate time frame of the record?

Coding: Behavioral symptom frequency in last 3 days.

Record the frequency of behavioral symptoms manifested by the patient across all three shifts.

Code ''0'' if the described behavioral symptom was not exhibited in last three days. This code applies to patients who have never exhibited the behavioral symptom or those who have previously exhibited the symptom but now no longer exhibit it, including those whose behavioral symptoms are fully managed by psychotropic drugs, or a behavior-management program. For example: A ''wandering'' patient who has not wandered in the last three days because he was restricted to bedrest and had a private duty nurse attending to him would be coded ''0''—Behavioral symptom not exhibited in last three days.

Code ''1'' if the described behavioral symptom occurred on 1 day.

Code ''2'' if the described behavioral symptom occurred on 2 days.

Code ''3'' if the described behavioral symptom occurred daily or more frequently (that is, multiple times each day) in the last 3 days.

Section E. Functional Status

Patients in post-acute care settings will have acute (and often chronic) illnesses, and they will be subject to a variety of factors that can severely impact self-sufficiency. For example, cognitive deficits can limit a person's ability or willingness to initiate or participate in self-care or constrict understanding of the tasks required to complete the ADLs. A wide range of physical and neurological illnesses can adversely affect physical factors important to self-care such as stamina, muscle tone, balance, and bone strength. Side effects of medications and other treatments can also contribute to needless loss of self-sufficiency.

Individualized plans of care can be successfully developed only when the patient's self-performance has been accurately assessed, including the amount and type of support being provided to the patient by others.

For patients in post acute settings, the focus of the admission assessment is twofold: (1) to determine baseline functional performance levels, and (2) to determine if these levels have recently changed. This information will then be used as a basis for developing a plan of care (for example, targeted rehabilitation and other services) with the goal of leading the patient to an expeditious and coordinated discharge to home or a lower level of care.

1. Activities of Daily Living (ADL) Self-Performance Summary (Over Last Three Days)

Intent: To record a summary of the patient's self-care performance in activities of daily living (that is, what the patient actually did for himself or herself or how much verbal or physical help was required by staff members) during the last three days. This requires a review of all ADL activities over this period.

Definition: ADL SELF–PERFORMANCE—Measures what the patient actually did (not what he or she might be capable of doing) within each ADL category over all shifts for all episodes over the last three days according to a performance-based scale.

a. Bed Mobility—How patient moves to and from a lying position, turns side to side, and positions the body while in bed.

b. Transfer—Bed/Chair—How patient moves between surfaces-that is, to/from bed, chair, wheelchair standing position. This definition excludes movement to/from bath or toilet, which is coded under Transfer Toilet (item E1i) and Transfer Tub/Shower (item E1l).

c. Locomotion—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, locomotion is defined as self-sufficiency once in the chair.

d. Walk in Facility—How patient walks in different areas of the facility. For a patient who uses a wheelchair exclusively, this would be coded as ''8'' (Activity did not occur).

e. Dressing Upper Body—How patient dresses and undresses (street clothes, underwear) above the waist. Includes prostheses, orthotics, fasteners, pullovers, etc.

f. Dressing Lower Body—How patient dresses and undresses (street clothes, underwear) from the waist down. Includes prostheses, orthotics (for example, anti-embolic stockings), belts, pants, skirt, shoes and fasteners.

g. Eating—How patient eats and drinks (regardless of skill). Includes intake or nourishment by other means (for example, tube feeding, total parenteral nutrition).

h. Toilet Use—How patient uses the toilet room (or commode, bed pan, urinal), adjusts clothes before and after using toilet, manages perineal hygiene, changes pad, manages ostomy or catheter. (EXCLUDE transfer to toilet which is coded under item E1i, Transfer Toilet).

i. Transfer Toilet—How patient moves on and off toilet or commode or bedpan.

j. Grooming/Personal Hygiene—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup; and washing/drying face and hands (EXCLUDE baths and showers which are coded in item E1k, Bathing).

k. Bathing—How patient takes full-body bath/shower or sponge bath (EXCLUDE washing of back and hair and TRANSFER [which is coded in item E1l, Transfer Tub/Shower]). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. Note: For this item and item E1l below, you must code for most dependent episode.

l. Transfer Tub/Shower—How patient transfers in/out of tub/shower. Code for most dependent episode.

Process: In order to promote the highest level of functioning among patients, clinical staff must first identify what the patient actually does for himself or herself, noting when assistance is received and clarifying the types of assistance provided (verbal cuing, physical support, etc.)

A patient's ADL self-performance may vary from day to day, shift to shift, or within shifts. There are many possible reasons for these variations, including mood, medical condition, relationship issues (for example, willing to perform for a nurse assistant he or she likes), medications and changes in underlying functional capacity. The responsibility of the person completing the assessment is to capture the total picture of the patient's ADL self-performance over the 3-day period, 24 hours a day—that is, not only how the evaluating clinician sees the patient, but how the patient performs on other shifts as well.

In order to accomplish this, you will need to know about the multiple episodes of the activity over the last 3-days—for example, how the patient dressed and undressed the upper body yesterday, the day before yesterday, and the day before that. To gather this information, there are two obvious sets of people to talk with—the patient and direct care staff—and when you have these conversations, be sure to plan to discuss all ADLs (get the total picture)—that is, if possible, talk with the patient and direct care staff on all three shifts (including weekends) and review documentation used to communicate with staff across shifts.

Ask questions pertaining to all aspects of the ADL activity definitions. For example,

when discussing Bed Mobility with a nurse assistant, be sure to inquire specifically how the patient moves to and from a lying position, how the patient turns from side to side, and how the patient positions himself or herself while in bed. A patient can be independent in one aspect of Bed Mobility yet require extensive assistance in another aspect. Be sure to consider each activity definition fully.

The wording used in each coding option is intended to reflect real-world situations, where slight variations are common. Where variations occur, the coding ensures that the patient is not assigned to an excessively independent or dependent category. For example, by definition, codes 0, 1, 2, and 3 (Independent, Set up Help only, Supervision, Minimal Assistance) permit one or two exceptions for the provision of heavier care. This is clinically useful and increases the likelihood that staff will code ADL Self-Performance items consistently and accurately.

The following chart provides general guidelines for recording accurate ADL Self-Performance.

Guidelines for Assessing (Item E1) ADL Self-Performance (Last 3 Days)

- The coding options for E1 record the patient's actual level of involvement in self-care and the type and amount of support actually received during the last three days—requiring that you have knowledge of all episodes of each of the ADLs (or as near as possible to all episodes).
- Do not record your assessment of the patient's capacity for involvement in self-care—that is, what you believe the patient might be able to do for himself or herself based on demonstrated skills or physical attributes. An assessment of functional prognosis is covered in Item L1 (Functional Improvement Goals by Discharge).
- Do not record the type and level of assistance that the patient ''should'' be receiving according to the written plan of care. The type and level of assistance actually provided may be quite different from what is indicated in the plan. Record what is actually happening.
- Engage direct care staff from all shifts who have cared for the patient over the last three days in discussions regarding the patient's ADL functional performance. Remind staff that the focus is on the last three days only. To clarify your own understanding and observations about each ADL activity (bed mobility, locomotion, transfer, etc.), ask probing questions, beginning with the general and proceeding to the more specific.
- When you are uncertain that the patient could perform the activity as described or conversely where you wonder why the patient is not more independent, observe a regularly scheduled session where this activity is carried out (for example, eating a meal, dressing in the morning). Observation will both help you to validate reported behaviors and will be useful as you go forward to care planning.

Here is a typical conversation between the RN and a nurse assistant regarding a patient's Bed Mobility assessment:

R.N. ''Describe to me how Mrs. L positions herself in bed. By that I mean, once she is in bed, how does she move from sitting up to lying down, lying down to sitting up, turning side to side, and positioning herself?''

N.A. ''She can lay down and sit up by herself, but I help her turn on her side.''

R.N. ''She lays down and sits up without any verbal instructions or physical help?''

N.A. ''No, I have to remind her to use her trapeze every time. But once I tell her how to do things, she can do it herself.'' se supervision

R.N. ''How do you help her turn side to side?''

N.A. ''She can help turn herself by grabbing onto her siderail. I tell her what to do. But she needs me to lift her bottom and guide her legs into a good position.''

R.N. ''Do you lift her by yourself or does someone help you?''

N.A. ''I do it by myself.''

R.N. ''How many times during the last three days did you give this type of help?''

N.A. ''Every time she was turned.''

Provided that ADL function in Bed Mobility was similar on all shifts, Mrs. L would receive an ADL Self-Performance (in the last three days) Code of ''4''.

Now review the first two exchanges in the conversation between the RN and the nurse assistant. If the RN did not probe further, he or she would not have received enough information to make an accurate assessment of either the patient's skills or the nurse assistant's actual workload, or whether the current plan of care was being implemented.

Coding: For each ADL category, code the appropriate response for the patient's actual performance during the last three days. Consider the patient's performance during all shifts, as function may vary. For example, for eating, a patient may receive 3 meals per day and two supplemental feedings. Thus, over 3 days, there would have been 15 feeding episodes. It is this performance experience that forms the basis for scoring item E1g.

0. Independent—No help, or set up or staff oversight/supervision –OR–help, setup or supervision provided only 1 or 2 times during period (with any task or subtask). [See examples of Setup Help in the box following these coding options.]

1. Setup Help Only—Article or device provided or placed within reach of patient 3 or more times. [See examples of Setup Help in the box following these coding options.]

2. Supervision—Oversight, encouragement, or cuing provided 3 or more times during period–OR–Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision).

3. Minimal Assistance (Limited Assistance)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times –OR– Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help).

4. Moderate Assistance (Extensive Assistance)—Patient performed part of activity on own (50% or more of subtasks) BUT help of the following type(s) was provided 3 or more times:

- Weight-bearing support (for example, holding weight of one or both lower limbs, trunk).
- Full staff performance of a task (some of time) or discrete subtask.

5. Maximal Assistance—Patient involved but completed less than 50% of subtasks on own (includes 2 + person assist), received weight bearing help or full performance of certain subtasks 3 or more times.

6. Total Assistance (Total Dependence)—Full staff performance of the activity during the entire period.

8. Activity Did Not Occur—During the last three days, the ADL activity was not performed by the patient or staff. In other words, the specific activity did not occur at all.

For example: A patient who was restricted to bed for the entire three day period and was never transferred from the bed would receive a code of ''8'' for Transfer (Item E1b).

However, do not confuse a patient who is totally dependent in an ADL activity (Code 6—Total Dependence) with the activity itself not occurring. For example: A patient who receives tube feedings and no food or fluids by mouth is engaged in eating (receiving nourishment), and must be evaluated under the Eating category for his or her level of assistance in the process. A patient who is highly involved in giving himself a tube feeding is not totally dependent and should be coded as a ''3.''

Note: Each of these ADL Self-Performance scoring categories is exclusive. There is no overlap between categories. Changing from one self-performance category to another demands an increase or decrease in the number of times that help is provided.

There will be times when there is no one type or level of assistance provided to the patient 3 or more times during a three-day period. However the sum total of support of various types will be provided three or more times. In this case, code for the least dependent self-performance category where the patient received that level or more dependent support 3 or more times during the 3 day period. Please review the following example for clarification of this principle.

Examples of Setup Help

- For bed mobility—Handing the patient the bar on a trapeze apparatus.
- For transfer—Giving the patient a transfer board or locking/unlocking the wheels on a wheelchair for a safe transfer.
- For locomotion.

Walking—Handing the patient a walker or cane.

Wheeling—Locking/unlocking the brakes on the wheelchair or adjusting the foot pedals to facilitate foot motion while wheeling.

- For dressing—Retrieving clothes from closet and laying out on the patient's bed; handing the patient a shirt; retrieving a prosthesis or orthotic.
- For eating—Cutting meat and opening containers at meals; giving one food category at a time.
- For toilet use—Handing the patient a bedpan or placing articles necessary for changing ostomy appliance within reach.

• For personal hygiene—Providing a wash basin and grooming articles.

• For bathing—Placing bathing articles at tub side within the patient's reach; handing the patient a towel upon completion of the bath.

2. ADL Assist Codes

Intent: To identify and document the level of weight bearing ADL assistance provided to the patient over the last 3 days.

Definition: a. Bed mobility—How patient moves to and from lying position, turns side to side, and positions body while in bed.

b. Transfer bed/chair—How patient moves between surfaces-to or from: bed, chair, wheelchair, standing position (Exclude to or from bath or toilet).

c. Locomotion—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how the patient moves once in the wheelchair.

d. Walk in facility—How the patient walks in room, corridor, or other place in the facility.

e. Dressing upper body—How the patient dresses and undresses (street clothes, underwear) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.

f. Dressing lower body—How the patient dresses and undresses (street clothes, underwear) from the waist down, includes prostheses, orthotics, belts, pants, skirts, shoes, and fasteners.

g. Eating—How the patient eats and drinks (regardless of skill) includes intake of nourishment by other means (for example, tube feeding, total parenteral nutrition).

h. Toilet use—How patient uses the toilet room (or commode, bedpan, urinal), cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (Exclude transfer to toilet).

i. Transfer/Toilet—How patient moves on and off toilet or commode

j. Grooming/Personal hygiene—How the patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing and drying face, and hands (Excludes baths and showers).

k. Bathing—How patient takes full body bath or shower or sponge bath (Exclude washing of back and hair and transfer). Includes how each part of the body is bathed: arms, upper and lower legs, chest, abdomen, perineal area.

l. Transfer tub/shower—How the patient transfers in and out of the tub or shower.

Coding: Code for the most help in the last 3 days.

0. Neither code applies.

1. Weight bearing support with 1 limb (arm or leg).

2. 2+ person physical assist.

3. ADL Changes

Intent: In this item the assessor compares the patient's current ADL function to self performance prior to the precipitating event item A7a.

Definition: a. The number of ADL areas (listed under E1) in which the patient is now more impaired in self performance than was prior to the precipitating event (A7a) determines the appropriate coding.

b. The number of ADL areas (from E1 above) in which patient was independent prior to precipitating event (item A7a).

Coding: Place the appropriate number of ADL areas in box a and box b.

4. Instrumental Activities of Daily Living (IADLs)

Intent: The intent of these items is to examine the areas of function that are most commonly associated with independent living.

Process: The patient is to be questioned directly about his or her capacity to perform the usual activities around the home or community in the last 24 hours of a 3-day assessment period. If the patient performed or contributed to the performance of the IADL task during this period (meal preparation, medication management, etc) this performance should be considered when coding. However, be aware that a patient's partial involvement in an activity in the last 24 hours may not necessarily express that patient's full capacity to perform the task.

For example: A patient may have performed part of the medication management with assistance from staff. Staff assistance may have been provided because medication containers are different than what the patient was used to at home. The patient states that within the last 24 hours, he or she could have performed the medication task if he or she had been in his or her own home. In fact, the patient had been independent prior to admission, and there have been no cognitive or functional changes that might cause you to call the patient's judgement into question. The assessor would code E4d as ''0'' Independent.

In talking to the patient, you are both involved in a process of speculation about IADL activities that did not occur at the facility, leading to the assessor's active coding decision.

Definition: a. Meal preparation—How meals are prepared (for example, planning meals, assembling ingredients, cooking, setting out food and utensils.)

b. Managing finances—Paying for newspaper or TV service, using the cafeteria.

c. Phone Use—How telephone calls are made or received (using assistive devices such as large numbers on the telephone, voice amplification as needed.)

d. Medication Management—How medications are managed (for example, remembering to take medications, opening bottles, taking correct dosage of pills, filling syringe, giving injections, applying ointments.)

e. Stairs—How moves up and down stairs (for example, one flight of steps, using handrails as needed.)

f. Car Transfer—How patient moves in and out of a car. Includes opening door, sitting, and rising from seat.

Coding: CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—If patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you would consider the patient's capacity (ability) would have been to perform the activity in the last 24 hours of the 3-day assessment period.

0. Independent—Would have required no help, setup or supervision.

1. Setup Help Only—Would have required help that would have been limited to providing or placing an article/device within reach of the patient; all other tasks would have been performed by the patient on his or her own.

2. Supervision—Would have required oversight, encouragement or cuing.

3. Limited Assistance—On some occasion(s) could have done on own, other times would have required help.

4. Moderate Assistance—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own.

5. Maximal Assistance—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of all subtasks on own.

6. Total Dependence—Full performance of the activity by other person would have been required at all times (no residual capacity exists).

5. IADL Areas Now More Limited

Intent: In this item the assessor compares the patient's current capacity to perform IADLs to self performance with IADLs prior to the precipitating event (Item A7a).

Process: Compare all the IADL capacity self performance area codes (for Items E4a–f) to the patient's function prior to the precipitating event. Determine the overall number of IADL areas that the patient is now more limited in.

Coding: Code for the most appropriate category.

0. None.

1. Some (1–3 IADL areas).

2. All or most (4–6 IADL areas).

6. Devices/Aids

Intent: To record the type of appliances, aids, or assistive devices the patient used over the last 3 days.

Definition: Locomotion Devices

a. Cane/crutch—A cane is a slender stick held in the hand and used for support during walking. Includes 3 or 4 prong canes. A crutch is a device for aiding a patient with walking. Usually it is a long staff with padded crescent-shaped portion at the top that is placed under the armpit.

b. Walker—A mobile device used to assist a patient with walking. Usually consists of a stable platform made of metal tubing that the patient grasps while taking a step. The patient then moves the walker forward and makes another step. Also check this item in those instances where the patient walks with a wheelchair or Meri-Walker for support. [For Meri-Walkers, if the patient is standing most of the time in the Meri-Walker and using it as a walker, code as a walker—if the patient sits in the Meri-Walker most of the time—code it as a wheelchair.]

c. Wheelchair/scooter—Includes use of a hand-propelled wheelchair as well as motorized chair or scooter, includes wheeling self and being wheeled by others.

Other Aids

d. Adaptive eating utensil—A device that is specially designed to help the patient be independent in eating. Some examples are, built-up spoon, rocker knife, plate guard, special mug.

e. Mechanical lift—A mechanical device such as a Hoyer lift, used to lift a patient.

f. Orthotics/prosthesis—An orthotic is a device added to the upper or lower extremities to stabilize or immobilize present deformity, protect against injury, or assist with function (for example, arm sling, finger splint). A prosthesis is a replacement of a missing body part by an artificial substitute, such as an artificial extremity. A device of a natural function.

g. Postural support (while sitting)—A device (pads, pillows, boards) used to maintain the patient's position while in a chair or wheelchair.

h. Slide Board—A flat surfaced board (usually polished to a smooth finish) used to help a patient transfer from bed to chair or chair to bed.

i. Other Adaptive Devices—Include assistive/adaptive devices such as trapezes, braces.

j. NONE OF THE ABOVE.

Process: Observe, interview patient or staff.

Coding: Check all that apply.

7. Stamina

Intent: Moderate physical activity in connection with activities of everyday life or chosen activities can help to keep patients fit in many ways. Below a certain threshold of activity, functional decline may be accelerated. Activities can include domestic IADLs (for example, light housework), or chosen physical activities (for example, recreation, going out to shop or walk).

It is necessary to understand if the patient is motivated, what the patient's needs may be, what barriers need to be overcome, and whether health education is needed.

Many people are interested in maintaining health. They usually know that lifestyle practices may be important, but they often need concrete information about how important their own life style is for health maintenance. For example, the patient may understand questions on walking and eating, but may not be willing to take corrective action.

Definition: Hours of physical activity at two points in time—examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping: (A) in last 24 hours and (B) immediately prior to precipitating event (A7a).

Process: Talk to the patient and family members if required. In assessing patient self-involvement, confirm patient stamina estimates. Talk to staff. Determine performance in last 24 hours and prior to precipitating event (Item A7a) and code accordingly.

Coding: Note—Item E7 has two coding columns, Column A and Column B.

0. None.
1. Less than one hour per day.
2. 1 to 2 hours per day.
3. 2+ to 3 hours per day.
4. 3+ to 4 hours per day.
5. More than 4 hours per day.

8. Walking and Stair Climbing

Intent: Walking is a crucial activity when considering a discharge back to the community. The interdisciplinary team members need current information about the patient's walking ability. This knowledge will help the team in devising an accurate service delivery and care plan resulting in an expeditious and coordinated discharge home.

CODE for walking or stair climbing episode that represents the most consistent pattern over the last 24 hours of the 3-day assessment period (includes episodes during therapy, activities, etc.)

Process: Observe the patient and interview staff.

Coding: a. Farthest distance walked without sitting down.

0. 150+ feet.
1. 51–149 feet.
2. 25–50 feet.
3. 10–24 feet.
4. Less than 10 feet.
8. ACTIVITY DID NOT OCCUR.

b. Walking support provided.

0. None.
1. Set up help only.
2. Supervision.
3. One person physical assistance.
4. Two+ person physical assistance.
8. ACTIVITY DID NOT OCCUR.

c. Stair climbing.

Intent: This item gives an indication of the patients stamina as measured by stair-climbing activity.

Process: Talk with the patient and family member if necessary. Consult with therapy staff who have observed or assisted the patient in stair climbing activity in the last 24 hours.

Definition: A full flight of stairs consists of 12–14 stairs (steps). A partial flight of stairs consists of 4 to 6 stairs (steps).

Coding: Code for the most dependent episode of stair climbing activity when the activity attempted in the last 24 hours. Note: There are only three possible codes when the patient does 4–6 stairs (steps) only (code—2, 5, 6).

0. Complete Independence—Up and down full flight of stairs with NEITHER physical help NOR support device.

1. Modified Independence—Up and down full flight of stairs with NO physical help and any of following:

Use of one or more supportive devices (support devices includes the required use of hand rails).

OR Use of an appliance (that is, cane, brace, prosthesis, walker).

OR Excessive time to climb the stairs (3 or more times normal).

2. Supervision—Up/down full flight of stairs with supervision or cuing–OR–up and down partial flight with NO physical help (device may or may not be used).

3. Minimal Assistance—Contact guard/steadying/assistance to go up/down full flight of stairs.

4. Moderate Assistance—Some weight bearing help to go up/down full flights of stairs, patient does most on own.

5. Maximal Assistance—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort–OR–receives physical help on partial flight of stairs.

6. Total Assistance—Did not go up/down 4–6 stairs (OR has 2-person assist) OR totally dependent.

8. Activity did not occur in last 24 hours.

9. Balance Related to Transitions

Intent: Balance is a key component of a patient's ability to transfer from standing to seated position and from seated to standing position. Problems with stability involve provision of support (either staff member or device) to ensure a safe transfer. It is important to assess a person's ability to balance in order that interventions (strength training exercises, safety awareness, restorative nursing, nursing-based rehabilitation) can be implemented to prevent injuries and foster increased independence in the patient.

Process: Over the last 24 hours, assess how the patient: transfers from seated to standing position, or turns and faces the opposite direction. Because this assessment is to be based on the most dependent episode over the last 24 hours, base both on your own observations and reports of staff.

Definition: a. Moved from seated to standing position.

b. (While standing) turned around and faced the opposite direction.

Coding: Code for the most dependent in the last 24 hours.

0. Smooth transition; stabilizes without assistance.

1. Transition not smooth, but able to stabilize without assistance.

2. Transition not smooth, unable to stabilize without assistance.

8. ACTIVITY DID NOT OCCUR.

10. Neuro-musculo-skeletal Impairment

Process: Review the patient's record for documentation of impairment of this type. An obvious example of a patient with this problem is someone who is comatose. Other patients at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders. In the absence of documentation in the clinical record, sensation can be tested in the following way:

- To test for pain, use a new safety pin or wooden ''orange stick'' (usually used for nail care). Always dispose of the pin or stick after each use to prevent contamination.
- Do not use pins with agitated or restless patients. Abrupt movements can cause injury.
- Ask the patient to close his or her eyes. If the patient cannot keep his or her eyes closed or cannot follow directions to close eyes, block what you are doing (in local areas of legs and feet) from view with a cupped hand or towel.
- Lightly press the pointed end of the pin or stick against the patient's skin. Do not press hard enough to cause pain, injury, or break in the skin. Use the pointed and blunt ends of the pin or stick alternately to test sensations on the patient's arms, trunk, and legs. Ask the patient to report if the sensation is ''sharp'' or ''dull.''
- Compare the sensations in symmetrical areas on both sides of the body.
- If the patient is unable to feel the sensation, or cannot differentiate sharp from dull, the area is considered desensitized to pain sensation.

• For patients who are unable to make themselves understood or who have difficulty understanding your directions, rely on their facial expressions (for example, wincing, grimacing, surprise), body motions (for example, pulling the limb away, pushing the examiner) or sounds (for example, ''Ouch!'') to determine if they can feel pain.

Definition: a. Leg (hip, knee, ankle, foot).

b. Arm (shoulder, elbow, wrist, hand).

c. Trunk and neck.

Coding: Code for the most limited in the last 24 hours.

A. Joint mobility/range of motion at joints listed (code for most impaired joint).

0. No impairment.

1. Impairment on one side.

2. Impairment on both sides.

B. Voluntary motor control (active, coordinated, purposeful movement—code for most dependent joint).

0. No loss.

1. Partial loss on one side.

2. Partial loss both sides.

3. Full loss one side.

4. Full loss both sides.

C. Intact touch/sensation on extremity (tactile sense) (Use same codes as E10B).

0. No loss.

1. Partial loss on one side.

2. Partial loss both sides.

3. Full loss one side.

4. Full loss both sides.

Section F. Bowel/Bladder Management

1. Bladder Continence

Intent: To describe the patient's pattern of bladder continence (control) over the last 7–14 days, and to compare current continence status to status prior to the current event which precipitated this post-acute stage. This information is key in care planning for incontinence.

Definition: Bladder Continence—Refers to control of urinary bladder function. This item describes the patient's bladder continence pattern even with scheduled toileting plans, continence training programs, or appliances. It does not refer to the patient's ability to toilet self—for example, a patient can receive extensive assistance in toileting and yet be continent, perhaps as a result of staff help. The patient's self-performance in toilet use is recorded in Item E1h.

Process: Complete your review in the following order. Remember to consider continence patterns over the last 7–14 day period, 24 hours a day, including weekends.

(1) Review the patient's clinical record and any urinary elimination (bladder) flow sheets (if available).

(2) Validate the accuracy of written records with the patient. Make sure that your discussions are held in private. Control of bladder function is a sensitive subject, particularly for patients that are struggling to maintain control. Many people with poor control problems will try to hide their problems out of embarrassment or fear of retribution. Others will not report the problem to staff because they mistakenly believe that incontinence is a natural part of aging or certain disease processes and that nothing can be done to reverse the problem. Despite these common reactions to incontinence, many patients are relieved when a health care professional shows enough concern to ask about the nature of the problem in a sensitive, straightforward manner.

(3) Validate continence patterns with people who know the patient well (for example, primary family member of a newly admitted patient, or direct care staff).

(4) When the information you have received is inconsistent and particularly if the staff report incontinence that is not reported by the patient, review for physical indications that the patient is in fact incontinent. This could include being present at scheduled toileting intervals, observing clothing, bed clothes, etc.

a. Control of urinary bladder function—(if patient dribbles, volume insufficient to soak through undergarments).

Coding: Choose the response that best reflects the patient's level of bladder continence in the last 7–14 days.

Code for the patient's actual bladder continence pattern—that is, the frequency with which the patient is wet and dry during the 7–14 day assessment period. Do not record the level of control the patient might have achieved under optimal circumstances. For bladder continence the difference between a ''5'' (Frequently Incontinent) and a ''6'' (Incontinent) is determined by the presence (''5'') or absence (''6'') of any bladder control.

0. Continent—Complete control; does not use any type of catheter or other urinary collection device.

1. Continent with Catheter—Complete control with any use of any type of catheter or urinary collection device that does not leak urine.

2. Biweekly Incontinence—Incontinent episodes less than once a week (that is, once in last 2 weeks).

3. Weekly Incontinence—Incontinent episodes once a week.

4. Occasionally Incontinent—Incontinent episodes 2 or more times a week, but not daily.

5. Frequently Incontinent—Tended to be incontinent daily, but some control present (that is, on day shift).

6. Incontinent—Has inadequate control of bladder, multiple daily episodes all or almost all of the time.

8. DID NOT OCCUR—No urine output from bladder.

b. Is now more impaired in bladder incontinence then was prior to precipitating event (item A7a).

Coding: 0. No, or unsure.

1. Yes, more impaired today.

2. Bladder Appliance.

Definition: a. External catheter (condom catheter)—A urinary collection appliance worn over the penis.

b. Indwelling catheter—A catheter that is maintained within the bladder for the purpose of continuous drainage of urine. This item includes catheters inserted through the urethra or via supra-pubic incision.

c. Intermittent catheterization—A catheter that is used periodically for draining urine from the bladder. This type of catheter is usually removed immediately after the bladder has been emptied. Includes intermittent catheterization whether performed by a licensed professional or by the patient. Catheterization may occur as one-time event (for example, to obtain a sterile specimen) or as part of a bladder emptying program (for example, every shift in a patient with an underactive or a contractile bladder muscle).

d. Medications for control—medications administered to the patient for the purpose of improving control of the bladder.

e. Ostomy—Any type of ostomy of the urinary tract.

f. Pads, briefs—Any type of absorbent disposable or reusable undergarment or item, whether worn by the patient (for example, diaper, adult brief) or placed on the bed or chair for protection from incontinence. Does not include the routine use of pads when a patient is never or rarely incontinent.

g. Urinals, bedpan—A urinal is a container into which a patient urinates. A bedpan is a pan-shaped device placed under a patient for collecting urine (and feces)

Process: Consult with the nursing staff and the patient. Be sure to ask about any items that are usually hidden from view because they are worn under street clothing (for example, pads or briefs). If necessary, check the clinical record.

Coding: Code for the last 24 hours.

0. No.

1. Yes.

3. Bladder Appliance Support

Intent: This item is designed to identify the type of assistance or support a patient needs in order to use any of the bladder appliances listed in F2.

Coding: Code for the level of bladder appliance support provided to the patient in the last 24 hours.

0. No appliances (in item F2).

1. Use of appliances, did not require help or supervision.

2. Use of appliances, required supervision or set up.

3. Minimal contact assistance (light touch only).

4. Moderate assistance—patient able to do 50% or more of subtasks involved in using equipment.

5. Maximal assistance—patient able to do 25–49% of all subtasks involved in using equipment.

6. Total dependence—patient requires assistance in all subtasks involved in using bladder equipment.

4. Bowel Continence

Process: The assessment for bowel continence should be completed simultaneously with the bladder continence review. This will thus include a review of the patient's clinical record and any bowel records (if available). Validate the accuracy of written records with the patient. Make sure that your discussions are held in private. Control of bowel function is a sensitive issue. Be sure to ask about the nature of the problem in a sensitive, straightforward manner.

• Validate continence patterns with people who know the patient well (for example, primary family member of newly admitted patient, direct care staff).

• Remember to consider continence patterns over the last 7–14 day period, 24 hours a day, including weekends.

Coding: Code for bowel continence over the last 7–14 days.

0. Continent—Complete control, does not use ostomy device.

1. Continent with Ostomy—Complete control with use of ostomy device that does not leak stool.

2. Biweekly Incontinence—Incontinent episodes less than once a week (that is, once in last two weeks).

3. Weekly Incontinence—Incontinent episodes once a week.

4. Occasionally Incontinent—2 to 3 times a week.

5. Frequently Incontinent—4+ times a week but not all of the time.

6. Incontinent—All of the time.

8.DID NOT OCCUR—No bowel movement during the entire 14-day assessment period.

5. Bowel Appliances

Definition: a. Bedpan—A bedpan is a pan-shaped device placed under a patient for collecting feces (and urine).

b. Enema—Introduction of solutions into the rectum and colon in order to stimulate bowel activity and to cause emptying of the lower intestine.

c. Medication for control—Medications administered to the patient for the pupose of improving control of the bowels. These medications can include laxatives, stool softeners, stimulants as well as anti-diarrheal preparations.

d. Ostomy—Any type of ostomy of the gastrointestinal tract.

Coding: Code for use of bowel appliances for the last 3 days.

0. No.

1. Yes.

6. Bowel Appliance Support

Intent: This item is designed to identify the type of assistance or support a patient needs in order to use any of the bowel appliances listed in F5.

Coding: Code for the level of bowel appliance support provided to the patient in the last 24 hours.

0. No appliances (in item F5).

1. Use of appliances, did not require help or supervision.

2. Use of appliances, required supervision or set up.

3. Minimal contact assistance (light touch only).

4. Moderate assistance—patient able to do 50 percent or more of subtasks involved in using equipment.

5. Maximal assistance—patient able to do 25–49 percent of all subtasks involved in using equipment.

6. Total dependence—patient requires assistance in all subtasks involved in using bowel equipment.

Section G. Diagnoses

1. Impairment Group

Intent: This item identifies the Impairment Group that best describes the primary reason for admission to the rehabilitation program.

Process: Consult with attending physician.

Coding: Each Impairment Group has been assigned a two-digit ID number, a decimal point, and a unique number (from one to four digits) for the subgroups. Code for the major diagnostic category of the patient by selecting the Impairment Group which best describes the condition requiring admission to rehabilitation. Then select a subgroup, if appropriate. Code as specifically as possible.

REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES

Rehabilitation impairment category	Associated impairment group codes
01 Stroke (Stroke)	01.1 Left body involvement (right brain). 01.2 Right body involvement (left brain). 01.3 Bilateral Involvement. 01.4 No Paresis. 01.9 Other Stroke.
02 Traumatic brain injury (TBI)	02.21 Open Injury. 02.22 Closed Injury.
03 Nontraumatic brain injury (NTBI)	02.1 Non-traumatic. 02.9 Other Brain.
04 04 Traumatic spinal cord (TSCI)	04.210 Paraplegia, Unspecified. 04.211 Paraplegia, Incomplete. 04.212 Paraplegia, Complete. 04.220 Quadriplegia, Unspecified. 04.2211 Quadriplegia, Incomplete C1–4. 04.2212 Quadriplegia, Incomplete C5–8. 04.2221 Quadriplegia, Complete C1–4. 04.2222 Quadriplegia, Complete C5–8. 04.230 Other traumatic spinal cord dysfunction.
05 Nontraumatic spinal cord (NTSCI)	04.110 Paraplegia, unspecified. 04.111 Paraplegia, incomplete. 04.112 Paraplegia, complete. 04.120 Quadriplegia, unspecified. 04.1211 Quadriplegia, Incomplete C1–4. 04.1212 Quadriplegia, Incomplete C5–8. 04.1221 Quadriplegia, Complete C1–4. 04.1222 Quadriplegia, Complete C5–8. 04.130 Other non-traumatic spinal cord dysfunction.
06 Neurological (Neuro)	03.1 Multiple Sclerosis. 03.2 Parkinsonism. 03.3 Polyneuropathy. 03.5 Cerebral Palsy. 03.8 Neuromuscular Disorders. 03.9 Other Neurologic.
07 Fracture of LE (FracLE)	08.11 Status post unilateral hip fracture. 08.12 Status post bilateral hip fractures. 08.2 Status post femur (shaft) fracture. 08.3 Status post pelvic fracture.
08 Replacement of LE joint (ReplLE)	08.51 Status post unilateral hip replacement. 08.52 Status post bilateral hip replacements. 08.61 Status post unilateral knee replacement. 08.62 Status post bilateral knee replacements. 08.71 Status post knee and hip replacements (same side). 08.72 Status post knee and hip replacements (different sides).
08 Other orthopedic (Ortho)	08.9 Other orthopedic.

REHABILITATION IMPAIRMENT CATEGORIES AND ASSOCIATED IMPAIRMENT GROUP CODES—Continued

Rehabilitation impairment category	Associated impairment group codes
10 Amputation, lower extremity (AMPLE)	05.3 Unilateral lower extremity above the knee (AK). 05.4 Unilateral lower extremity below the knee (BK). 05.5 Bilateral lower extremity above the knee (AK/AK). 05.6 Bilateral lower extremity above/below the knee (AK/BK). 05.7 Bilateral lower extremity below the knee (BK/BK).
11 Amputation, other (AMP–NLE)	05.1 Unilateral upper extremity above the elbow (AE). 05.2 Unilateral upper extremity below the elbow (BE). 05.9 Other amputation.
12 Osteoarthritis (OsteoA)	06.2 Osteoarthritis.
13 Rheumatoid, other arthritis (RheumA)	06.1 Rheumatoid Arthritis. 06.9 Other arthritis.
14 Cardiac (Cardiac)	09 Cardiac.
15 Pulmonary (Pulmonary)	10.1 Chronic Obstructive Pulmonary Disease. 10.9 Other pulmonary.
16 Pain Syndrome (Pain)	07.1 Neck pain. 07.2 Back pain. 07.3 Extremity pain. 07.9 Other pain.
17 Major multiple trauma, no brain injury or spinal cord injury (MMT–NBSCI).	08.4 Status post major multiple fractures. 14.9 Other multiple trauma.
18 Major multiple trauma, with brain or spinal cord injury (MMT–BSCI).	14.1 Brain and spinal cord injury. 14.2 Brain and multiple fractures/amputation. 14.3 Spinal cord and multiple fractures/amputation.
19 Guillian Barre (FB)	03.4.
20 Miscellaneous (Misc)	*12.1 Spina Bifida. 12.9 Other congenital. 13 Other disabling impairments. 15 Developmental disability. 16 Debility. 17 Infection. 17.2 Neoplasms. 17.31 Nutrition (endocrine/metabolic) with intubation/parenteral nutrition. 17.32 Nutrition (endocrine/metabolic) without intubation/parenteral nutrition. 17.4 Circulatory disorders. 17.51 Respiratory disorders—Ventilator Dependent. 17.52 Respiratory disorders—Non-ventilator Dependent. 17.6 Terminal care. 17.7 Skin disorders. 17.8 Medical/Surgical complications. 17.9 Other medically complex conditions.
21 Burn (Burns)	11 Burns.

We are in the process of anayzing the effect of moving the few cases within this impairment category to one of the other spinal cord RICs (either 05 or 04 depending upon the ''fit'').

2. Other Diseases

Intent: To document the presence of diseases that have an impact or potential impact on the patient's overall function (physical, cognitive, mood and behavioral), treatment or discharge plans.

Definition: ENDOCRINE

a. Diabetes Mellitus 250.00—Any of several metabolic disorders characterized by abnormal insulin secretion and elevated blood glucose levels. Category includes insulin-dependent diabetes mellitus (IDDM) as well as other types (for example, non-insulin dependent diabetes mellitus [NIDDM], adult onset diabetes mellitus [AODM], gestational diabetes, and diabetes associated with particular conditions or medications).

b. Hypothyroidism 244.9—Under-activity of the thyroid gland (insufficiency of thyroid hormone) resulting in a decrease in the basal metabolic rate.

HEART/CIRCULATION

c. Cardiac arrhythmias 427.9—A disturbance in the cardiac electrical conduction system resulting in irregularities in heart rate and rhythm.

d. Congestive heart failure 428.0—A dysfunction that occurs when cardiac output is insufficient to meet the person's metabolic demands.

e. Coronary artery disease (CAD) 746.85—A narrowing of one or more of the coronary arteries by atherosclerotic plaque or vascular spasm; results in a decrease in oxygenated blood flow (ischemia) to the heart. Usually associated with angina.

f. Deep vein thrombosis 451.1—A condition in which a blood clot (thrombus) is formed in the deeper/larger veins, usually in the lower extremities.

g. Hypertension 401.9—A persistent elevation of systolic or arterial blood pressure. This category includes primary (essential) and secondary hypertension.

h. Hypotension 458.9—An absolute systolic blood pressure value of less than 90 mm Hg (or a decline of 20 mm Hg or greater in systolic blood pressure from the person's usual baseline, or a decline of 10 mm Hg or greater in diastolic blood pressure from the person's usual baseline). This category also includes orthostatic hypotension (a reduction ≥ 20 mm Hg in systolic blood pressure upon standing).

i. Peripheral vascular disease (arteries) 443.9—A variety of syndromes that result in decreased blood flow in the peripheral arterial vessels, usually of the lower extremities. This category includes arteriosclerosis obliterans, small vessel syndrome, Raynaud's phenomenon, arterial aneurysms (for example, thoracic, abdominal, popliteal), and temporal arteritis. Do not include deep vein thrombosis in this category; if present, use item G2f.

j. Post Acute MI (within 30 days) 410.92—The immediate period following the necrosis of myocardial tissue resulting from obstruction of a coronary artery.

k. Post heart surgery (for example, valve, CABG) V45.81—Cardiovascular surgery such

as percutaneous transluminal coronary angioplasty (PTCA), coronary artery bypass graft (CABG), valve replacement, percutaneous balloon valvuloplasty.

l. Pulmonary embolism 415.1—Obstruction of one or more of the pulmonary arteries by a thrombus (blood clot).

m. Pulmonary failure 518.8—Failure of the respiratory system to meet oxygenation needs (severe hypoxemia).

n. Other cardiovascular disease 429.2—Any other cardiac diagnosis not coded elsewhere in Section G (for example, valvular heart disease).

MUSCULOSKELETAL

o. Fracture—hip V43.64—Hip fracture (for example, femoral neck; intertrochanteric; subcapital) that has been repaired via surgical arthroplasty or internal fixation. Category also includes fractures treated with traction that may have involved the surgical placement of pins. Also includes surgical hip replacement (for example, total or hemiarthroplasty) following fracture of the hip (for example, femoral neck; intertrochanteric; subcapital fractures, etc). Hips stabilized via open reduction and internal fixation (ORIF) with pins or screws would be included in this item.

p. Fracture—lower extremity 812.40—Any fracture of the lower extremity, other than hip fracture. Includes surgically and non-surgically treated fractures. Category does not include pathological fractures of the lower extremity; if the patient has a diagnosis of pathologic bone fracture of the lower extremity, code item G4.

q. Fracture(s)—other 829.0—Any other fracture type or location not captured in Section G.

r. Osteoarthritis 715.90—A progressive degenerative disease of joint cartilage and bone characterized by joint pain; may be accompanied by joint deformity and limitation of movement.

s. Osteoporosis 733.00—A metabolic bone disorder characterized by a loss of bone density resulting in weakened bones and susceptibility to fractures.

t. Rheumatoid Arthritis 714.0—A progressive degenerative joint disease characterized by recurrent inflammation of synovial tissue and joint deformities.

NEUROLOGICAL

u. Alzheimer's disease 331.0—A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

v. Aphasia or Apraxia (784.3, 784.69)—Symptoms of neurological defects characterized by a difficulty or inability to express thoughts (in speech or writing) or comprehend language (aphasia), or a difficulty/inability to carry out purposeful movements or use objects properly due to a failure to identify them or understand their meaning (apraxia).

w. Cerebral Palsy 343.9—A group of nonprogressive muscular and motor disorders secondary to a neurological defect or trauma at birth.

x. Dementia other than Alzheimer's disease 290.0—Includes diagnosis of organic brain syndrome (OBS) or Chronic Brain Syndrome (CBS), senile dementia, multi-infarct dementia, and dementia related to other neurological diseases other than Alzheimer's Disease (for example., Picks, Creutzfeld-Jacob, Huntington's Disease).

y. Hemiplegia/hemiparesis left side 342.90—Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on left side of the body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

z. Hemiplegia/hemiparesis right side 342.90—Paralysis/partial paralysis (temporary or permanent impairment of sensation, function, motion) of both limbs on right side of body. Usually caused by cerebral hemorrhage, thrombosis, embolism, or tumor. There must be a diagnosis of hemiplegia or hemiparesis in the resident's record.

aa. Multiple sclerosis 340—A progressive central nervous system disease characterized by demyelination in brain and spinal cord resulting in various neurological symptoms (for example, paresthesias; motor disorders; diplopia or blindness; urinary incontinence); usually involves recurrent exacerbations and remissions.

ab. Parkinson's Disease 332.0—A progressive disease affecting the centers of the brain responsible for control and regulation of movement.

ac. Quadriplegia 344.00–344.09—Paralysis (temporary or permanent impairment of sensation, function, motion) of all four limbs. Usually caused by cerebral hemorrhage, thrombosis, embolism, tumor, or spinal cord injury. There must be a diagnosis of quadriplegia in the patient's record.

ad. Seizure Disorder 780.39—Disorder of cerebral function characterized by sudden attacks of altered consciousness, sensory changes, motor activity, or inappropriate behavior. May be focal (localized) or generalized.

ae. Spinal cord dysfunction—non-traumatic 336.9—A non-traumatic disorder affecting the spinal cord (for example, neoplasm; abscess; hematoma; neurologic manifestations of pernicious anemia; spina bifida); may be associated with pain, sensory impairment, abnormal reflexes, motor dysfunction.

af. Spinal cord dysfunction—traumatic 952.9—Alteration of neurological function (for example, motor, sensory, reflexes) secondary to compression or laceration of the spinal cord.

ag. Stroke (CVA) 436—A vascular insult to the brain that may be caused by intracranial bleeding, stenosis, thrombosis, infarcts, or emboli; may result in permanent neurological and physical dysfunction.

PSYCHIATRIC/MOOD

ah. Anxiety Disorder 300.00—A disorder characterized by prominent symptoms of anxiety or phobic avoidance. This category includes generalized anxiety disorder, panic disorder, phobias, obsessive-compulsive disorder, post-traumatic stress disorder, acute distress disorder, and other anxiety disorders (for example, due to general medical condition; substance-induced).

ai. Depression 311—A mood disorder often characterized by a depressed mood (for example, feels sad or empty; appears tearful), decreased ability to think or concentrate, loss of interest or pleasure in usual activities, insomnia or hypersomnia, loss of energy, change in appetite, feelings of hopelessness or worthlessness or guilt. May include thoughts of death or suicide.

aj. Other psychiatric disorders 300.9—Other diagnosed psychiatric disorders not coded elsewhere on this assessment (for example, psychotic disorders, such as anorexia, bulimia; eating disorders).

PULMONARY

ak. Asthma 493.9—Intermittent periods of wheezing and dyspnea as a result of variable and recurring airway obstruction.

al. COPD 496—A group of conditions resulting in generalized airway obstruction (particularly the small airways) associated with varying combinations of asthma, chronic bronchitis, and emphysema. May also be called COLD (chronic obstructive lung disease). This category also includes chronic restrictive lung diseases such as asbestosis.

Note: Do not code asthma or emphysema in this category if either of these are the patient's definitive diagnoses. If asthma only is present, code in item G2ak. If emphysema only is present, code in item G2am.

am. Emphysema 492.8—A specific chronic obstructive pulmonary disease which is characterized by destructive changes in the alveoli which reduce the surface area for gas exchange.

OTHER

an.Cancer 199.1—A diagnosis of a carcinoma characterized by a localized malignant tumor or abnormal cell growth that has not spread to other areas or systems of the body. This category also includes metastatic cancer—a diagnosis of a carcinoma characterized by a malignant tumor or abnormal cell growth that has spread to other areas or systems of the body.

ao. Post surgery-non-orthopedic, non-cardiac V50.9—Status post any surgical procedure not noted in Section G.

ap. Renal Failure 586—Derangement and insufficiency of renal excretory and regulatory function. This category includes acute (ARF) and chronic renal failure (CRF).

aq. NONE OF THE ABOVE

Process: Review patient's current medical record (including current physician treatment orders and nursing care plans), referral information and hospital discharge summary. If the patient was admitted from an acute care or rehabilitation hospital, the discharge forms often list diagnoses and corresponding ICD–9–CM codes that were current during the hospital stay. If these diagnoses are still present, record them using the appropriate code to categorize the nature of the patient's treatment regimen.

There will be times when a particular diagnosis will not be documented in the medical record. If that is the case, accept statements by the patient that seem to have clinical validity, consult with the physician for confirmation, and initiate necessary physician documentation.

For example: If a new patient reports that he or she had a severe depression and was

seeing a private psychiatrist in the community, this information may not have been documented in records accompanying the patient from an acute care hospital to the post acute setting.

Physician involvement in this part of the assessment process would be beneficial. The physician can be asked to review the items in Section G at the time of visit closest to the scheduled MDS–PAC assessment. Use this scheduled visit as an opportunity to ensure that ''active'' diagnoses are noted and ''inactive'' diagnoses are appropriately designated. This is also an important opportunity to share the entire assessment with the physician. It is the responsibility of clinical staff to solicit physician input. Inaccurate or missed diagnoses can be a serious impediment to care planning. Thus, share this section of the assessment with the physician and ask for his or her input.

Full physician review of the most recent assessment or ongoing input into the assessment currently being completed can be very useful to overall care planning. For the physician, the assessment completed by clinical staff can provide insights that would have otherwise not been possible. For clinical staff, the informed comments of the physician may suggest new avenues of inquiry, or help to confirm existing observations, or suggest the need for additional consultation and follow-up.

Record a diagnosis only if the disease is being treated or monitored; or has a relationship to current ADL status, cognitive status, behavior status, medical treatment, nursing monitoring, or risk of death. For example, do not place a code for item G2g (hypertension) if one episode occurred several years ago unless the hypertension is either currently being controlled with drug therapy, diet, biofeedback, etc., or is being regularly monitored for recurrence. Likewise gallbladder surgery that occurred 15 years ago would not be recorded in item G2ao (Post surgery—non-orthopedic, non-cardiac) unless it had a relationship to the patient's current health status.

Coding: Record all documented diagnoses in the appropriate category. Do not record any conditions that have been resolved and no longer affect the patient's functional status or care plan—leave the box blank. For each item that is present enter the most appropriate code to describe the patient's documented diagnosis.

[Blank] Not present.

1. Other primary diagnosis/diagnoses for current stay (not primary impairment). These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (for example, drug therapy; therapeutic rehabilitation services; laboratory monitoring); other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning).

3. Diagnosis present, patient monitored but condition is not being actively treated.

If none of the conditions in Section G2 apply, check NONE OF ABOVE (G2aq). If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section G2, record the general diagnosis in Section G2 and then enter the more detailed diagnosis (with ICD–9–CM code) under Section G4.

3. Infections

Intent: To document the presence of infections that have an impact or potential impact on the patient's overall function (physical, cognitive, mood and behavioral), treatment and/or discharge plans.

a. Antibiotic resistant infection—any infection in which the bacteria have developed a resistance to the effective actions of an antibiotic (for example, Methicillin resistant staphylococcus aureus [MRSA 041.11], Vancomycin-resistant enterococcus [VRE 041.9]).

b. Cellulitis 682.9—inflammation of cellular or connective tissue, spreading as in erysipelas. The process of inflammation spreading throughout the tissue is called cellulitis.

c. Hepatitis 070.9—an inflammatory process in the liver usually caused by viral infection. This category includes acute and chronic viral hepatitis.

d. HIV/AIDS 042—Code this item only if—(A) there is supporting documentation in the medical record of (1) a positive blood test result for the Human Immunodeficiency Virus (HIV), or (2) a diagnosis of Acquired Immuno-deficiency Syndrome (AIDS), or (3) a diagnosis of AIDS-related complex (ARC); or (B) if the patient (or surrogate decision-maker) informs you of the presence of any of these diagnoses.

e. Pneumonia 486—an acute bacterial or viral infection of the lungs.

f. Osteomyelitis 730.2—an infection of bone, usually caused by bacteria or other pathogens. This category also includes infection of a surgically-implanted prosthesis.

g. Septicemia 038.9—clinical manifestations of bacterial infection of the circulatory system (bacteremia) associated with inadequate tissue perfusion (hypotension, renal failure and risk of death).

h. Staphylococcus infection (other than item ''G3a'' above) 041.10—any infection identified as staphylococcus by culture that is not considered to be resistant to antibiotic treatment.

i. Tuberculosis (active) 011.90—Diagnosis of active tuberculosis as evidenced by symptoms and/or currently receiving drug therapy (for example, isoniazid (INH), ethambutol, rifampin, cycloserine). Includes patients who have converted to PPD positive tuberculin status and are receiving drug treatment.

j. Urinary Tract Infection 599.0—includes chronic and acute symptomatic infection. Code only if there is supporting documentation or significant laboratory findings in the medical record, or the patient is currently being treated or evaluated for a UTI.

k. Wound Infection (958.3, 998.59, 136.9)—Category includes documentation of infection(s) of any type of wound (for example, surgical; traumatic; pressure ulcer) of any part of the body. Note: Report of wound culture may or may not be present in the medical record; diagnosis may be based on presence of drainage, erythema, edema, etc. around wound site.

l. NONE OF THE ABOVE.

Process: Review patient's medical record.

Coding: Record all documented diagnoses of infection(s) in the appropriate category. Do not record any conditions that have been resolved and no longer affect the patient's functional status or care plan—leave the box blank. For each item that is present enter the most appropriate code to describe the patient's documented diagnosis.

[Blank] Not present.

1. Other primary diagnosis/diagnoses for current stay. These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (drug therapy; therapeutic rehabilitation services; laboratory monitoring; other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning; respiratory therapy).

3. Diagnosis present, patient monitored but condition is not being actively treated.

If none of the conditions in Section G3 apply, check NONE OF ABOVE (G3l). If you have more detailed information available in the clinical record for a more definitive diagnosis than is provided in the list in Section G3, record the general diagnosis in Section G3 and then enter the more detailed diagnosis (with ICD–9–CM code) under Section G4.

For example: If the medical record states that the patient has ''Pneumocystis carinii pneumonia'' record the nature of this diagnosis in item G3e (Pneumonia) and then record the more specific diagnosis and ICD–9–CM code in Section G4.

4. Other Current or More Detailed Diagnoses and ICD–9 Codes

Intent: To identify and document conditions not listed in Items G1, G2 and G3 that have an impact or potential impact on the patient's current ADL status, mood and behavioral status, medical treatments, nursing monitoring, therapeutic rehabilitation, discharge plan or risk of death. Also, to record more specific designations for general disease categories listed in Sections G2 and G3.

Process: Review patient's current medical record, referral information and hospital discharge summary.

Coding: If the patient does not have any other or more detailed diagnoses documented, leave the boxes blank.

Enter the description of the diagnoses on the lines provided. For each diagnosis complete the following:

Write in diagnosis in lines ''a'' through ''e''.

Column A: enter the ICD–9–CM code for the diagnosis in the boxes, AND

Column B: enter the code (from the following codes) that best characterizes the diagnosis.

1. Other primary diagnosis/diagnoses for current stay (not primary impairment). These are the diagnoses used to support and justify services being provided.

2. Diagnosis present, patient is receiving active treatment (for example, drug therapy; therapeutic rehabilitation services; laboratory monitoring); other medical or skilled nursing intervention (for example, wound care; IV antibiotics; suctioning).

3. Diagnosis present, patient monitored but condition is not being actively treated.

Any new diagnosis at reassessment or discharge is to be recorded in G4.

5. Complications/Comorbidities

Intent: To identify and document comorbidities that may effect the patient's functional status or health.

Definition: ''Complications, comorbid conditions, and high-risk medical disorders may occur with any Impairment Group when the occurrence delays or compromises rehabilitation by:

Existing prior to the rehabilitation program.

Occurring or existing during the rehabilitation program.

Causing subject transfer to acute care.

Causing subject death during the rehabilitation program'' (Uniform Data System for Medical Rehabilitation, Guide for the Uniform Data Set for Medical Rehabilitation-Version 5.1, Appendix A: UDSmr Policy Regarding ICD–9 Coding, p. A19.) NOTE: HCFA has excluded from the definition of comorbidities the recording of diagnoses by Rehabilitation Impairment Category. For example, stroke is not a comorbidity for the stroke Rehabilitation Impairment Category, cardiac is not a comorbidity for the cardiac Rehabilitation Impairment Category. The ''Rehabilitation Impairment Categories and Associated Impairment Group Codes'' were discussed previously in this guide.

Process: Review the patient's medical record, referral information, hospital discharge summary, and consult with other clinical staff.

Coding: For the comorbidities to enter in lines G5a thru G5d including the ICD–9–CM codes refer to ''Appendix C: List of Comorbidities'' which is one of the appendixes of this proposed rule. If no comorbid condition exists write in the words ''No comorbid condition'' once and enter ''0000.00'' in the associated boxes.

Section H. Medical Complexities

Intent: To record clinical signs, symptoms, and conditions that affect or could affect the patient's health, functional, and psychosocial status and to identify risk factors for illness, accidents, and functional decline. Such factors need to be considered for treatment, rehabilitation, and discharge planning.

Definition: Medical complexities—include a number of indicators which help clinicians and others form a picture of the clinical intensity and level of service the patient receives in the post acute setting.

1. Vital Signs

Intent: To record the status of the patient's vital signs (that is, pulse; blood pressure; respiratory rate; temperature).

Definition: Abnormal vital signs—see ranges in box below.

Process: To interpret whether vital signs are within the range of ''normal'' usually requires an evaluation of several measurements rather than relying on a single value at one point in time. Therefore, review the results from the evaluation of the patient's vital signs over the past three days. In addition to reviewing vital signs, review the patient's clinical record, specifically, vital signs ''flow sheets'', and physician or nursing documentation in the medical record, referral sheet, or discharge summary.

Coding: Code for the ''most abnormal'' set of vital signs over the last 3 days.

0. All vital signs were normal/standard (that is, when compared to standard values).

1. Vital signs abnormal, but not on all days during assessment period.

2. Vital signs consistently abnormal (on all days).

2. Problem Conditions

Intent: To record clinical signs, symptoms, and conditions that affect or could affect the patient's health, functional, and psychosocial status and to identify risk factors for illness, accidents, and functional decline. Such factors need to be considered for treatment, rehabilitation, and discharge planning.

Process: Gather information from a variety of sources. Begin by reviewing the discharge referral record and current medical record, including laboratory data, consultation reports, and nursing observations. This will be the primary source of information. Check that it is complete by soliciting input from all members of the interdisciplinary team, including direct care providers (for example, certified nurse assistants). Finally, in your scheduled contact with the patient to assess other areas, interview, observe, and examine the patient to ensure nothing has been overlooked. Remember, you are reviewing problem conditions that have been present in the last 3 days.

Definition: FALLS/BALANCE

a. Dizziness/vertigo/lightheadedness—The patient has experienced the sensation of unsteadiness, that he or she is ''turning'', or that the surroundings are whirling/spinning around; or if the patient complained specifically of dizziness/vertigo/or lightheadedness in the last 3 days.

b. Fell (since admission or last assessment)—Patient/family reports or medical record or discharge summary indicates the patient fell since admission or since last assessment.

c. Fell in 180 days prior to admission—Patient/family reports or medical record or discharge summary indicates the patient fell in the 180 days prior to admission.

CARDIAC/PULMONARY

d. Advanced cardiac failure (ejection fraction <25 percent)—Check if EITHER documented cardiac disease with significant decrease in cardiac output (for example, documented ejection fraction <25 percent) in last 60 days OR diastolic dysfunction, as indicated by repeated episodes of heart failure with a normal ejection fraction).

e. Chest pain/pressure on exertion—The patient experiences any type of pain in the chest (or radiating to arm or jaw pain), which may be described as burning, pressure, stabbing, or discomfort, etc. associated with physical exertion.

f. Chest pain/pressure at rest—The patient experiences any type of pain in the chest (or radiating to arm or jaw pain), which may be described as burning, pressure, stabbing, or discomfort, etc. that starts spontaneously and without physical exertion (at rest).

g. Edema-generalized—Generalized abnormal pooling or accumulation of fluid in tissues throughout the body (not limited to specific site).

h. Edema-localized—Abnormal pooling or accumulation of fluid in specific tissues (for example, pedal edema; lymphedema of upper extremity).

i. Edema-pitting—Abnormal pooling or accumulation of fluid in tissues. Assessed by pressing the patient's skin firmly with the thumb for at least five seconds behind the medial malleolus, dorsum of the foot, or over the shin. If present, a ''thumb print'' will remain over the area of edema.

j. Impaired aerobic capacity/endurance (tires easily, poor task endurance)—A symptom characterized by a limited ability to sustain a period of exercise or exertion due to decreased cardiac or respiratory function (may be as a result of disease or deconditioning).

FLUID STATUS—It is often difficult to recognize when a frail, ill person is experiencing fluid overload that could precipitate congestive heart failure, or alternatively dehydration. Ways to monitor the problem, particularly in patients who are unable to recognize or report the common symptoms of fluid variation, are as follows:

k. Constipation—The patient passes two or fewer bowel movements per week, or strains more than one out of four times when having a bowel movement.

l. Dehydrated: output exceeds input (for example, BUN/creatinine ratio >25)—check this item if the patient's laboratory results reveal a blood urea nitrogen (BUN) to creatinine ratio greater than 25 OR if the patient has 2 or more of the following indicators.

- Patient's fluid intake is less than 2500 ml of fluids daily (water or liquids in beverages, water in food/supplements/parenteral nutrition, IV fluids).
- Patient has clinical signs of dehydration (for example, dry mucous membranes, decrease in skin elasticity).
- Patient's fluid loss exceeds the amount of fluids he or she takes in (for example, loss from vomiting, fever, diarrhea that exceeds fluid replacement)—review the Input and Output record;

m. Diarrhea—Frequent elimination of watery stools from any etiology (for example, diet, viral or bacterial infection).

n. Internal bleeding—Includes gastrointestinal and other types of intestinal bleeding. Bleeding may be frank (such as bright red blood) or occult (such as guaiac positive stools); any documented bleeding as diagnosed by GI evaluation or any evidence of current bleeding through rectal exam or guaiac testing. Could also include: hematuria (blood in urine); hemoptysis (coughing up blood); or severe epistaxis (nosebleed), etc. present over the last 3 days that did not spontaneously resolve or that occurred more than once.

o. Recurrent nausea/vomiting—Patient reports recurrent (more than one episode) sensations of having to vomit or actual regurgitation of stomach contents; code regardless of etiology (for example, drug side effect or toxicity; influenza; anxiety; obstruction; reaction to particular odors or sights).

p. Refusal/inability to take liquids orally—Patient either rejects intake of fluids (for example, liquids, jello, sorbets, etc.) as a conscious decision or pushes them away, OR has a physical condition that inhibits intake of oral liquids (for example, nausea/vomiting; dysphagia; severe candidiasis of oral mucosa, etc.).

OTHER

q. Delusions/Hallucinations—Delusions are fixed, false beliefs not shared by others that the patient holds even when there is obvious proof or evidence to the contrary (for example, belief he or she is terminally ill; belief that spouse is having an affair; belief that food served by the hospital/facility is poisoned).

Hallucinations are false perceptions that occur in the absence of any real stimuli. A hallucination may be auditory (for example, hearing voices), visual (for example, seeing people, animals), tactile (for example, feeling bugs crawling over skin), olfactory (for example, smelling fumes), or gustatory (for example, having strange tastes).

r. Fever—Rectal temperatures above 100°Fahrenheit (38°Celsius) are considered significant. Many frail patients have normally low rectal baseline temperatures (for example, 96°). A fever is present when the patient's temperature (°F) is 2.4 degrees greater than the baseline temperature.

s. Hemi-neglect (inattention to one side)—For example, patient denies that their left arm belongs to them, shaves only on one side of face, ignores items to their left.

t. Cachexia (severe malnutrition)—A condition of undernutrition and wasting that may occur in a variety of chronic diseases and malignancies.

u. Morbid Obesity—According to a National Institute of Health consensus panel, a body weight that is double (twice) the ''ideal'' body weight of standard height-weight tables OR 100 pounds (45 g) overweight.

Extremely obese persons are at great risk of serious disorders, including diabetes, hypertension, osteoarthritis, impairment in psychosocial well-being, and death from cardiovascular disease. (Refer to the latest (1983) Metropolitan Life Insurance Company standard height-weight table below to identify ideal/desirable body weights).

HEIGHT AND WEIGHT TABLE FOR WOMEN

Height (in feet and inches)	Small frame	Medium frame	Large frame
4′10″	102–111	109–121	118–131
4′11″	103–113	111–123	120–134
5′0″	104–115	113–126	122–137
5′1″	106–118	115–129	125–140
5′2″	108–121	118–132	128–143
5′3″	111–124	121–135	131–147
5′4″	114–127	124–138	134–151
5′5″	117–130	127–141	137–155
5′6″	120–133	130–144	140–159
5′7″	123–136	133–147	143–163
5′8″	126–139	136–150	146–167
5′9″	129–142	139–153	149–170
5′10″	132–145	142–156	152–173
5′11″	135–148	145–159	155–176
6′0″	138–151	148–162	158–179

HEIGHT AND WEIGHT TABLE FOR MEN

Height (in feet and inches)	Small frame	Medium frame	Large frame
5′2″	128–134	131–141	138–150
5′3″	130–136	133–143	140–153
5′4″	132–138	135–145	142–156
5′5″	134–140	137–148	144–160
5′6″	136–142	139–151	146–164
5′7″	138–145	142–154	149–168
5′8″	140–148	145–157	152–172
5′9″	142–151	148–160	155–176
5′10″	144–154	151–163	158–180
5′11″	146–157	154–166	161–184
6′0″	149–160	157–170	164–188
6′1″	152–164	160–174	168–192
6′2″	155–168	164–178	172–197
6′3″	158–172	167–182	176–202
6′4″	162–176	171–187	181–207

v. End-stage disease, life expectancy of 6 or fewer months—The intent of this item is to heighten staff awareness of the potential terminal nature of the patient's condition so that an appropriate course of care can be developed. In one's best clinical judgement, the patient in the final (end) stage of a disease process (for example, COPD; malignancy; cardiac disease; Alzheimer's disease, etc.) and has only six or fewer months to live. Although it is often difficult to make such a prognosis, this judgement should be substantiated by a physician and the presence of a deteriorating clinical course.

w. NONE OF THE ABOVE—The patient has not experienced any of the above conditions.

Coding: Check all problems present in the last three days, unless other time frames are indicated. If none apply, check NONE OF THE ABOVE.

3. Respiratory Conditions

Intent: To identify and record signs, symptoms or conditions of respiratory distress that could have a direct or indirect affect on the patient's ability to function, participate in rehabilitation and on the patient's plan of care, including discharge. More than one condition may apply.

Definition: a. Inability to lie flat due to shortness of breath—In the last 3 days the patient reported feeling ''breathless'' or short of breath (dyspneic), or has been observed to be short of breath, while lying supine; requires more than one pillow or has the head of the bed mechanically raised in order to breathe more comfortably.

b. Shortness of breath with exertion—In the last 3 days the patient has reported becoming ''breathless'' or short of breath (dyspneic), or has been observed to be short of breath, even with mild exertion such as taking a bath, transferring from bed to chair, toileting.

c. Shortness of breath at rest—In the last three days the patient reported feeling ''breathless'' or short of breath (dyspneic), or was observed being short of breath, at rest (for example, sitting, talking).

d. Oxygen saturation < 90 percent—In the last 3 days the patient's oxygen saturation level (obtained by oximeter) was less than 90 percent (either while receiving or not receiving oxygen therapy).

e. Difficulty coughing and clearing airway secretions—In the last 3 days the patient reports or has been observed to be unable to cough effectively to expel respiratory secretions (for example, secondary to weakness, pain) or is unable to mobilize secretions or sputum from mouth (for example, secondary to dysphagia or pain) or tracheostomy (for example, secondary to viscosity of sputum; inability to physically remove secretions from tracheostomy entrance). Examples might include a post abdominal surgery patient unable to cough due to incisional pain, or a comatose patient that required suctioning to manage secretions.

f. Recurrent aspiration—In the last 3 days a patient with a history of at least one or more episodes of aspiration (inspiration) of fluids/food/secretions, etc. into lungs, exhibits clinical signs and symptoms of another episode. Recurrence often occurs in patients with swallowing difficulties or who receive tube feedings (that is esophageal reflux of stomach contents). Clinical indicators include productive cough, shortness of breath, wheezing. It is not necessary that there be X-ray evidence of lung aspiration for this item to be checked.

g. Recurrent Respiratory Infection—In the last 3 days patient with a history of respiratory infection (for example., pneumonia; bronchitis) with evidence of a recurrence (for example, prior infection not resolved with medical intervention; infection has been experienced multiple times).

h. NONE OF THE ABOVE—In the last 3 days none of the above conditions were present.

Process: Interview and observe the patient. Review the patient's medical record, including consultation reports by a respiratory therapist and laboratory data such as arterial blood gases (ABG's), as indicated.

Coding: Check all conditions that were present in the last three days. If no conditions apply, check NONE OF THE ABOVE.

4. Pressure Ulcers

Intent: To identify and document the presence, stage and number of pressure ulcers, and, if present, record the characteristics (that is the size, exudate, and predominant tissue) of the ulcer(s).

Definition: Pressure Ulcer—Any lesion caused by unrelieved pressure resulting in damage of underlying tissue. Pressure ulcers usually occur over bony prominences and are graded or staged to classify the degree of tissue damage observed (Agency for Health Care Policy Research, 1992).

Pressure Ulcer Stage—The following pressure ulcer staging definitions are consistent with the recommendations of the Agency for Health Care Policy Research (AHCPR, 1992) and the National Pressure Ulcer Advisory Panel (NPUAP, 1989). A shorter version of these definitions appear on the form as coding options for Items H4a (highest current pressure ulcer stage).

a. Highest current pressure ulcer stage.

0. No pressure ulcer.

1. (Stage 1) Any area of persistent skin redness.

2. (Stage 2) Partial loss of skin layers.

3. (Stage 3) Deep craters in the skin.

4. (Stage 4) Breaks in skin exposing muscle or bone.

5. Not stageable (necrotic eschar predominant, no prior staging available).

PUSH (Pressure Ulcer Healing Scale) Score—A tool to monitor pressure ulcer healing over time. The PUSH Score is measured by assessing wound size, amount of exudate, and characteristics of predominant tissue. The PUSH is used in Items 4c through 4f.

(a) Highest current pressure ulcer stage.

Intent: In conjunction with other items, to facilitate the monitoring of pressure ulcer healing or worsening over time.

Process: Examine the patient for pressure ulcers and determine pressure ulcer stage. Without a full body inspection, an ulcer can be missed. If the patient has more than one ulcer, determine which ulcer has the highest (worst) ulcer stage. This type of information may be found in referral records (including discharge summaries), clinical progress notes, flow sheets, or patient care plans. Review these records to determine the highest ulcer ever achieved for any ulcer the patient currently has.

Coding: Record the highest (worst) current pressure ulcer stage. If the predominant tissue of the ulcer is necrotic eschar, prohibiting accurate staging, code ''5'', Not Stageable (necrotic eschar predominant; no prior staging available). If the patient has no pressure ulcers, record ''0'' (No pressure ulcers) in the box provided.

(b) Number of current pressure ulcers.

Process: Examine the patient for pressure ulcers. Without a full body inspection, an ulcer can be missed. COUNT the number of pressure ulcers.

Coding: Record the number of pressure ulcers, including ulcers that cannot be accurately staged (that is, if the predominant tissue of the ulcer is necrotic eschar). If the patient has no pressure ulcers, record ''0'' (No pressure ulcers) in the box provided.

(c–f) PUSH Scale (Items c through f).

The next four items (c through f) represent the PUSH Scale 3.0 developed by the National Pressure Ulcer Advisory Panel (NPUAP, 1998) to monitor pressure ulcer healing over time. For purposes of this assessment there are three important things to remember for this section:

• The PUSH Scale (items ''c'' through ''f'') can only be calculated for ulcers of Stage 2 and higher OR for ulcers where necrotic eschar is the predominant tissue. If highest pressure ulcer stage is ''0'' or ''1'', enter code of ''0'' in c, d, e, and f.

• Select the LARGEST ulcer. Note: The largest ulcer may not necessarily be the ulcer with the highest ulcer stage.

• Although the PUSH Scale was designed to evaluate the healing of a pressure ulcer, its use in this assessment is to provide a ''snapshot'' of the status for the largest ulcer present at the time of the assessment. When tracked over time, we can know the highest PUSH score that characterizes the patient's pressure ulcer status.

(c) Length multiplied by width (open wound surface area).

Materials: You will need a centimeter ruler to measure the surface area of an open wound. Although it's not necessary, it is also helpful to use a calculator for multiplying ulcer measurements to calculate the total open wound surface area.

Process: • Using a centimeter ruler, measure the greatest length (head to toe) and the greatest width (side to side) of the ulcer margins (for example, the edges of the ''open'' areas). If necrotic eschar is the predominant tissue and the ulcer is not ''open'', measure from edge to edge of the eschar.

• Multiply these two measurements (length x width) to obtain an estimate of the surface area in square centimeters (cm^2). Do not guess! Always use a centimeter ruler and always use the same method each time the ulcer is measured.

Coding: Record the number that corresponds to the largest pressure ulcer's open wound surface area using the following codes:

0. 0 cm^2.
1. <0.3 cm^2.
2. 0.3–0.6 cm^2.
3. 0.7–1.0 cm^2.
4. 1.1–2.0 cm^2.
5. 2.1–3.0 cm^2.
6. 3.1–4.0 cm^2.
7. 4.1–8.0 cm^2.
8. 8.1–12.0 cm^2.
9. 12.1–24.0 cm^2.
10. >24 cm^2.

(d) Exudate amount.

Process: Estimate the amount of exudate (drainage) present after removal of the dressing and before applying any topical agent to the ulcer for the selected (largest) pressure ulcer.

Coding: Record the response that best estimates the amount of exudate (drainage).

0. None.
1. Light.
2. Moderate.
3. Heavy.

(e) Tissue Type.

Process: Inspect the selected (largest) pressure ulcer and note the tissue that occupies the majority of the ulcer bed. Divide the ulcer bed into four imaginary quadrants, each representing about ¼ of the original ulcer surface. Estimate the portion or amount of each tissue type on the ulcer. Determine the predominant tissue type on the ulcer.

Coding: Record the response that describes the most predominant tissue type.

0. Closed/Resurfaced—The wound is completely covered with epithelium (new skin).

1. Epithelial Tissue—For superficial ulcers, new pink or shiny tissue (skin) that grows in

from the edges or as islands on the ulcer surface.

2. Granulation Tissue—Pink or beefy red tissue with a shiny, moist, granular appearance.

3. Slough—Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps/or is mucinous.

4. Necrotic tissue (eschar)—Black, brown or tan tissue that adheres firmly to the wound bed or ulcer edges and may be either firmer or softer than surrounding skin.

(f) Total PUSH (Pressure Ulcer Healing Scale) Score.

Process: Add up the scores from Items H4c (open wound surface area) + H4d (exudate amount) + H4e (tissue type). This sum represents the total PUSH Score.

Coding: Record the number that represents the Total PUSH Score in the box provided.

5. Other Skin Integrity

(a) Number of stasis ulcers (in the last 24 hours).

Definition: Stasis ulcer—An open lesion, usually of the ankle or lower third of the lower extremities, caused by chronic venous stasis or insufficiency. In the medical record one may also find this type of ulcer referred to as a ''venous ulcer'' or ulcer related to peripheral vascular disease (PVD).

Process: Examine the patient and review the clinical record. COUNT the number of stasis ulcers present in the last 24 hours.

Coding: Record the number of stasis ulcers in the box provided. If there are no stasis ulcers, code a ''0'' in the box.

(b) Number of surgical wounds (in the last 24 hours).

Definition: Surgical wounds—Includes healing and non-healing, open or recently closed (since onset of precipitating event in A7a) surgical incisions, skin grafts or drainage sites on any part of the body. This category does not include healed surgical sites or stomas.

Process: Examine the patient's body and COUNT the number of surgical wounds present in the last 24 hours.

Coding: Record the number of surgical wounds in the box provided. If there are no surgical wounds, code a ''0'' in the box.

(c) Ulcer resolved or healed in last 90 days.

Definition: Ulcer—For this item, the term ulcer refers to ANY lesion caused by pressure (that is, pressure ulcer; bedsore; decubitus ulcer) or venous stasis/insufficiency (that is, stasis ulcer).

Process: Review the patient's clinical record over the last 90 days for documentation of the presence of a pressure or stasis ulcer that has been healed (that is, closed/resurfaced; new tissue entirely covers the wound). Validate findings by examining the patient's body.

Coding: Record the most appropriate response to indicate that the patient had an ulcer that was resolved or healed in the last 90 days. If the patient did not have an ulcer that resolved in the last 90 days, use a code of ''0'' in the box. Note: The patient may still have other ulcers in various stages of healing.

0. No, or never had ulcer.

1. Yes.

6. Other Skin Problems or Lesions Present

Intent: To document the presence of skin problems other than ulcers or surgical wounds, and conditions that are risk factors for more serious problems.

Definition: a. Burns (second or third degree)—Includes burns from any cause (for example, heat, electricity, chemicals, radiation, or gases) that affects skin deeper than the epidermis or outermost layer of skin. This category does not include first degree burns (changes in skin color only).

b. Open lesions other than rashes, cuts (for example, cancer lesions, ulcers)—Any open area of the skin unrelated to pressure, venous stasis, surgery, trauma or rashes.

c. Rashes—Includes inflammation or eruption of the skin that may include change in color, spotting, blistering, etc. and symptoms such as itching, burning, or pain. Record rashes from any cause (for example, eczema, heat, drugs, bacteria, fungus, viruses [such as herpes zoster, chicken pox], parasites [such as scabies, lice], contact with irritating substances such as urine or detergents, allergies, etc.). Intertrigo refers to rashes (dermatitis) within skin folds.

d. Skin tears or cuts (other than surgery)—Any traumatic break in the skin penetrating to subcutaneous tissue not caused by surgical puncture or incision. Examples include lacerations, punctures wounds, etc.

e. NONE OF THE ABOVE.

Review the patient's record for documentation of impairment of this type. An obvious example of a patient with this problem is someone who is comatose. Other patients at high risk include those with quadriplegia, paraplegia, hemiplegia or hemiparesis, peripheral vascular disease and neurological disorders.

Process: Ask the patient if he or she has any problem areas. Ask the nurse assistant and examine the patient. Review the patient's record. You are assessing for skin problem areas present over the last 24 hours.

Coding: Check all that apply for the last 24 hours. If there is no evidence of such problems in the last 24 hours, check NONE OF THE ABOVE.

Section I. Pain Symptoms

Intent: The intent of this section is to identify other health conditions that have an impact on the patient's quality of life, health risks, and plan of care, including the discharge plan.

1. Pain Symptoms

Intent: To evaluate and record the presence, frequency and intensity of pain and how it is managed. Pain can impact the patient in many ways, including affecting his or her ability to meet established goals. It is essential that pain is assessed and an effective pain management plan put in place in order to optimize the patient's recovery and quality of life. Items I1a through I1b refer to pain in the last 3 days. In item I1c, how the patient's current perception of pain compares to pain status prior to precipitating event (item A7a). For care planning purposes these items can be used to determine the characteristics of the patient's pain and to monitor his or her response to pain management interventions.

Definition: Pain—pain refers to any type of physical pain or discomfort in any part of the body. Pain may be localized to one area, or may be more generalized. It may be acute or chronic, continuous or intermittent (comes and goes), or occur at rest or with movement. The pain experience is very subjective; pain is whatever the patient says it is. If the patient complains of pain, record that pain is present.

Pain assessment may depend on the observation of others (that is, cues), either because the patient does not complain, or is unable to verbalize or describe symptoms.

Process: This evaluation is based solely on the patient's perception of pain, or in cases where the patient has limited ability to communicate, staff's interpretation of behaviors that might indicate pain. Ask the patient to categorize the highest level of pain they have experienced over each time period.

Ask the patient if he or she has experienced any pain or discomfort in the last three days and ask him/her to describe it. If the patient states he or she has pain, take his or her word for it. Pain is a subjective experience.

Observe the patient for indicators of pain. Observation is particularly important in patients who are unable to communicate their experiences of pain. Indicators may include moaning, crying, and other vocalizations; wincing or frowning and other facial expressions; or body posture such as guarding/protecting an area of the body, lying very still or decreasing usual activities (to prevent pain from occurring).

In severely cognitively impaired patients, the pain experience is particularly difficult to discern. For example, in patients who cannot verbalize that they are feeling pain, discomfort may be manifested by behaviors such as calling out for help, pained facial expressions, refusing to eat, or striking out at a nurse assistant who tries to move them or touch a body part. Although such behaviors may not be solely indicative of pain, code for the frequency and intensity of symptoms if in your best clinical judgement it is possible that the behavior could be caused by the patient experiencing pain.

Ask nurse assistants and therapists who work with the patient if the patient had complaints or indicators of pain the last three days.

Coding: For each of the following items (I1a through I1b) code for the HIGHEST LEVEL OF PAIN the patient experienced in the last three days, even while receiving treatments.

a. FREQUENCY—Measures how often the patient experiences pain (reports or shows evidence of pain).

Codes: 0. No pain.

1. Pain less than daily.

2. Daily—single shift.

3. Daily—multiple shifts.

b. INTENSITY '' Measures the level of pain as the patient perceives it (described or manifested by the patient). Use the following scale to indicate the level of pain experienced:

Codes: 0. No pain.

1. Mild pain—Although the patient experiences some (''a little'') pain he or she is usually able to carry on with daily routines, socialization, or sleep.

2. Moderate pain—Patient experiences ''a medium'' amount of pain.

3. Severe pain—Patient experiences intense pain.

4. Times when pain is horrible or excruciating—Worst possible pain the person can imagine.

c. CURRENT PAIN STATUS as compared to pain status prior to precipitating event item (A7a). Patient's experience of pain NOW as compared to pain status prior to precipitating event. Note: If the patient has no pain now and no pain prior to precipitating event (item A7a), code ''0'', same.

Coding: 0. Same.

1. Better.

2. Worse.

8. UNKNOWN—The patient is unable to describe how the pain compares OR there is no available information in the clinical record or via family or professional caregivers.

Section J. Oral/Nutritional Status

1. Oral Problems

Intent: To record any oral or nutritional problems in the last 3 days.

Definition: a. Chewing Problem—Inability to chew regular food easily and without pain or difficulties, regardless of cause (for example, poor mastication, immobile jaw, recent oral surgery, temporomandibular joint pain, decreased sensation/motor control).

b. Dental Problem—Upon exam and interview of the patient, problems with teeth are identified (for example, ill—fitting or lack of dentures, painful tooth, poor dental hygiene).

Process: Examine and interview the patient—this is the crucial part of the process, without this examination, oral problems often go undetected. Review clinical records. Talk to the nurse assistants who have recently helped the patient with his/her ADL's.

Coding: Record the most appropriate response in the box provided. Code ''0'' for No and ''1'' for Yes.

2. Swallowing

Intent: The ability to swallow safely can be affected by many disease processes and functional decline. Alterations in one's ability to swallow can result in choking and aspiration, both of which can cause morbidity and mortality. Often patients with swallowing difficulties require altered consistencies of food and fluids OR may not be able to ingest nutrition by mouth. This item details the diet consistencies and modifications in place to address swallowing difficulties.

Process: Observe patient. Review the patient's clinical record, including MD, dietitian and Speech Language Pathology notes if applicable.

Coding: Using the codes provided, indicate which item best describes the dietary prescriptions to address swallowing difficulties.

0. Normal—Safe and efficient swallowing of all diet consistencies.

1. Requires diet modification to swallow solid foods (mechanical diet or able to ingest specific foods only).

2. Requires modification to swallow solid foods and liquids (puree, thickened liquids).

3. Combined oral and tube feeding [tube feeding (via NGT, GT, JT), and some oral intake]

4. No oral intake (NPO)

3. Height and Weight

Intent: To establish a height and weight in order to monitor nutrition and hydration status over time, to establish a baseline to monitor changes in weight over time.

Process: Base weight on the most recent measure in the last 3 days. Utilize your facility's standard of practice to ensure consistency in measuring weights (for example, in a.m. after voiding, before breakfast, with shoes off and in night clothes).

Coding: Record in ''box a.''—Height in inches and in ''box b''—Weight in pounds.

4. Weight Change

Intent: To assess any presence of weight loss or gain.

Process: Review clinical record, weight records, and dietary notes to assess weight history. Since patient may have only been in your facility a few days, it may be difficult to obtain accurate factual information. Utilize patient and family interview to determine appropriate coding.

a. Weight Loss.

Definition:Weight loss in percentages (for example, 5 percent or more in last 30 days).

Process: New admission '' Ask the patient or family about weight changes over the last 30 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight loss in percentages during the specified time periods.

Current patient '' Review the clinical records and compare current weight with weights of 30 days ago. Calculate weight loss in percentages during the specified time periods.

Coding: 0. No or unknown.

1. Yes, planned loss.

2. Yes, unplanned loss.

b. Weight Gain.

Definition: Weight gain in percentages (for example, 5 percent or more in last 30 days).

Process: New admissions—Ask the patient or family about weight changes over the last 30 days. Consult physician, review transfer documentation and compare with admission weight. Calculate weight gain during the specified time periods.

Current weight '' Review the clinical records and compare current weight with weights of 30 days ago. Calculate weight gain during the specified time periods.

Coding: 0. No or unknown.

1. Yes, planned gain.

2. Yes, unplanned gain.

5. Parenteral or Enteral Intake

Intent: To record the proportion of all calories received, and the average fluid intake, through parenteral or tube feeding in the last 3 days.

a. The proportion of total calories the patient received through parenteral or tube feedings in last 3 days.

Definition:Proportion of total calories received—the proportion of all calories ingested during the last 3 days that the patient actually received (not just ordered) by parenteral or tube feedings. Determined by calorie count.

Process: Review clinical record, particularly the intake flow sheets. Consult with the dietitian who can derive a calorie count received from parenteral or tube feedings.

Coding: Code for the best response. If the patient took no food or fluids by parenteral or tube feedings, or took just sips of fluid, code ''0'' (None).

0. None.

1. 1 percent to 25 percent.

2. 26 percent to 50 percent.

3. 51 percent to 75 percent.

4. 76 percent to 100 percent.

b. Average fluid intake per day by IV or tube in last 3 days.

Definition: Average fluid intake per day by IV or tube in last 3 days refers to the actual amount of fluid the patient received by these modes (not the amount ordered).

Process: Review the Intake and Output record from the last 3 days. Add up the total amount of fluid received each day by IV and/or tube feedings only. Divide the total fluid intake during this time by 3. This will give you the average of fluid intake per day.

Coding: Code for the average number of cc's of fluid the patient received per day by IV or tube in last 3 days.

Codes: 0. None.

1. to 500 cc/day.

2. 501 to 1000 cc/day.

3. 1001 to 1500 cc/day.

4. 1501 to 2000 cc/day.

5. 2001 or more cc/day.

Section K. Procedures/Services

Intent: To document the service, treatments, procedures and devices the patient received over the last 3 days.

1. Clinical Visits and Orders

Intent: To document the number of physician, nurse practitioner, and physician assistant visits in which the patient was examined and notes written, as well as the number of order changes in the last 3 days.

Process: Review the medical record, including physician, nurse practitioner, and physician assistant orders over the last 3 days. See specific processes under each of the following definitions:

Definition: a. Total number of physician visits (by attending, consultant, etc.) in which the patient was examined and MD notes written—This category also includes any primary care or consulting osteopath, podiatrist or dentist. Review the medical record and add up the total number of physician visits the patient had in the last three days. Count only those where the patient was actually seen and examined/assessed by the physician as indicated by physician notes specifically indicating findings/results of the examination. Examination/assessment may be a partial or full exam that occurs at the facility or physician's office/clinic. This category does not include exams conducted in an emergency room.

b. Number of times physician or nurse practitioner called to bedside for emergency (for example, cardiorespiratory arrest, hemorrhaging, to evaluate change in condition)—Once again the physician category also includes bedside visits for emergencies by MD, osteopath, podiatrist, or dentist.

c. Number of nurse practitioner (NP) visits in which patient examined and notes

written—Review the medical record and add up the total number of NP visits the patient had in the last 3 days. Count only those where the patient was actually seen and examined/assessed as indicated by NP notes specifically indicating findings/results of the examination.

d. Number of physician assistant (PA) visits in which patient examined and notes written—Review the medical record and add up the total number of PA visits the patient had in the last 3 days. Count only those where the patient was actually seen and examined/assessed as indicated by PA notes specifically indicating findings/results of the examination.

e. Number of new or changed orders—Includes written, telephone, fax, or consultation orders for new or altered treatment. Does NOT include admission orders, return admission orders or renewal orders without changes. Does include orders for lab tests. Review the physician order sheet in the medical record and add up the total amount of new or changed orders by M.D., osteopath, podiatrist, dentist, NP or PA.

Coding: For each clinical visit or order, record how often it was provided to the patient in the last 3 days.

2. Treatments and Services

Intent: To document the following:

- Column A—over the last 3 days, code for treatment frequency [either daily (Code 3) or less than daily (Code 2) or ordered, not yet implemented (Code 1)].
- Column B—Record whether patient will receive service after discharge.

Process: *Column A*—Review patient's plan of care with the primary caregiver, and review the current medical record, referral information and hospital discharge summary. Use the following coding instructions to indicate how often each of these services was provided in the last 3 days. Note: These treatments and services must either be ordered by a physician or performed by a licensed professional and documented appropriately.

Column B—This column is to be completed ONLY at the discharge assessment (Item AA3 = 5). Review the patient's plan of care with the primary caregiver, and review the current medical record. Use the coding instructions for Column B (below) to indicate whether the patient will receive the service/treatment after discharge.

Coding: *Column A*—For each treatment or service indicate how often it was provided to the patient in the last 3 days. If none of these treatments were provided, check NONE OF ABOVE (Item K2aiA, located in the bottom right hand corner of Section K2, Treatments and Services). For any activity that did not occur, or was not ordered, leave the box next to that item blank. Code for most intense treatment on any one day using the following codes:

[Leave blank] if treatment did not occur, not ordered.

Code ''1'' If the treatment was ordered, but has not yet been implemented.

Code ''2'' If the treatment occurred less than daily.

Code ''3'' If the treatment occurred daily.

Column B—For each treatment or service (''a'' through ''ah'') indicate whether the patient will receive it after discharge. Leave ''Blank'' for No, Code ''1'' for Yes. This information is obtained on a Discharge Assessment only.

Definition: MEDICATION RELATED

a. Diabetic management—Involves a variety of activities centered around stabilization of blood sugar, including determining sliding scale insulin dosages, and blood sugar monitoring. In order to use codes 1–3 in Column A, there must be documentation of changes in type of insulin, insulin dosing, or reports/documentation of blood sugar levels.

b. Injections—Subcutaneous, intramuscular, or intradermal injections of any type of medication, antigen, or vaccine. Although antigens and vaccines are considered ''biologicals'' and not medication per se, it is important to track when they are given in order to monitor for systemic reactions. This category does not include intravenous fluids or medications. If the patient received IV medications, record in Item K2c. (If the patient received IV fluids, record in Item J5b).

c. IV antibiotics/medications—Administration of antibiotics or other medications by means of infusion therapy. Includes any drug or biological (for example, contrast material) given by intravenous push or drip through a central or peripheral port. Does not include a saline or heparin flush to keep a heparin lock patent, or IV fluids without medication.

SKIN TREATMENT

d. Application of dressing—Includes dry gauze dressings, dressings moistened with saline or other solutions, transparent dressings, hydrogel dressings, and dressings with hydrocolloid or hydroactive particles.

e. Application of ointments, topical medications—Includes ointments or medications used to treat a skin condition (for example, cortisone, antifungal preparations, chemotherapeutic agents, etc.). This definition does not include ointments used to treat non-skin conditions (for example, nitropaste for chest pain).

f. Debridement (chemical or surgical)—Chemical debridement is the process of removing dirt or dead tissue from a wound or burn using chemical agents or dressing change products to promote wound healing. Surgical debridement is the process of surgically removing dirt or dead tissue from a wound or burn to promote wound healing.

g. Nutritional/hydration intervention to manage skin problems—Any nutritional intervention whose purpose is to promote wound healing (for example, high protein drinks, TPN/PPN).

h. Pressure relieving bed/chair—Pressure relieving devices for the bed include air fluidized, low airloss therapy beds, flotation, water, or bubble mattress or pad placed on the bed. Do not include egg crate mattresses in this category. Pressure relieving devices for the chair include gel, air (for example, Roho) or other cushioning placed on a chair or wheelchair. Do not include egg crate cushions in this category.

i. Turning and repositioning—Includes a continuous, consistent program for changing the patient's position and realigning the body.

j. Ulcer Care—Includes any intervention for treating an ulcer at any ulcer stage. Examples include use of dressings, chemical or surgical debridement, wound irrigations, and hydrotherapy.

k. Wound care (surgical)—Includes any intervention for treating or protecting any type of surgical wound. Examples of care include topical cleansing, wound irrigation, application of microbial ointments, dressings of any type, suture removal, and warm soaks or heat application.

MANAGEMENT OF HEALTH PROBLEMS

l. Bladder training—A planned program aimed at assessing and treating bladder incontinence.

m. Scheduled toileting—A plan whereby staff members at scheduled times either take the patient to the toilet room, or give the patient a urinal, or remind the patient to go to the toilet. Includes habit training or prompted voiding.

n. Bowel program—A planned program aimed at treating bowel incontinence. A bowel program also includes a program of planned bowel elimination as with patients with spinal cord injury.

o. Cardiac monitoring/Rehabilitation—Cardiac monitoring includes electrical surveillance of heart rates and patterns either through EKG or telemetry. Rehabilitation is a formalized program focusing on regaining function and endurance that has been limited by either a chronic or acute cardiac disease.

p. Cast(s)—A device used to immobilize limbs or joints to promote healing or as a treatment for various musculoskeletal problems.

q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)—Assistive breathing device which provides the patient with a continuous flow of air throughout the breathing cycle.

r. Drains (cutaneous drains and other drains)—A heavy gauged tube used to remove air, fluid, or exudate from a body cavity or wound (exclude chest tubes).

s. Dialysis (includes hemodialysis and peritoneal dialysis)—Hemodialysis is a method for removing unwanted byproducts from the blood of patients with renal insufficiency or failure through the use of a machine (dialyzer). Peritoneal dialysis (CAPD) is a method of removing unwanted by-products from the body through the instillation of dialysate into the peritoneal cavity and using the abdominal wall as a filter.

t. Enteral Feeding Tube—Any tube inserted into the gastrointestinal tract for the purpose of nutrition, hydration, or medication administration. (This includes, jejunostomy, gastrostomy, and PEG tubes).

u. IV line-Central—A catheter which is placed in the more ''central'' veins such as subclavian, jugular, or superior vena cava, for the purpose of monitoring, and administration of medications and fluids. This item includes the insertion, discontinuation, and maintenance of this IV line, including dressing changes, evaluation for patency, assessment for adverse effects (for example, infection), and flushes.

v. IV line-peripheral—A catheter which is placed in a peripheral vein (usually hand or arm) for administration of medications and fluids. This item includes the insertion, discontinuation, and maintenance of this IV line, including dressing changes, evaluation for patency, assessment for adverse effects (for example, infiltration; infection; cellulitis) and flushes.

w. NG feeding tube—A tube inserted through the nose and extending into the stomach.

x. Oxygen—Either the intermittent or continuous use of oxygen to support, promote or maintain vital functions and comfort.

y. Pain management other than drugs—Any documented non-pharmaceutical intervention designed to decrease or alleviate pain. Examples may include (but are not limited to) acupuncture, relaxation therapy, hypnosis, TENS therapy.

z. Suctioning-oral/nasopharyngeal—Removing secretions or other matter from the respiratory system through the mouth or nose.

aa. Suctioning-tracheal—Removing secretions or other matter from the respiratory system through a tracheostomy.

ab. Tracheostomy care—The process of maintaining a clean and functioning tracheostomy, includes assessing the surrounding skin, changing dressing around tracheostomy tube, cleaning and changing inner cannula, monitoring cuff pressures, and securing the tracheostomy tube.

ac. Transfusion(s)—Giving whole blood or blood component (for example, red blood cells) to replace blood loss through injury, surgery, or disease.

ad. Ventilator or respirator—Assures adequate ventilation in patients who are, or who may become, unable to support their own respiration. Includes any type of electrically or pneumatically powered closed system mechanical ventilatory support devices.

ae. Ventilator weaning—Any patient who was in the process of being weaned off the ventilator or respirator in the last 3 days should be coded under this definition.

OTHER

af. Family training in assistance to patient in health measures or skills required after return to the community—Any documented family teaching to support the patient's discharge home. Examples include, but are not limited to, observing for signs of declining health (for example, hypoglycemia; cognitive change; new or worsening urinary incontinence); administering medications; observing for drug side effects or adverse drug reactions; providing ostomy care or dressing changes; coaching strength training exercises; assisting in transferring and locomotion; providing appropriate verbal/physical cues for feeding; how to label closets and drawers so patient can retrieve clothes; application of behavioral management techniques; when to report change or request assistance.

ag. Patient training in health maintenance or skills required after return to community—Any documented patient teaching to support the patient's discharge home. Examples include, but are not limited to, recognizing and reporting signs of declining health (for example, hypoglycemia; cognitive change; new or worsening urinary incontinence); self-administration of medications; recognizing and reporting drug side effects or adverse drug reaction; recording adherence to strength training exercises; self-ostomy care; how the Lifeline emergency response system works; how to access help in an emergency.

ah. Design and implementation of discharge plan—Discharge plan developed by the interdisciplinary team; includes making the necessary arrangements and contacts with community services.

ai. NONE OF THE ABOVE—Code if the patient has received NONE of the treatments or services above.

3. Nursing Practice or Restorative Care

Intent: To determine the extent to which the patient receives nursing rehabilitation or restorative services from other than specialized therapy staff (for example, occupational therapist, physical therapist, etc.). Rehabilitative or restorative care refers to nursing interventions that promote the patient's ability to adapt and adjust to living as independently and safely as is possible. This concept actively focuses on achieving and maintaining optimal physical, mental, and psychosocial functioning.

Skill practice in such activities as walking and mobility, dressing and grooming, eating and swallowing, transferring, amputation care, and communication can improve or maintain function in physical abilities and ADLs and prevent further impairment.

Definition: Rehabilitation/restorative care—Included are nursing interventions that assist or promote the patient's ability to attain his or her maximum functional potential. This item does not include procedures or techniques carried out by or under the direction of qualified therapists, as identified in item K4. In addition, to be included in this section, a rehabilitation or restorative practice must meet all of the following additional criteria:

- Measurable objectives and interventions must be documented in the care plan and in the clinical record.
- Evidence of periodic evaluation by licensed nurse must be present in the clinical record.
- Nurse assistants/aides must be trained in the techniques that promote patient involvement in the activity.
- These activities are carried out or supervised by members of the nursing staff. Sometimes under licensed nurse supervision, other staff and volunteers will be assigned to work with specific patients.
- This category does not include exercise groups with more than four patients per supervising helper or caregiver.

Definition: a. Range of motion (passive)—The extent to which, or the limits between which, a part of the body can be passively moved around a fixed point, or joint. Passive range of motion exercise is a program of movements to maintain flexibility and useful motion in the joints of the body.

b. Range of motion (active)—Exercises performed by a patient, with cuing or supervision by staff, that are planned, scheduled, and documented in the clinical record.

c. Splint or orthotic assistance—Assistance can be of 2 types: (1) where staff provide verbal and physical guidance and direction that teaches the patient how to apply, manipulate, and care for an orthotic device or splint, or (2) where staff have a scheduled program of applying and removing a splint or brace, assess the patient's skin and circulation under the device, and reposition the limb in correct alignment. These sessions are planned, scheduled, and documented in the clinical record.

Training and skill practice—Activities including repetition, physical or verbal cuing, and task segmentation provided by any staff member or volunteer under the supervision of a licensed nurse.

d. Bed mobility—Activities used to improve or maintain the patient's self-performance in moving to and from a lying position, turning side to side, and positioning him or herself in bed.

e. Bladder/Bowel—Activities used to improve or maintain the patient's self-performance in bladder and bowel evacuation (includes ostomy care).

f. Transfer—Activities used to improve or maintain the patient's self-performance in moving between surfaces or planes either with or without assistive devices.

g. Walking—Activities used to improve or maintain the patient's self-performance in walking, with or without assistive devices.

h. Dressing or grooming—Activities used to improve or maintain the patient's self-performance in dressing and undressing, bathing and washing, and performing other personal hygiene tasks.

i. Eating or swallowing—Activities used to improve or maintain the patient's self-performance in feeding oneself food and fluids, or activities used to improve or maintain the patient's ability to ingest nutrition and hydration by mouth.

j. Amputation/prosthesis care—Activities used to improve or maintain the patient's self-performance in putting on and removing a prosthesis, caring for the prosthesis, and providing appropriate hygiene at the site where the prosthesis attaches to the body (for example, leg stump or eye socket).

k. Communication—Activities used to improve or maintain the patient's self-performance in using newly acquired functional communication skills or assisting the patient in using residual communication skills and adaptive devices.

Process: Review the clinical record and the current care plan. Consult with facility staff. Look for rehabilitation, restorative care schedule, assignment, and implementation record sheet on the nursing unit.

Coding: For the last three days, enter the number of days on which the technique, procedure, or activity was practiced for a total of at least 15 minutes during each day (24-hour period). The 15 minutes does not have to occur all at once. Remember that persons with dementia learn skills best through repetition that occurs multiple times per day. Review for each activity throughout the 24-hour period. Enter zero ''0'' if none, or if the service was provided for less than 15 minutes per day in the last 3 days.

4. Therapy Services

This item involves therapies that occurred after admission to the facility and meet the following criteria: (1) were ordered by a physician, (2) were performed by a qualified therapist (that is, one who meets state credentialing requirements) OR (3) were performed by therapy assistant under the direction of the therapist.

The therapy treatment may occur either inside or outside the facility. Includes only therapies based on a therapist's assessment and treatment plan that is documented in the patient's clinical record.

Intent: To record the (A) total number of days treatment was ordered in the last 3 days, (B) number of days administered (for 15 minutes or more), (C) total number of minutes each of the following therapies was provided in the last 3 days (or ordered if days administered =0 and days ordered >0), and (D) whether the patient will receive the service after discharge. Note: In order for therapy minutes to be recorded in the most precise 15 minute increment, either the physician's order or the therapist's plan of care must indicate minutes of therapy ordered by the physician or recommended in the therapist's plan of care.

Definition: a. Speech-language pathology, audiology services—Services that are provided by a qualified speech-language pathologist.

b. Occupational therapy—Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include services provided by a qualified occupational therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified occupational therapist.

c. Physical therapy—Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may provide therapy but not supervise others (aides or volunteers) giving therapy. Include service provided by a qualified physical therapy assistant who is employed by (or under contract to) the facility only if he or she is under the direction of a qualified physical therapist.

d. Respiratory therapy—Included are coughing, deep breathing, administration of heated nebulizers, aerosol treatments, and mechanical ventilation, etc., which must be provided by a qualified professional (that is, trained nurse, respiratory therapist). This item does not include use of hand-held medication dispensers. Count only the time that the qualified professional spends with the patient. For high intensity respiratory patients who receive 24° respiratory care, have a discussion with the therapist to get an estimate of the actual amount of time spent at the bedside providing care.

e. Psychological therapy by any licensed mental health professional—Therapy given by any licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

f. Therapeutic recreation—Therapy ordered by a physician that provides therapeutic stimulation beyond the general activity program in a facility. The physician's order must include a statement of frequency, duration and scope of the treatment. Such therapy must be provided by a state licensed or nationally certified Therapeutic Recreation Specialist or Therapeutic Recreation Assistant. The Therapeutic Recreation Assistant must work under the direction of a Therapeutic Recreation Specialist.

Process: Review the patient's clinical record and consult with each of the qualified therapists.

Coding: For Boxes (Columns) A, B and C count only post-admission therapies (given in or outside the facility).

Column A: Days ordered—In the first column, enter the number (#) of days the treatment was ordered during the last three days. Enter ''0'' if none. Maximum code is ''3''.

Column B: Days administered—In the second column, enter the number (#) of days the therapy was administered for at least 15 minutes or more in the last three days. Enter ''0'' if none. Maximum code is ''3''.

Column C: Minutes delivered—In the third column, enter the total number (#) of minutes the particular therapy was provided in the last 3 days. The time should include only the actual treatment time (not time waiting, writing reports, or conducting an evaluation). Enter total number of minutes ordered if days administered (K4B) = 0 and days ordered (K4A) > 0. Enter ''0'' if the therapy was not ordered or administered. [Note—Enter cumulative time over all 3 days even when total time on a day (or days) was less than 15 minutes].

Column D: Post Discharge Therapy—Code at discharge assessment only (A3=5). Record whether the patient will receive the therapy service after discharge. Code ''0'' for No, or ''1'' for Yes. This information is obtained on a Discharge Assessment only.

5. Devices and Restraints

Intent: To record the frequency, over the last three days, with which the patient was restrained by any of the devices listed below at any time during the day or night.

Definition: This category includes the use of any device (for example, physical or mechanical device, material, or equipment attached or adjacent to the patient's body) that the patient cannot easily remove and that restricts freedom of movement or normal access to his or her body. If device is used as an ''enabler,'' you still must code device in this item.

a. Full bed rails—Full rails may be one or more rails along both sides of the patient's bed that block three-quarters to the whole length of the mattress from top to bottom. This definition also includes beds with one side placed against the wall (prohibiting the patient from entering and exiting on that side) and the other side blocked by a full rail (one or more rails). A veil screen (used in pediatric units) or veil bed is included in this category.

b. Other types of side rails used (for example, one-side half rail, one-side full rail, two-sided half rails).

c. Trunk restraint—Includes any device or equipment or material that the patient cannot easily remove (for example, vest or waist restraint).

d. Chair prevents rising—Any type of chair with locked lap board or chair that places patient in a recumbent position that restricts rising or a chair that is soft and low to the floor (for example, bean bag chair). Includes ''comfort cushions'' (for example, lap buddy), ''merry walkers.''

Process: Check the patient's clinical records and restraint device flow sheets. Consult nursing staff. Observe the patient.

Coding: For each device type, enter the code that best describes the pattern of restraint or device use for the last 3 days:

0. Not used in last three days

1. Used, but used less than daily in last three days

2. Daily use—night only in the last three days

3. Daily use—days only in the last three days

4. Night and day use, but not constant use in the last three days

5. Constant use for full 24 hours (with periodic release) during the last three days

Section L. Functional Prognosis

Intent: A major goal of post acute care is to rehabilitate the patient to a level of function and health that enables return to the patient's previous living arrangement or, if not appropriate, to the most independent living arrangement possible. Developing plans of care to achieve this goal and prepare for post-discharge needs requires (1) establishing individualized goals in specific areas of function and health, (2) estimating the degree to which the patient will improve, (3) evaluating the patient's and family's individual needs, values, motivation for participation in rehabilitation, and (4) estimating the rate of patient change (and goal achievement) and length of stay. This section asks the interdisciplinary team to take this information and make some predictions on rehabilitation prognosis. These predictions are essential in planning services needed during the stay as well as upon discharge.

1. Functional Improvement Goals

Intent: This section looks at some key functional areas, and asks staff to make a prediction whether the patient will meet these goals in the indicated time frame.

Definition: ADLs

a. Bed mobility/transfer—Goals that involve how patient moves to and from a lying position, turns side to side, and positions body while in bed. Also includes goals involving how patient moves between surfaces—to or from: bed, chair, wheelchair.

b. Dressing—Goals that involve how the patient dresses and undresses (street clothes and underwear) including prostheses, orthotics, fasteners, pullovers, belts, pants, skirts, and shoes.

c. Eating—Goals centering on how the patient eats and drinks (regardless of skill). This includes intake of nourishment by other means (for example, tube feeding, total parenteral nutrition).

d. Locomotion—Goals involving how the patient moves between locations in his/her room and adjacent corridor on the same floor.

If patient uses a wheelchair, the goals would involve how the patient moves once the patient is in the wheelchair.

e. Toileting—Goals that involve how the patient uses the toilet room (or commode, urinal, bedpan), cleanses himself/herself after toilet use or incontinent episode(s), changes pads, manages ostomy or catheter, and adjusts clothes. This item does include goals centering on transfers on and off the toilet or commode.

OTHER

f. Medication Management—Goals involving how the patient manages medications (remembering to take medications, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments).

g. Pain Control—Goals involving the control (cessation or mitigation) of pain by the patient. Pain control goals could involve both pharmacologic and non-pharmacologic interventions.

h. Managing Finances—In the inpatient environment this includes goals involving financial activities such as paying for the newspaper, paying for TV service. When considering home discharge, this item involves paying bills, managing checking account, or bank account.

Process: Using your best clinical judgment, code each of these functional areas using the scale described below. A review of the physician orders, notes and plans of care would be essential in this process to confirm what goals have been established.

Coding: Choose the response that best reflects the clinical staff's prognosis for goal attainment in each of the specified areas in the last 24 hours. Code for the most aggressive goal in each area. For admission assessment and reassessment, code for clinical staff expectations of patient goals in the areas listed below by time of discharge. For discharge assessments, code for staff expectation of patient functional goal in the post discharge period.

0. No goal exists—There is currently no goal in the patient's plan of care that aims to improve or maintain the patient's current functional performance or health (in the area specified) in the area indicated.

1. Goal—improvement, full recovery to premorbid status anticipated—Goals for improvement in the area specified have been set, and clinical staff project that the patient will improve to the level of function or health (in the area specified) that he or she experienced prior to the precipitating event (Item A7a).

2. Goal—improvement, partial recovery anticipated—Goals for improvement in the specified area have been set, but given the patient's current status and availability of services within the expected length of stay, clinical staff project that the patient will not improve to the level of function or health (in the area specified) he or she experienced prior to the precipitating event (Item A7a).

3. Goal—improvement, recovery uncertain—Goals for improvement in the specified area have been set, but given the patient's current health, functional or emotional status, clinical staff are unable to determine if the patient will partially or fully return to the level of function or health (in the specified area) he or she experienced prior to the precipitating event (Item A7a).

4. Goal—maintenance, prevention of further decline—Goals for maintenance (preservation) of function or health in the specified area have been set, and clinical staff project that the patient will meet maintenance goals as evidenced by NO further deterioration in function or health (in the area specified).

2. Attributes Relevant to Rehabilitation

Intent: The intent of this section is to measure the patient's and his or her family's motivation to participate in the rehabilitation program and goals. This is essential to establish the patient and the patient's support system's participation in the established plan of care. When conflicts arise, the plan of care needs to be modified to reflect efforts to resolve these conflicts. For example, if the patient is in the post-acute setting for rehabilitation after a stroke, but is ''refusing rehabilitation,'' this issue becomes the primary issue to deal with rather than the fact that the patient's mobility is limited.

Definition: a. Patient believes he/she is capable of increased independence—The patient states that he/she has the capacity to improve or be more independent (albeit with therapeutic support) or demonstrates this belief by actively participating in rehabilitative programming.

b. Patient unable to recognize new limitations—The patient lacks insight into the level of his/her altered function; may use poor judgement, thereby placing self at safety risk; may resist participation in therapeutic programming aimed at improving function or compensating for deficits.

c. Patient fails to initiate or to continue to carry out ADLs (once initiated) for which he/she has some demonstrated capability—The patient refrains from participating in self-care in one or more ADL areas in which he/she has shown self-care abilities.

Process: Interview the patient. Get a sense of what his/her goals are from this post-acute admission. Also discuss what the patient's family or support person's perceptions are. Observe the patient's behavior and participation in plan of care. Are there differences in the Care Plan goals established by the team and the patient's and family's goals?

Coding: Indicate ''0'' for No, ''1'' for Yes, or ''8'' for Unknown in the box corresponding to each item, indicating that they have been observed, verbalized or documented in the last 3 days.

3. Change Over the Last 3 Days

Intent: To evaluate and predict the rate in which the patient will progress toward his or her established goals.

Process: Obtain information via review of the medical record, staff and patient interview.

Definition: a. Change in overall functional status over last 3 days.

b. Change in overall health status over last 3 days.

Coding: From the following codes, choose the response that best reflects your best clinical judgement of the patient's rate of overall functional and health status change over the last 3 days.

0. Improved.

1. About the same as at admission (or last assessment if this is not an admission assessment).

2. Worse.

4. Estimated Length of Stay From Date of Admission

Intent: It is essential to put a time frame around established goals in the plan of care. The guiding time frame in this process is the anticipated length of stay. This is established based on a number of factors including but not limited to, diagnosis, functional ability and prognosis, medical complications, support systems, patient motivation, and anticipated living arrangement and payor source. All this information must be taken into consideration when making a prediction.

Process: Use a chart review, patient/support system interview, or obtain interdisciplinary clinical input to code for the anticipated length of stay.

Coding: Starting from (and including) the date entered in AA2b or if AA2b is blank AA2a (Admission Date), using your best clinical judgement, determine the patient's expected length of stay in the current setting prior to returning to a community setting. Choose the response that best reflects the anticipated time frame.

0. 1–6 days.

1. 7–13 days.

2. 14—30 days.

3. 31—90 days.

4. 91 or more days.

5. Discharge to community not expected—It is anticipated that the patient will never return to the community, even if they are transferred to another facility. This category also includes patients who are expected to die during this admission.

6. Expected discharge will be to another health care setting prior to return to community—Examples include transfer to nursing facility with eventual discharge to the community.

Section M. Resources for Discharge

Intent: In this section some key elements related to discharge planning are addressed. Before formulating a discharge plan, the resources available to support the patient's discharge home should be evaluated based on the patient's current needs. In conjunction with previous sections of the assessment, these items lay the ground work for developing a realistic discharge/transition plan.

1. Available Social Supports

Intent: To identify the availability of family or friends to provide support during the post-acute phase and after discharge.

Process: Information should be obtained through patient/family interview and through medical record review. Determine if there is any indication that family or close friends are present and available. Privately employed caregivers would not be coded in this item.

Definition: a. Emotional Support—The provision of encouragement, comfort, attentive listening.

b. Intermittent physical support with ADLs or IADLs—less than daily—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing

housework, shopping etc, on a less than daily basis.

c. Intermittent physical support with ADLs or IADLs—daily—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing housework, shopping etc., on a daily basis (for example, once a day), but not full time.

d. Full time physical support (as needed) with ADLs or IADLs—The provision of ''hands on'' assistance to the patient with personal care, transfers, mobility, or doing housework, shopping etc., on a daily basis full time.

e. All or most of necessary transportation—Includes providing transportation by driving patient in a car (or other motorized vehicle) OR accompanying patient using bus, subway, or other public transportation.

Coding: Ask if one or more family members/close friends are willing and able to provide support after discharge. Enter the most appropriate response next to the type of support. Enter ''0'' for No, ''1'' for Possibly yes, and ''2'' for Definitely Yes.

2. Caregiver Status

Intent: The following items identify issues with the patient's family or informal caregivers in preparation for discharge. Often, when a family member needs post-acute care, the entire family is affected. It is important to determine how the caregiver(s) is coping, whether he/she requires additional supports, or if he/she is willing and able to provide the patient with extended care in their home.

Process: Interview the patient and family/caregiver, as well as staff who are closely involved with the patient's care. Review medical record, including Social Service notes.

Coding: Enter a ''0'' for ''No'', and a ''1'' for ''Yes'' in the box next to each statement that applies to the patient and their care givers/family.

0. No.

1. Yes.

a. Family (or close friend) overwhelmed by patient's illness.

b. Family relationship(s) require unusual amounts of staff time.

3. Living Arrangement

Intent: The intent of this item is to establish the permanent living arrangement both prior to admission [A] and that which is expected after discharge [B]. If the initial arrangement expected at discharge is different than column M3B—code in column C for Temporary Discharge arrangement (A3 = 5).

Process: Obtain information through patient and family interview. Medical record review may also be helpful.

Definition: a. Type of residence.

0. Unknown.

1. Private home—Any house or condominium in the community whether owned by the patient or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.

2. Private apartment—Any apartment in the community whether owned by the patient or another person.

3. Rented Room—A rented room either part of a private house or a boarding room establishment.

4. Board and Care/assisted living/group home—An alternative housing option which integrates shared living environment with some degree of supportive services such as home health services, personal care, meal service, transportation.

5. Homeless (with or without shelter)—Person does not have a residence—lives out on streets, woods, etc. or uses a community based shelter for individuals who do not have a residential address.

6. Long Term Care Facility (nursing home)—A residence that provides 24-hour skilled or intermediate nursing care.

7. Post Acute Care SNF—Facility (or designated beds within a SNF) dedicated to the care of patients with intense rehabilitative or clinically complex needs. Most patients are admitted to the post acute care facility from an acute hospital, or rehabilitation hospital. These patients will have a short, intense stay in the post acute care SNF.

8. Hospice—An interdisciplinary program of palliative care and support services that addresses the physical, social, spiritual, and financial needs of terminally ill patients and their families.

9. Acute unit/hospital—A facility licensed as an acute care hospital or unit. Patients in acute care may receive comprehensive and complex diagnostic services, treatments, and surgery.

10. Other—Any other setting not categorized above.

b. Live(d) with.

0. Unknown.

1. Alone—Living with a pet is coded as living alone.

2. Spouse only—If patient is living as married (common law marriage) with another person, use this code.

3. Spouse and others—husband or wife, and other family members, friends, boarders.

4. Child—Lives with child, no spouse present.

5. Other relative(s)—Not spouse or children.

6. Friends.

7. Group setting—An alternative housing option which integrates a shared living environment with some degree of supportive services such as home health services, personal care, meal service, transportation.

8. Personal Care Attendant—A health care worker either hired by an agency or the patient himself. This worker is trained to provide the patient with help in ADL's and other types of assistance.

9. Other—Any other living arrangement not categorized above.

Process: Review the medical record. Consult the patient and family. This is meant to measure permanent placement. If a patient is going to be discharged to a skilled nursing facility for a short period of time, and then discharged back to their home, the permanent living arrangement would be either 1 or 2 depending on home service arrangements.

Coding: a. Type of residence—

- In Column A—indicate the type of residence where the patient permanently resided prior to admission.
- In Column B—indicate the type of residence where the patient is expected to permanently reside after discharge.
- In Column C—indicate the type of residence where the patient is expected to temporarily reside initially after discharge. Code this item only if this arrangement is different than that coded in Column B.

b. Lived with—

- In Column A—indicate with whom the patient permanently resided prior to admission.
- In Column B—indicate with whom the patient is expected to permanently reside after discharge.
- In Column C—indicate with whom the patient is expected to temporarily reside initially after discharge. Code this item only if this arrangement is different than that coded in Column B.

Appendix C: List of Comorbidities

ICD9 code No.	Abbreviated code title
011	Pulmonary tuberculosis*
011.0	TB of lung, infiltrative
011.00	TB lung infiltr-unspec
011.01	TB lung infiltr-no exam
011.02	TB lung infiltr-exm unkn
011.03	TB lung infiltr-micro DX
011.04	TB lung infiltr-cult DX
011.05	TB lung infiltr-histo DX
011.06	TB lung infiltr-oth test
011.1	TB of lung, nodular
011.10	TB lung nodular-unspec
011.11	TB lung nodular-no exam
011.12	TB lung nodul-exam unkn
011.13	TB lung nodular-micro DX
011.14	TB lung nodular-cult DX
011.15	TB lung nodular-histo DX
011.16	TB lung nodular-oth test
011.2	TB of lung w cavitation
011.20	TB lung w cavity-unspec
011.21	TB lung w cavity-no exam
011.22	TB lung cavity-exam unkn
011.23	TB lung w cavit-micro DX
011.24	TB lung w cavity-cult DX
011.25	TB lung w cavit-histo DX
011.26	TB lung w cavit-oth test
011.3	Tuberculosis of bronchus
011.30	TB of bronchus-unspec
011.31	TB of bronchus-no exam
011.32	TB of bronchus-exam unkn
011.33	TB of bronchus-micro DX
011.34	TB of bronchus-cult DX
011.35	TB of bronchus-histo DX
011.36	TB of bronchus-oth test
011.4	TB fibrosis of lung
011.40	TB lung fibrosis-unspec
011.41	TB lung fibrosis-no exam
011.42	TB lung fibros-exam unkn
011.43	TB lung fibros-micro DX
011.44	TB lung fibrosis-cult DX
011.45	TB lung fibros-histo DX
011.46	TB lung fibros-oth test
011.5	TB bronchiectasis
011.50	TB bronchiectasis-unspec
011.51	TB bronchiect-no exam
011.52	TB bronchiect-exam unkn
011.53	TB bronchiect-micro DX
011.54	TB bronchiect-cult DX
011.55	TB bronchiect-histo DX
011.56	TB bronchiect-oth test
011.6	Tuberculous pneumonia
011.60	TB pneumonia-unspec

ICD9 code No.	Abbreviated code title
011.61	TB pneumonia-no exam
011.62	TB pneumonia-exam unkn
011.63	TB pneumonia-micro DX
011.64	TB pneumonia-cult DX
011.65	TB pneumonia-histo DX
011.66	TB pneumonia-oth test
011.7	Tuberculous pneumothorax
011.70	TB pneumothorax-unspec
011.71	TB pneumothorax-no exam
011.72	TB pneumothorx-exam unkn
011.73	TB pneumothorax-micro DX
011.74	TB pneumothorax-cult DX
011.75	TB pneumothorax-histo DX
011.76	TB pneumothorax-oth test
011.8	Pulmonary TB nec
011.80	Pulmonary TB nec-unspec
011.81	Pulmonary TB nec-no exam
011.82	Pulmon TB nec-exam unkn
011.83	Pulmon TB nec-micro DX
011.84	Pulmon TB nec-cult DX
011.85	Pulmon TB nec-histo DX
011.86	Pulmon TB nec-oth test
011.9	Pulmonary TB nos
011.90	Pulmonary TB nos-unspec
011.91	Pulmonary TB nos-no exam
011.92	Pulmon TB nos-exam unkn
011.93	Pulmon TB nos-micro DX
011.94	Pulmon TB nos-cult DX
011.95	Pulmon TB nos-histo DX
011.96	Pulmon TB nos-oth test
012	Other respiratory TB*
012.0	Tuberculous pleurisy
012.00	TB pleurisy-unspec
012.01	TB pleurisy-no exam
012.2	TB pleurisy-exam unkn
012.3	TB pleurisy-micro DX
012.04	TB pleurisy-cult DX
012.5	TB pleurisy-histolog DX
012.6	TB pleurisy-oth test
012.1	TB thoracic lymph nodes
012.10	TB thoracic nodes-unspec
012.11	TB thorax node-no exam
012.12	TB thorax node-exam unkn
012.13	TB thorax node-micro DX
012.14	TB thorax node-cult DX
012.15	TB thorax node-histo DX
012.16	TB thorax node-oth test
012.2	Isolated trach/bronch TB
012.20	Isol tracheal TB-unspec
012.21	Isol tracheal TB-no exam
012.22	Isol trach TB-exam unkn
012.23	Isolat trach TB-micro DX
012.24	Isol tracheal TB-cult DX
012.25	Isolat trach TB-histo DX
012.26	Isolat trach TB-oth test
012.3	Tuberculous laryngitis
012.30	TB laryngitis-unspec
012.31	TB laryngitis-no exam
012.32	TB laryngitis-exam unkn
012.33	TB laryngitis-micro DX
012.34	TB laryngitis-cult DX
012.35	TB laryngitis-histo DX
012.36	TB laryngitis-oth test
012.8	Respiratory TB nec
012.80	Resp TB nec-unspec
012.81	Resp TB nec-no exam
012.82	Resp TB nec-exam unkn
012.83	Resp TB nec-micro DX
012.84	Resp TB nec-cult DX
012.85	Resp TB nec-histo DX
012.86	Resp TB nec-oth test
013	CNS tuberculosis*
013.0	Tuberculous meningitis
013.00	TB meningitis-unspec
013.01	TB meningitis-no exam
013.02	TB meningitis-exam unkn
013.03	TB meningitis-micro DX
013.04	TB meningitis-cult DX
013.05	TB meningitis-histo DX
013.06	TB meningitis-oth test
013.1	Tuberculoma of Meninges
013.10	Tubrclma meninges-unspec
013.11	Tubrclma mening-no exam
013.12	Tubrclma menin-exam unkn
013.13	Tubrclma mening-micro DX
013.14	Tubrclma mening-cult DX
013.15	Tubrclma mening-histo DX
013.16	Tubrclma mening-oth test
013.2	Tuberculoma of brain
013.20	Tuberculoma brain-unspec
013.21	Tubrcloma brain-no exam
013.22	Tubrclma brain-exam unkn
013.23	Tubrcloma brain-micro DX
013.24	Tubrcloma brain-cult DX
013.25	Tubrcloma brain-histo DX
013.26	Tubrcloma brain-oth test
013.3	TB abscess of brain
013.30	TB brain abscess-unspec
013.31	TB brain abscess-no exam
013.32	TB brain absc-exam unkn
013.33	TB brain absc-micro DX
013.34	TB brain abscess-cult DX
013.35	TB brain absc-histo DX
013.36	TB brain absc-oth test
013.4	Tuberculoma spinal cord
013.40	Tubrclma sp cord-unspec
013.41	Tubrclma sp cord-no exam
013.42	Tubrclma sp cd-exam unkn
013.43	Tubrclma sp crd-micro DX
013.44	Tubrclma sp cord-cult DX
013.45	Tubrclma sp crd-histo DX
013.46	Tubrclma sp crd-oth test
013.5	TB abscess spinal cord
013.50	TB sp crd abscess-unspec
013.51	TB sp crd absc-no exam
013.52	TB sp crd absc-exam unkn
013.53	TB sp crd absc-micro DX
013.54	TB sp crd absc-cult DX
013.55	TB sp crd absc-histo DX
013.56	TB sp crd absc-oth test
013.6	TB encephalitis/myelitis
013.60	TB encephalitis-unspec
013.61	TB encephalitis-no exam
013.62	TB encephalit-exam unkn
013.63	TB encephalitis-micro DX
013.64	TB encephalitis-cult DX
013.65	TB encephalitis-histo DX
013.66	TB encephalitis-oth test
013.8	CNS tuberculosis nec
013.80	CNS tb nec-unspec
013.81	CNS tb nec-no exam
013.82	CNS tb nec-exam unkn
013.83	CNS tb nec-micro DX
013.84	CNS tb nec-cult DX
013.85	CNS tb nec-histo DX
013.86	CNS tb nec-oth test
013.9	CNS tuberculosis nos
013.90	CNS tb nos-unspec
013.91	CNS tb nos-no exam
013.92	CNS tb nos-exam unkn
013.93	CNS tb nos-micro DX
013.94	CNS tb nos-cult DX
013.95	CNS tb nos-histo DX
013.96	CNS tb nos-oth test
014	Intestinal tb*
014.0	tuberculous peritonitis
014.00	TB peritonitis-unspec
014.01	TB peritonitis-no exam
014.02	TB peritonitis-exam unkn
014.03	TB peritonitis-micro DX
014.04	TB peritonitis-cult DX
014.05	TB peritonitis-histo DX
014.06	TB peritonitis-oth test
014.8	Intestinal tb nec
014.80	Intestinal tb nec-unspec
014.81	Intestin tb nec-no exam
014.82	Intest tb nec-exam unkn
014.83	Intestin tb nec-micro DX
014.84	Intestin tb nec-cult DX
014.85	Intestin tb nec-histo DX
014.86	Intestin tb nec-oth test
015	TB of bone and joint*
015.0	TB of vertebral column
015.00	TB of vertebra-unspec
015.01	TB of vertebra-no exam
015.02	TB of vertebra-exam unkn
015.03	TB of vertebra-micro DX
015.04	TB of vertebra-cult DX
015.05	TB of vertebra-histo DX
015.06	TB of vertebra-oth test
015.1	TB of hip
015.10	TB of hip-unspec
015.11	TB of hip-no exam
015.12	TB of hip-exam unkn
015.13	TB of hip-micro DX
015.14	TB of hip-cult DX
015.15	TB of hip-histo DX
015.16	TB of hip-oth test
015.2	TB of knee
015.20	TB of knee-unspec
015.21	TB of knee-no exam
015.22	TB of knee-exam unkn
015.23	TB of knee-micro DX
015.24	TB of knee-cult DX
015.25	TB of knee-histo DX
015.26	TB of knee-oth test
015.5	TB of limb bones
015.50	TB of limb bones-unspec
015.51	TB limb bones-no exam
015.52	TB limb bones-exam unkn
015.53	TB limb bones-micro EX
015.54	TB limb bones-cult DX
015.55	TB limb bones-histo DX
015.56	TB Limb bones-oth test
015.6	TB of mastoid
015.60	TB of mastoid-unspec
015.61	TB of mastoid-no exam
015.62	TB of mastoid-exam unkn
015.63	TB of mastoid-micro DX
015.64	TB of mastoid-cult DX
015.65	TB of mastoid-histo DX
015.66	TB of mastoid-oth test
015.7	TB of bone nec
015.70	TB of bone nec-unspec
015.71	TB of bone nec-no exam
015.72	TB of bone nec-exam unkn
015.73	TB of bone nec-micro DX
015.74	TB of bone nec-cult DX
015.75	TB of bone nec-histo DX
015.76	TB of bone nec-oth test
015.8	TB of joint nec
015.80	TB of joint nec-unspec
015.81	TB of joint nec-no exam
015.82	TB joint nec-exam unkn
015.83	TB of joint nec-micro DX
015.84	TB of joint nec-cult DX
015.85	TB of joint nec-histo DX
015.86	TB of joint nec-oth test
015.9	TB of bone & joint nos

ICD9 code No.	Abbreviated code title
015.90	TB bone/joint nos-unspec
015.91	TB bone/jt nos-no exam
015.92	TB bone/jt nos-exam unkn
015.93	TB bone/jt nos-micro DX
015.94	TB bone/jt nos-cult DX
015.95	TB bone/jt nos-histo DX
015.96	TB bone/jt nos-oth test
016	Genitourinary TB*
016.0	TB of kidney
016.00	TB of kidney-unspec
016.01	TB of kidney-no exam
016.02	TB of kidney-exam unkn
016.03	TB of kidney-micro DX
016.04	TB of kidney-cult DX
016.05	TB of kidney-histo DX
016.06	TB of kidney-oth Test
016.1	TB of bladder*
106.10	TB of bladder-unspec
016.11	TB of bladder-no exam
016.12	TB of bladder-exam unkn
016.13	TB of bladder-micro DX
016.14	TB of bladder-cult DX
016.15	TB of bladder-histo DX
016.16	TB of bladder-oth test
106.2	TB of ureter
016.20	TB of ureter-unspec
016.21	TB of ureter-no exam
016.22	TB of ureter-exam unkn
016.23	TB of ureter-micro DX
016.24	TB of ureter-cult DX
016.25	TB of ureter-histo DX
016.26	TB of ureter-oth test
016.3	TB of urinary organ nec
016.30	TB urinary nec-unspec
016.31	TB urinary nec-no exam
016.32	TB urinary nec-exam unkn
016.33	TB urinary nec-micro DX
016.34	TB urinary nec-cult DX
016.35	TB urinary nec-histo DX
016.36	TB urinary nec-oth test
016.4	TB of epididymis
016.40	TB epididymis-unspec
016.41	TB epididymis-no exam
016.42	TB epididymis-exam unkn
016.43	TB epididymis-micro DX
016.44	TB epididymis-cult DX
016.45	TB epididymis-histo DX
016.46	TB epididymis-oth test
016.5	TB male genital org nec
016.50	TB male genit nec-unspec
016.51	TB male gen nec-no exam
016.52	TB male gen nec-ex unkn
016.53	TB male gen nec-micro DX
016.54	TB male gen nec-cult DX
016.55	TB male gen nec-histo DX
016.56	TB male gen nec-oth test
016.6	TB of ovary and tube
016.60	TB ovary & tube-unspec
016.61	TB ovary & tube-no exam
016.62	TB ovary/tube-exam unkn
016.63	TB ovary & tube-micro DX
016.64	TB ovary & tube-cult DX
016.65	TB ovary & tube-histo DX
016.66	TB ovary & tube-oth test
016.7	TB female genit org nec
016.70	TB female gen nec-unspec
016.71	TB fem gen nec-no exam
016.72	TB fem gen nec-exam unkn
016.73	TB fem gen nec-micro DX
016.74	TB fem gen nec-cult DX
016.75	TB fem gen nec-histo DX
016.76	TB fem gen nec-oth test
016.9	Genitourinary TB nos
016.90	GU TB nos-unspec
016.91	GU TB nos-no exam
016.92	GU TB nos-exam unkn
016.93	GU TB nos-micro DX
016.94	GU TB nos-cult DX
016.95	GU TB nos-histo DX
016.96	GU TB nos-oth test
017	Tuberculosis nec*
017.0	TB skin & subcutaneous
017.00	TB skin/subcutan-unspec
017.01	TB skin/subcut-no exam
017.02	TB skin/subcut-exam unkn
017.03	TB skin/subcut-micro DX
017.04	TB skin/subcut-cult DX
017.05	TB skin/subcut-histo DX
017.06	TB skin/subcut-oth Test
017.1	Erythema nodosum in TB
017.10	Erythema nodos TB-unspec
017.11	Erythem nodos TB-no exam
017.12	Erythem nod TB-exam unkn
017.13	Erythem nod TB-micro DX
017.14	Erythem nodos TB-cult DX
017.15	Erythem nod TB-histo DX
017.16	Erythem nod TB-oth test
017.2	TB of periph lymph node
017.20	TB periph lymph-unspec
017.21	TB periph lymph-no exam
017.22	TB periph lymph-exam unk
017.23	TB periph lymph-micro DX
017.24	TB periph lymph-cult DX
017.25	TB periph lymph-histo DX
017.26	TB periph lymph-oth test
017.3	TB of eye
017.30	TB of eye-unspec
017.31	TB of eye-no exam
017.32	TB of eye-exam unkn
017.33	TB of eye-micro DX
017.34	TB of eye-cult DX
017.35	TB of eye-histo DX
017.36	TB of eye-oth test
107.4	TB of ear
017.40	TB of ear-unspec
017.41	TB of ear-no exam
017.42	TB of ear-exam unkn
017.43	TB of ear-micro DX
017.44	TB of ear-cult DX
017.45	TB of ear-histo DX
017.46	TB of ear-oth test
017.5	TB of thyroid gland
017.50	TB of thyroid-unspec
017.51	TB of thyroid-no exam
017.52	TB of thyroid-exam unkn
017.53	TB of thyroid-micro DX
017.54	TB of thyroid-cult DX
017.55	TB of thyroid-histo DX
017.56	TB of thyroid-oth test
017.6	TB of adrenal gland
017.60	TB of adrenal-unspec
017.61	TB of adrenal-no exam
017.62	TB of adrenal-exam unkn
017.63	TB of adrenal-micro DX
017.64	TB of adrenal-cult DX
017.65	TB of adrenal-histo DX
017.66	TB of adrenal-oth test
017.7	TB of spleen
017.70	TB of spleen-unspec
017.71	TB of spleen-no exam
017.72	TB of spleen-exam unkn
017.73	TB of spleen-micro DX
017.74	TB of spleen-cult DX
017.75	TB of spleen-histo DX
017.76	TB of spleen-oth test
017.8	TB of esophagus
017.80	TB esophagus-unspec
017.81	TB esophagus-no exam
017.82	TB esophagus-exam unkn
017.83	TB esophagus-micro DX
017.84	TB esophagus-cult DX
017.85	TB esophagus-histo DX
017.86	TB esophagus-oth test
017.9	TB of organ nec
017.90	TB of organ nec-unspec
017.91	TB of organ nec-no exam
017.92	TB organ nec-exam unkn
017.93	TB of organ nec-micro DX
017.94	TB of organ nec-cult DX
017.95	TB of organ nec-histo DX
017.96	TB of organ nec-oth test
018	Miliary tuberculosis*
018.0	Acute miliary TB
018.00	Acute miliary TB-unspec
018.01	Acute miliary TB-no exam
018.02	AC miliary TB-exam unkn
018.03	AC miliary TB-micro DX
018.04	Acute miliary TB-cult DX
018.05	AC miliary TB-histo DX
018.06	AC miliary TB-oth test
018.8	Miliary TB nec
018.80	Miliary TB nec-unspec
018.81	Miliary TB nec-no exam
018.82	Miliary TB nec-exam unkn
018.83	Miliary TB nec-micro DX
018.84	Miliary TB nec-cult DX
018.85	Miliary TB nec-histo DX
018.86	Miliary TB nec-oth test
018.9	Miliary tuberculosis nos
018.90	Miliary TB nos-unspec
018.91	Miliary TB nos-no exam
018.92	Miliary TB nos-exam unkn
018.93	Miliary TB nos-micro DX
018.94	Miliary TB nos-cult DX
018.95	Miliary TB nos-histo DX
018.96	Miliary TB nos-oth test
027.0	Listeriosis
027.1	Erysipelothrix infection
027.2	Pasteurellosis
027.8	Zoonotic bact dis nec
027.9	Zoonotic bact dis nos
036.0	Meningococcal meningitis
036.2	Meningococcemia
036.3	Meningococc adrenal synd
036.40	Meningococc carditis nos
036.42	Meningococc endocarditis
036.43	Meningococc myocarditis
037	Tetanus
038.0	Streptococcal septicemia
038.1	Staphylococc septicemia
038.10	Staphylcocc septicem nos
038.11	Staph aureus septicemia
038.19	Staphylcocc septicem nec
038.2	Pneumococcal septicemia
038.3	Anaerobic septicemia
038.4	Gram-neg septicemia nec
038.40	Gram-neg septicemia nos
038.41	H. influenae septicemia
038.42	E coli septicemia
038.43	Pseudomonas septicemia
038.44	Serratia septicemia
038.49	Gram-neg septicemia nec
038.8	Septicemia nec
038.9	Septicemia nos
042	Human immuno virus dis
052.0	Postvaricella encephalit
052.1	Varicella pneumonitis
053.0	Herpes zoster meningitis
054.3	Herpetic encephalitis

ICD9 code No.	Abbreviated code title
054.5	Herpetic septicemia
054.72	H Simplex meningitis
054.79	H Simplex Complicat nec
055.0	Postmeasles Encephalitis
055.1	Postmeasles Pneumonia
070.20	Hpt B acte coma wo dlta
070.21	Hpt B acte coma w dlta
070.22	Hpt B chrn coma wo dlta
070.23	Hpt B chrn coma w dlta
070.41	Hpt C acute w hepat coma
070.42	Hpt DLT wo b w hpt coma
070.43	Hpt E w hepat coma
070.44	Chrnc hpt C w hepat coma
070.49	Oth vrl hepat w hpt coma
070.06	Viral hepat nos w coma
072.1	Mumps meningitis
072.2	Mumps encephalitis
072.3	Mumps pancreatitis
079.5	Retrovirus
090.42	Congen syph meningitis
093.20	Syphil endocarditis nos
093.82	Syphilitic myocarditis
094.2	Syphilitic meningitis
094.87	Syph rupt cereb aneurysm
098.89	Gonococcal inf site nec
112.4	Candidiasis of lung
112.5	Disseminated candidiasis
112.81	Candidal endocarditis
112.83	Candidal meningitis
114.2	Coccidioidal meningitis
115	Histoplasmosis*
115.1	Histoplasma capsulatum
115.00	Histoplasma capsulat nos
115.01	Histoplasm capsul mening
115.02	Histoplasm capsul retina
115.03	Histoplasm caps pericard
115.04	Histoplasm caps endocard
115.05	Histoplasm caps pneumon
115.09	Histoplasma capsulat nec
115.1	Histoplasma duboisii
115.10	Histoplasma duboisii nos
115.11	Histoplasm dubois mening
115.12	Histoplasm dubois retina
115.13	Histoplasm dub pericard
115.14	Histoplasm dub endocard
115.15	Histoplasm dub pneumonia
115.19	Histoplasma duboisii nec
115.9	Histoplasmosis, unspec
115.90	Histoplasmosis nos
115.91	Histoplasmosis meningit
115.92	Histoplasmosis retinitis
115.93	Histoplasmosis pericard
115.94	Histoplasmosis endocard
115.95	Histoplasmosis pneumonia
115.99	Histoplasmosis nec
130.0	Toxoplasm meningoenceph
130.3	Toxoplasma myocarditis
130.4	Toxoplasma pneumonitis
136.3	Pneumocystosis
204.00	Act lym leuk w/o rmsion
205.00	Act myl leuk w/o rmsion
206.00	Act mono leuk w/o rmsion
207.00	Act erth/erylk w/o rmson
208.00	Act leuk uns cl w/o rmsn
260	Kwashiorkor
261	Nutritional marasmus
262	Oth severe malnutrition
277.00	Cystic fibros w/o ileus
277.01	Cystic fibrosis w ileus
286.0	Cong factor viii diord
286.1	Cong factor ix disorder
286.6	Defibrination syndrome
320.0	Hemophilus meningitis
320.1	Pneumococcal meningitis
320.2	Streptococcal meningitis
320.3	Staphylococc meningitis
320.7	Mening in oth bact dis
320.81	Anaerobic meningitis
320.82	Mningts gram-neg bct nec
320.89	Meningitis oth spcf bact
320.9	Bacterial meningitis nos
321.0	Cryptococcal meningitis
321.1	Mening in oth fungal dis
321.4	Meningit d/t sarcoidosis
321.8	Mening in oth nonbac dis
324.0	Intracranial abscess
324.1	Intraspinal abscess
324.9	CNS abscess nos
345.11	Gen CNV epil w intr epil
345.3	Grand mal status
348.1	Anoxic brain damage
376.01	Orbital cellulitis
376.02	Orbital periostitis
376.03	Orbital osteomyelitis
398.0	Rheumatic myocarditis
403.01	Mal hyp ren w renal fail
404.01	Mal hyper hrt/ren w chf
404.03	Mal hyp hrt/ren w chf&rf
410.01	Ami anterolateral, init
410.11	Ami anterior wall, init
410.21	Ami inferolateral, init
410.31	Ami inferopost, initial
410.41	Ami inferior wall, init
410.51	Ami lateral nec, initial
410.61	True post infarct, init
410.71	Subendo infarct, initial
410.81	Ami nec, initial
410.91	Ami nos, initial
415.1	Pulmon embolism/infarct
415.11	Iatrogen pulm emb/infarc
415.19	Pulm embol/infarct nec
421.0	AC/subac bact endocard
421.1	AC endocardit in oth dis
421.9	AC/subac endocardit nos
422.0	AC myocardit in oth dis
422.90	Acute myocarditis nos
422.91	Idiopathic myocarditis
422.92	Septic myocarditis
422.93	Toxic myocarditis
422.99	Acute myocarditis nec
427.41	Ventricular fibrillation
427.5	Cardiac arrest
430	Subarachnoid hemorrhage
431	Intracerebral hemorrhage
432.0	Nontraum extradural hem
432.1	Subdural hemorrhage
433.01	OCL bslr art w infrct
433.11	OCL crtd art w infrct
433.21	OCL vrtb art w infrct
433.31	OCL mlt bi art w infrct
433.81	OCL spcf art w infrct
433.91	OCL art nos w infrct
434.01	CRBL thrmbs w infrct
434.11	CRBL emblsm w infrct
434.91	CRBL art ocl nos w infrc
436	CVA
440.23	ATH ext ntv art ulcrtion
440.24	ATH ext ntv art gngrene
441.0	Dissecting aneurysm
441.00	DSCT of aorta unsp site
441.01	DSCT of thoracic aorta
441.02	DSCT of abdominal aorta
441.03	DSCT of thoracoabd aorta
441.1	RUPTUR thoracic aneurysm
441.3	RUPT abd aortic aneurysm
441.5	RUPT aortic aneurysm nos
441.6	Thoracoabd aneurysm rupt
446.3	Lethal midline granuloma
451.89	Thrombophlebitis nec
452	Portal vein thrombosis
453	OTH venous thrombosis*
453.0	BUDD-Chiari syndrome
453.1	Thrombophlebitis migrans
453.2	Vena cava thrombosis
453.3	Renal vein thrombosis
464.11	AC tracheitis w obstruct
464.21	AC laryngotrach w obstr
464.31	AC epiglottitis w obstr
466.1	Acute bronchiolitis
480.0	Adenoviral pneumonia
480.1	RESP syncyt viral pneum
480.2	Parinfluenza viral pneum
480.8	Viral pneumonia nec
480.9	Viral pneumonia nos
481	Pneumococcal pneumonia
482	Oth bacterial pneumonia*
482.0	K. pneumoniae pneumonia
482.1	Pseudomonal pneumonia
482.2	H.influenzae pneumonia
482.3	Streptococcal pneumonia
482.30	Streptococcal pneumn nos
482.31	Pneumonia strptococcus A
482.32	Pneumonia strptococcus B
482.39	Pneumonia oth strep
482.4	Staphylococcal pneumonia
482.40	Staphylococcal pneu nos
482.41	Staph aureus pneumonia
482.49	Staph pneumonia nec
482.8	Bacterial pneumonia nec
482.81	Pneumonia anaerobes
482.82	Pneumonia e coli
482.83	Pneumo oth grm-neg bact
482.84	Legionnaires' disease
482.89	Pneumonia oth spcf bact
482.9	Bacterial pneumonia nos
483	Pneumonia: organism nec*
483.0	Pneu mycplsm pneumoniae
483.1	Pneumonia d/t chlamydia
483.8	Pneumon oth spec orgnsm
484	Pneum in oth infec dis*
484.1	Pneum w cytomeg incl dis
484.3	Pneumonia in whoop cough
484.5	Pneumonia in anthrax
484.6	Pneum in aspergillosis
484.7	Pneum in oth sys mycoses
484.8	Pneum in infect dis nec
485	Bronchopneumonia org nos
486	Pneumonia, organism nos
487	Influenza*
487.0	Influenza with pneumonia
506.0	Fum/vapor bronc/pneumon
506.1	Fum/vapor ac pulm edema
507.0	Food/vomit pneumonitis
507.1	Oil/essence pneumonitis
507.8	Solid/liq pneumonit nec
510.0	Empyema with fistula
510.9	Empyema w/o fistula
511.1	Bact pleur/effus not tb
513.0	Abscess of lung
513.1	Abscess of mediastinum
514	Pulm congest/hypostasis
515	Postinflam pulm fibrosis
518.3	Pulmonary eosinophilia
518.5	Post traum pulm insuffic
518.81	Acute respiratry failure
519.2	Mediastinitis
528.3	Cellulitis/abscess mouth
530.4	Perforation of esophagus
530.82	Esophageal hemorrhage

ICD9 code No.	Abbreviated code title
531.00	AC stomach ulcer w hem
531.01	AC stomac ulc w hem-obst
531.10	AC stomach ulcer w perf
531.11	AC stom ulc w perf-obst
531.20	AC stomac ulc w hem/perf
531.21	AC stom ulc hem/perf-obs
531.40	CHR stomach ulc w hem
531.41	CHR stom ulc w hem-obstr
531.50	CHR stomach ulcer w perf
531.51	CHR stom ulc w perf-obst
531.60	CHR stomach ulc hem/perf
531.61	CHR stom ulc hem/perf-ob
532.00	AC duodenal ulcer w hem
532.01	AC duoden ulc w hem-obst
532.10	AC duodenal ulcer w perf
532.11	AC duoden ulc perf-obstr
532.20	AC duoden ulc w hem/perf
532.21	AC duod ulc hem/perf-obs
532.40	CHR duoden ulcer w hem
532.41	CHR duoden ulc hem-obstr
532.50	CHR duoden ulcer w perf
532.51	CHR duoden ulc perf-obst
532.60	CHR duoden ulc hem/perf
532.61	CHR duod ulc hem/perf-ob
533.00	AC peptic ulcer w hemorr
533.01	AC peptic ulc w hem-obst
533.10	AC peptic ulcer w perfor
533.11	AC peptic ulc w perf-obs
533.20	AC peptic ulc w hem/perf
533.21	AC pept ulc hem/perf-obs
533.40	CHR peptic ulcer w hem
533.41	CHR peptic ulc w hem-obs
533.50	CHR peptic ulcer w perf
533.51	CHR peptic ulc perf-obst
533.60	CHR pept ulc w hem/perf
533.61	CHR pept ulc hem/perf-ob
534.00	AC marginal ulcer w hem
534.01	AC margin ulc w hem-obst
534.10	AC marginal ulcer w perf
534.11	AC margin ulc w perf-obs
534.20	AC margin ulc w hem/perf
534.21	AC marg ulc hem/perf-obs
534.40	CHR marginal ulcer w hem
534.41	CHR margin ulc w hem-obs
534.50	CHR marginal ulc w perf
534.51	CHR margin ulc perf-obst
534.60	CHR margin ulc hem/perf
534.61	CHR marg ulc hem/perf-ob
535.01	Acute gastritis w hmrhg
535.11	ATRPH gastritis w hmrhg
535.21	GSTR Mcsl Hyprt w hmrg
535.31	ALCHL Gstritis w hmrhg
535.41	OTH SPF Gastrt w hmrhg
535.51	GSTR/DDNTS NOS w hmrhg
535.61	Duodenitis w hmrhg
537.4	Gastric/Duodenal fistula
537.83	Angio Stm/dudn w hmrhg
540.0	AC Append w peritonitis
557.0	AC VASC insuff intestine
562.02	DVRTCLO SML Int w hmrhg
562.03	DVRTCLI SML Int w hmrhg
562.12	DVRTCLO colon w hmrhg
562.13	DVRTCLI colon w hmrhg
567.0	Peritonitis in infec dis
567.1	Pneumococcal peritonitis
567.2	Suppurat peritonitis nec
567.8	Peritonitis nec
567.9	Peritonitis nos
569.60	Colstomy/enter comp nos
569.61	Colosty/enterost infectn
569.69	Colstmy/enteros comp nec
569.83	Perforation of intestine
569.85	Angio intes w hmrhg
570	Acute necrosis of liver
572.0	Abscess of liver
572.4	Hepatorenal syndrome
573.4	Hepatic infarction
575.4	Perforation gallbladder
576.3	Perforation of bile duct
577.2	Pancreat cyst/pseudocyst
579.3	Intest postop nonabsorb
580.0	AC proliferat nephritis
580.4	AC rapidly progr nephrit
580.81	AC nephritis in oth dis
580.89	Acute nephritis nec
580.9	Acute nephritis nos
583.4	Rapidly prog nephrit nos
584.5	Lower nephron nephrosis
584.6	AC renal fail, cort necr
584.7	AC ren fail, medull necr
584.8	AC renal failure nec
584.9	Acute renal failure nos
590.2	Renal/perirenal abscess
596.6	Bladder rupt, nontraum
659.30	Septicemia in labor-unsp
659.31	Septicem in labor-deliv
665.00	Prelabor rupt uter-unsp
665.01	Prelabor rupt uterus-del
665.03	Prelab rupt uter-antepar
665.10	Rupture uterus nos-unsp
665.11	Rupture uterus nos-deliv
669.10	Obstetric shock-unspec
669.11	Obstetric shock-deliver
669.12	Obstet shock-deliv w p/p
669.13	Obstetric shock-antepar
669.14	Obstetric shock-postpart
669.30	AC ren fail w deliv-unsp
669.32	AC ren fail-deliv w p/p
669.34	AC renal failure-postpar
673.00	OB air embolism-unspec
673.01	OB air embolism-deliver
673.02	OB air embol-deliv w p/p
673.03	OB air embolism-antepart
673.04	OB air embolism-postpart
673.10	Amniotic embolism-unspec
673.11	Amniotic embolism-deliv
673.12	Amniot embol-deliv w p/p
673.13	Amniotic embol-antepart
673.14	Amniotic embol-postpart
673.20	OB pulm embol nos-unspec
673.22	Pulm embol nos-del w p/p
673.23	Pulm embol nos-antepart
673.24	Pulm embol nos-postpart
673.30	OB pyemic embol-unspec
673.31	OB pyemic embol-deliver
673.32	OB pyem embol-del w p/p
673.33	OB pyemic embol-antepart
673.34	OB pyemic embol-postpart
673.80	OB pulmon embol nec-unsp
673.81	Pulmon embol nec-deliver
673.82	Pulm embol nec-del w p/p
673.83	Pulmon embol nec-antepar
673.84	Pulmon embol nec-postpar
674.00	Puerp cerebvasc dis-unsp
682	Other cellulitis/abscess*
682.0	Cellulitis of face
682.1	Cellulitis of neck
682.22	Cellulitis of trunk
682.3	Cellulitis of arm
682.4	Cellulitis of hand
682.5	Cellulitis of buttock
682.6	Cellulitis of leg
682.7	Cellulitis of foot
682.8	Cellulitis, site nec
765.01	Extreme immatur <500G
765.02	Extreme immatur 500–749G
765.03	Extreme immatur 750–999G
781.7	Tetany
785.51	Cardiogenic shock
785.59	Shock w/o trauma nec
799.1	Respiratory arrest
958.0	Air embolism
958.1	Fat embolism
958.5	Traumatic anuria
996.02	Malfunc prosth hrt valve
996.61	React-cardiac dev/graft
996.62	React-oth vasc dev/graft
996.63	React-nerv sys dev/graft
996.64	React-indwell urin cath
996.66	React-inter joint prost
996.67	React-oth int ortho dev
996.69	React-int pros devic nec
997.62	Infection amputat stump
998.0	Postoperative shock
998.3	Postop wound disruption
998.5	Postoperative infection
998.6	Persist postop fistula
999.1	Air embol comp med care
V440	Tracheostomy status
V451	Renal dialysis status
V461	Dependence on respirator

*Denotes this is a category rather than a code.

Appendix D—The IRF Market Basket

Section 1886(j)(3)(C) of the Act requires the Secretary to establish an increase factor (for purposes of setting prospective payment system rates) based on a market basket index. The proposed market basket includes both operating and capital costs of rehabilitation facilities (that is, freestanding rehabilitation hospitals and rehabilitation hospital units). The index currently used for operating costs for rehabilitation facilities is the excluded hospital market basket. This market basket is based on 1992 cost report data and includes Medicare participating rehabilitation, long term care, psychiatric, cancer, and children's hospitals. Since freestanding rehabilitation hospitals are a component of the excluded hospital market basket, this index most closely reflects the cost shares of rehabilitation facilities. Because the excluded hospital market basket only includes operating costs, we are proposing to use the excluded hospital market basket with the addition of a capital portion to the index. We provide a brief explanation of the methodology used to develop our proposed index for rehabilitation facilities. We refer to this index as the excluded hospital (with capital) market basket. In the following discussion we describe: the methodology used to determine the operating portion of the market basket, the methodology used to determine the capital portion of the market basket, and additional analyses that help support the extent to which rehabilitation cost shares are reflected in the market basket that we are proposing.

The operating portion of the excluded hospital market basket consists of major cost categories and their respective weights. The major cost categories include wages, benefits, drugs, and a residual. The weights for the major cost categories are developed from the Medicare cost reports for FY 1992. The cost

report data used includes those hospitals excluded from the inpatient hospital prospective payment system where the Medicare average length of stay is within 15 percent (higher or lower) of the total facility average length of stay. Limiting the sample in this way provides a more accurate reflection of the structure of costs for Medicare. The detailed cost categories are derived from the Asset and Expenditure Survey, 1992 Census of Service Industries, by the Bureau of the Census, Economics and Statistics Administration, U.S. Department of Commerce. This is used in conjunction with the 1992 Input-Output Tables published by the Bureau of Economic Analysis, U.S. Department of Commerce. A more detailed description of the development of this index can be found in our final rule, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 1998 Rates; published in the **Federal Register** at 62 FR 45965–45996, on August 29, 1997.

As previously stated, the market basket we are proposing needs to reflect both operating and capital costs. Capital costs include depreciation, interest, and other capital-related costs. The cost categories for the capital portion of the market basket that we are proposing is developed in a similar manner as those for the inpatient hospital prospective payment system capital input price index, which is explained in the August 30, 1996 **Federal Register**. We calculated weights for capital costs, using the same set of Medicare cost reports used to develop the operating share for excluded hospitals. The resulting capital weight for the 1992 base year is 9.080 percent.

Because capital is consumed over time, depreciation and interest costs in the current year reflect both current and previous capital purchases. We use vintage weighting of current and previous capital price changes to capture this effect. Vintage weighting, which is explained in the August 30, 1996 **Federal Register** (61 FR 46197 through 46203), is the process of weighting price changes for individual years in proportion to that year's share of total purchases still being consumed.

In order to vintage weight the capital portion of the index as described above, the average useful life of both assets and debt instruments (for example, a loan, bond, or promissory note) needs to be developed. For depreciation expenses, the useful life of fixed and movable assets is calculated from the Medicare cost reports for excluded hospitals, including freestanding rehabilitation hospitals. The average useful life for fixed assets is 21 years and the average useful life for movable assets is 13 years. For interest expenses, we use the same useful life of debt instruments used in the hospital prospective payment system capital input price index. We believe that this useful life is appropriate, because it reflects the average useful life of hospital issuances of commercial and municipal bonds from all hospitals, including rehabilitation facilities. The average useful life of interest expense is determined to be 22 years. After the useful life is determined, a set of weights is calculated by determining the average proportion of depreciation or interest expense incurred during any given year during the useful life. This information is developed using the Medicare cost reports. These calculations are the same as those described for the inpatient hospital prospective payment system capital input price index in the August 30, 1996 **Federal Register**. The price proxies for each of the capital cost categories are the same as those used for the inpatient hospital prospective payment system capital input price index. The cost categories, price proxies, and base-year fiscal year 1992 weights for the excluded hospital (with capital) market basket are presented in Table 1. The vintage weights for the index are presented in Table 2.

TABLE 1.—HCFA EXCLUDED HOSPITAL INPUT PRICE INDEX WITH CAPITAL (FY 1992) STRUCTURE AND WEIGHTS

Cost category	Price/wage variable	Weights (%) Base-year: 1992
TOTAL		100.000
Compensation		57.935
Wages and Salaries	HCFA Prospective payment system Occupational	47.417
Employee Benefits	HCFA Prospective payment system	10.519
Professional fees: Non-Medical	ECI—Compensation: Prof. & Tech	1.908
Utilities		1.523
Electricity	WPI—Commercial Electric Power	0.916
Fuel Oil, Coal, etc	WPI—Commercial Natural Gas	0.365
Water and Sewerage	CPI–U—Water & Sewage	0.243
Professional Liability Insurance	HCFA—Prof. Liab. Prem	0.983
All Other Products and Services		28.572
All Other Products		22.027
Pharmaceuticals	WPI—Prescription Drugs	2.791
Food: Direct Purchase	WPI—Processed Foods	2.155
Food: Contract Service	CPI–U—Food Away fr. Home	0.998
Chemicals	WPI—Industrial Chemicals	3.413
Medical Instruments	WPI—Med. Inst. & Equip	2.868
Photographic Supplies	WPI—Photo Supplies	0.364
Rubber and Plastics	WPI—Rub. & Plast. Products	4.423
Paper Products	WPI—Convert. Paper and Paperboard	1.984
Apparel	WPI—Apparel	0.809
Machinery and Equipment	WPI—Mach. & Equipment	0.193
Miscellaneous Products	WPI—Finished Goods	2.029
All Other Services		6.544
Telephone	CPI–U—Telephone Services	0.574
Postage	CPI–U—Postage	0.268
All Other: Labor Intensive	ECI—Compensation: Service Workers	4.945
All Other: Non-Labor Intensive	CPI–U—All Items (Urban)	0.757
Capital-Related Costs		9.080
Depreciation		5.611
Fixed Assets	Boeckh-Institutional Construction: 21 year useful life	3.570
Movable Equipment	WPI—Machinery & Equipment: 13 year useful life	2.041
Interest Costs		3.212
Non-profit	Avg. Yield Municipal Bonds: 22 year useful life	2.730
For-profit	Avg, Yield AAA Bonds: 22 year useful life	0.482
Other Capital-Related Costs	CPI–U—Residential Rent	0.257

*The wage and benefit proxies are a blend of 10 employment cost indices (ECI). A detailed discussion of the price proxies can be found in the August 30, 1996 FEDERAL REGISTER final rule.

TABLE 2.—HCFA EXCLUDED HOSPITAL INPUT PRICE INDEX WITH CAPITAL (FY 1992) VINTAGE WEIGHTS

Year	Fixed assets (21 year weights)	Movable assets (13 year weights)	Interest: capital-related (22 year weights)
1	0.0201	0.0454	0.0071
2	0.0225	0.0505	0.0082
3	0.0225	0.0562	0.0100
4	0.0285	0.0620	0.0119
5	0.0301	0.0660	0.0139
6	0.0321	0.0710	0.0161
7	0.0336	0.0764	0.0185
8	0.0353	0.0804	0.0207
9	0.0391	0.0860	0.0244
10	0.0431	0.0923	0.0291
11	0.0474	0.0987	0.0350
12	0.0513	0.1047	0.0409
13	0.0538	0.1104	0.0474
14	0.0561	.....	0.0525
15	0.0600	.....	0.0590
16	0.0628	.....	0.0670
17	0.0658	.....	0.0742
18	0.0695	.....	0.0809
19	0.0720	.....	0.0875
20	0.0748	.....	0.0931
21	0.0769	.....	0.0993
22	.....	.....	0.1034
Total	1.0000	1.0000	1.0000

We further analyzed the extent to which the weights in the excluded hospital (with capital) market basket that we are proposing reflects the cost weights in rehabilitation hospitals; particularly since more than 50 percent of excluded hospitals are psychiatric hospitals. For this purpose, we conducted an analysis comparing the cost weights of rehabilitation hospitals to the cost weights for excluded hospitals. We analyzed the variations of major costs, such as wages, drugs, and capital for rehabilitation and excluded hospitals. This analysis showed that while these weights differed slightly between rehabilitation hospitals and excluded hospitals, the difference is very small. When these weights are substituted into the market basket structure for sensitivity analysis, the effect is never more than 0.2 percentage points in any given year. This difference is less than the 0.25 percentage point criteria that determines whether a forecast error adjustment under the inpatient hospital prospective payment system is warranted. We conducted this analysis in both the base year (FY 1992), and for the most recent set of cost reports (FY 1997) to determine if the difference in weights changed over time. Again, the differences were very small. Based on this analysis, we concluded that using the excluded hospital (with capital) market basket for the IRF prospective payment system will provide a reasonable measure of the price changes facing rehabilitation hospitals. We request comments on any other data sources that may be available to provide detailed cost category information on rehabilitation hospitals, or on data sources for cost categories in rehabilitation units.

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Part III

Environmental Protection Agency

Revisions to the Methodology for Deriving Ambient Water Quality Criteria for the Protection of Human Health (2000); Notice

ENVIRONMENTAL PROTECTION AGENCY

[WH–FRL–6893–6]

Revisions to the Methodology for Deriving Ambient Water Quality Criteria for the Protection of Human Health (2000)

AGENCY: Environmental Protection Agency (EPA).

ACTION: Notice of Availability.

SUMMARY: EPA is announcing the availability of final revisions to the Methodology for Deriving Ambient Water Quality Criteria for the Protection of Human Health (2000) (hereafter ''2000 Human Health Methodology'') published pursuant to section 304(a)(1) of the Clean Water Act (CWA). The 2000 Human Health Methodology supersedes the existing Guidelines and Methodology Used in the Preparation of Health Effect Assessment Chapters of the Consent Decree Water Criteria Documents, published by EPA in November 1980 (USEPA, 1980) (hereafter ''1980 AWQC National Guidelines'' or ''1980 Methodology''). Today's Notice is intended to support the requirements of section 304(a)(1) of the CWA that EPA periodically revise criteria for water quality to accurately reflect the latest scientific knowledge on the kind and extent of all identifiable effects on health and welfare that may be expected from the presence of pollutants in any body of water, including ground water. These revisions are prompted by the many significant scientific advances that have occurred during the past 20 years in such key areas as cancer and noncancer risk assessments, exposure assessments, and bioaccumulation assessments. These revisions are not regulations and do not impose legally-binding requirements on EPA, States, Tribes, or the public.

DATES: Technical Support Documents (TSD) on exposure assessment guidance and bioaccumulation guidance applicable to the 2000 Human Health Methodology are expected to become available early in calendar year 2001.

ADDRESSES: The 2000 Human Health Methodology is published in the document entitled, Methodology for Deriving Ambient Water Quality Criteria for the Protection of Human Health (2000). This document is available on the EPA website at *www.epa.gov/OST/humanhealth*. A Technical Support Document (TSD) volume on risk assessments applicable to the 2000 Human Health Methodology is also available from the website. Materials in the public docket will be available for public inspection and copying during normal business hours at the Office of Water Docket, 401 M St., SW, Washington, DC 20460 by appointment only. Appointments may be made by calling (202) 260–3027 and requesting item W–97–20. A reasonable fee will be charged for photocopies.

FOR FURTHER INFORMATION CONTACT: Denis R. Borum, Health and Ecological Criteria Division (4304), U.S. EPA, Ariel Rios Building, 1200 Pennsylvania Avenue, NW, Washington, DC 20460; (202) 260–8996; borum.denis@epa.gov.

SUPPLEMENTARY INFORMATION: This Supplementary Information Section is organized as follows:

I. Background Information

A. What are Human Health Ambient Water Quality Criteria?

Human health ambient water quality criteria (AWQC) are numeric values for pollutant concentrations in ambient waters considered to be protective of human health. The criteria are developed under section 304(a) of the Clean Water Act (CWA) and are based solely on data and scientific judgments on the relationship between pollutant concentrations and environmental and human health effects. Protective assumptions are made regarding the potential human exposure intakes. These criteria do not reflect consideration of economic impacts or the technological feasibility of meeting the chemical concentrations in ambient water. Section 304(a)(1) of the CWA requires EPA to develop and publish, and from time to time revise, criteria for water quality accurately reflecting the latest scientific knowledge. The criteria are used by States and authorized Tribes to establish water quality standards and ultimately provide a basis for controlling discharges or releases of pollutants. The criteria also provide guidance to EPA when promulgating Federal regulations under CWA Section 303(c) when such actions are necessary.

In 1980, we published AWQC (*i.e.,* Section 304(a) criteria) for 64 pollutants/pollutant classes and provided a methodology for deriving the criteria. The 1980 AWQC National Guidelines for developing human health AWQC addressed three types of endpoints: noncancer, cancer and organoleptic (taste and odor) effects. Criteria for the protection against noncancer and cancer effects were estimated by using risk assessment-based procedures, including extrapolation from animal toxicity or human epidemiological studies. Basic human exposure assumptions were applied to the criterion equation. When using cancer as the critical risk assessment endpoint, which was assumed not to have a threshold, the AWQC were presented as concentrations associated with specified incremental lifetime risk levels. When using noncancer effects as the critical endpoint, the AWQC reflected an assessment of a ''no-effect'' level, based on an assumption of a threshold for noncancer effects.

B. How Is the Human Health Methodology Used?

The Methodology is used by EPA to derive or revise its section 304(a) criteria. It provides the detailed means for developing the water quality criteria, including systematic procedures for evaluating cancer risk, noncancer health effects, human exposure, and bioaccumulation potential in fish. This Methodology is also guidance for States and authorized Tribes to help them establish water quality criteria to protect human health. States and authorized Tribes must develop water quality standards that include designated uses and water quality criteria necessary to support those uses.

C. Why Was the Methodology Revised?

EPA periodically revises water quality criteria to ensure that they reflect the latest scientific knowledge on the kind and extent of all identifiable effects on health and welfare that may be expected from the presence of pollutants in any body of water, including ground water. Since 1980, many significant scientific advances have occurred which prompt revisions to the Methodology. Specifically, advances in such key areas as cancer and noncancer risk assessments, exposure assessments, and bioaccumulation make the revisions appropriate at this time. We therefore updated the Methodology to provide States and authorized Tribes with the most current procedures to reflect these changes in risk and exposure assessment. States and authorized Tribes can use the Methodology to modify their water quality criteria, as appropriate, to ensure that their criteria are protective of designated uses.

Another reason for these revisions is the need to address differences in the risk assessment and risk management approaches used by the EPA Office of Water for the derivation of AWQC—under the authority of the CWA—and Maximum Contaminant Level Goals (MCLGs)—under the authority of the Safe Drinking Water Act (SDWA). Three notable differences in these revisions include the treatment of chemicals designated as Group C possible human carcinogens under the 1986 Guidelines for Carcinogen Risk Assessment (USEPA, 1986a), the consideration of non-water sources of exposure when setting an AWQC or MCLG for a noncarcinogen, and cancer risk ranges.

1. *Group C Chemicals.* Chemicals classified as Group C—*i.e.,* possible human carcinogens'under the existing (1986) EPA cancer classification scheme have been typically classified as such for any of the following reasons.

(1) Carcinogenicity has been documented in only one test species and/or only one cancer bioassay, and the results do not meet the requirements of ''sufficient evidence.''

(2) Tumor response is of marginal statistical significance due to inadequate design or reporting.

(3) An agent causes benign, but not malignant, tumors and no response in a variety of short-term tests for mutagenicity.

(4) There are responses of marginal statistical significance in a tissue known to have a high or variable background rate.

The 1986 Guidelines for Carcinogen Risk Assessment (hereafter ''1986 cancer guidelines'') specifically recognized the need for flexibility with respect to quantifying the risk of Group C agents (USEPA, 1986a). The 1986 cancer guidelines noted that agents judged to be in Group C, possible human carcinogens, may generally be regarded as suitable for quantitative risk assessment, but that case-by-case judgments may be made for them.

EPA has historically treated Group C chemicals differently under the CWA and the SDWA. It is important to note that the 1980 AWQC National Guidelines for setting AWQC under the CWA predated EPA's carcinogen classification system, which was proposed in 1984 and finalized in 1986 (USEPA, 1984, 1986a). The 1980 AWQC National Guidelines did not explicitly

differentiate among agents with respect to the weight of evidence for characterizing them as likely to be carcinogenic to humans. For all pollutants judged as having adequate data for quantifying carcinogenic risk—including those now classified as Group C—AWQC were derived based on cancer incidence data. In the November 1980 **Federal Register** Notice, we emphasized that the AWQC for carcinogens should state that the recommended concentration for maximum protection of human health is zero. At the same time, the criteria published for specific carcinogens presented water concentrations for these pollutants corresponding to individual lifetime cancer risk levels in the range of 10^{-7} to 10^{-5} (ranging from one case in a population of ten million to one case in a population of one hundred thousand).

In the development of national primary drinking water regulations under the SDWA, EPA is required to promulgate a health-based MCLG for each contaminant. Our policy has been to set the MCLG at zero for chemicals with strong evidence of carcinogenicity associated with exposure from water. For chemicals with limited evidence of carcinogenicity, including many Group C agents, the MCLG was usually obtained using a Reference Dose (RfD) based on its noncancer effects with the application of an additional factor of 1 to 10. If valid noncancer data for a Group C agent were not available to establish an RfD, but adequate data were available to quantify the cancer risk, then the MCLG was based upon a nominal lifetime excess cancer risk calculation in the range of 10^{-6} to 10^{-5} (ranging from one case in a population of one million to one case in a population of one hundred thousand). Even in those cases where the RfD approach has been used for the derivation of the MCLG for a Group C agent, the drinking water concentrations associated with excess cancer risks in the range of 10^{-6} to 10^{-5} were also provided for comparison.

It should also be noted that in actions taken under the Federal Insecticide, Fungicide, and Rodenticide Act (FIFRA), EPA's pesticides program has applied both of these methods for addressing Group C chemicals and finds both methods (quantified ''C's'' and nonquantified ''C's'') applicable on a case-by-case basis. Unlike the drinking water program, however, the pesticides program does not add an extra uncertainty factor to account for potential carcinogenicity when using the RfD approach.

The EPA is in the process of revising its cancer guidelines, including its descriptions of human carcinogenic potential. Once final guidelines are published, they will be the basis for assessment under this Methodology. In the meanwhile, the 1986 cancer guidelines are used and extended with principles discussed in EPA's 1999 Guidelines for Carcinogen Risk Assessment—Review Draft (hereafter ''1999 draft revised cancer guidelines''). These principles arise from scientific discoveries about cancer made in the last 15 years and from EPA policy of recent years supporting full characterization of hazard and risk both for the general population and potentially sensitive groups such as children. These principles are incorporated in recent and ongoing assessments such as the reassessment of dioxin, consistent with the 1986 cancer guidelines. Until final guidelines are published, information is presented to describe risk under both the 1986 guidelines and the 1999 draft revisions. To bring in new science and characterization principles, draft revisions have weight-of-evidence narratives for hazard characterization that use consistent descriptive terms (USEPA, 1999a). In order to provide some measure of consistency in an otherwise free-form, narrative characterization, standard descriptors are utilized as part of the hazard narrative to express the conclusion regarding the weight of evidence for carcinogenic hazard potential. There are five standard hazard descriptors: ''carcinogenic to humans'', ''likely to be carcinogenic to humans'', ''suggestive evidence of carcinogenicity but not sufficient to assess human carcinogenic potential'', ''data are inadequate for an assessment of human carcinogenic potential'', and ''not likely to be carcinogenic to humans.'' Each standard descriptor may be applicable to a wide variety of data sets and weights of evidence and are presented only in the context of a weight-of-evidence narrative. Furthermore, more than one conclusion may be reached for a pollutant. For instance, using a descriptor in context, a narrative could say that a pollutant is likely to be carcinogenic by inhalation exposure and not likely to be carcinogenic by oral exposure.

In the 2000 Human Health Methodology, we quantify those pollutants considered ''carcinogenic to humans'' or ''likely to be carcinogenic to humans.'' In practice, even though the terminology of the 1999 draft revised cancer guidelines differs, this is the approach currently used by the EPA pesticides program.

2. *Consideration of Non-water Sources of Exposure.* The 1980 AWQC National Guidelines for setting AWQC recommended that contributions from non-water sources, namely air and non-fish dietary intake, be subtracted from the Acceptable Daily Intake (ADI), thus reducing the amount of the ADI ''available'' for water-related sources of intake. In practice, however, when calculating human health criteria, those other exposures were generally not considered because reliable data on those exposure pathways were not available. Consequently, the AWQC were usually derived such that drinking water and fish ingestion accounted for the entire ADI (now called RfD).

Through the mid-1980s, the drinking water program generally used a similar ''subtraction'' method in the derivation of MCLGs, albeit inconsistently. More recently, the drinking water program has used a ''percentage'' method in the derivation of MCLGs for noncarcinogens. In this approach, the percentage of total exposure typically accounted for by drinking water is applied to the RfD to determine the maximum amount of the RfD apportioned to drinking water reflected by the MCLG value. This percentage is called the relative source contribution (RSC). In using this percentage procedure, the drinking water program also applies a ceiling of 80 percent of the RfD and a floor of 20 percent of the RfD. That is, the MCLG cannot account for more than 80 percent of the RfD, nor less than 20 percent of the RfD.

The drinking water program usually takes a conservative approach to public health by applying an RSC factor of 20 percent to the RfD when adequate exposure data do not exist, assuming that the major portion (80 percent) of the total exposure comes from other sources, such as diet.

The 2000 Human Health Methodology includes guidance for routine consideration of non-water sources of exposure [both ingestion exposures (*e.g.*, food) and exposures other than the oral route (*e.g.*, inhalation)] via an approach called the Exposure Decision Tree. RSC estimates will be made by EPA using this approach, which allows for use of either subtraction or percentage methods, depending on chemical-specific circumstances, within the 20 to 80 percent range described above.

3. *Cancer Risk Ranges.* In addition to the different risk assessment approaches discussed above for deriving AWQC and MCLGs for Group C agents, there have been different risk management approaches by the drinking water and

ambient surface water programs on using lifetime excess risk values when setting health-based criteria for carcinogens. The surface water program historically derived AWQC for carcinogens that generally corresponded to lifetime excess cancer risk levels of 10^{-7} to 10^{-5}. The drinking water program has set MCLGs for Group C agents based on a slightly less stringent risk range of 10^{-6} to 10^{-5}, while MCLGs for chemicals with strong evidence of carcinogenicity (that is, classified as Group A (known) or B (probable) human carcinogen) are set at zero. The drinking water program is now following the 1999 draft revised cancer guidelines to determine the type of low-dose extrapolation based on mode of action.

It is also important to note that under the drinking water program, for those substances having an MCLG of zero, enforceable Maximum Contaminant Levels (MCLs) have generally been promulgated to correspond with cancer risk levels ranging from 10^{-6} to 10^{-4}. Unlike AWQC and MCLGs which are strictly health-based criteria, MCLs are developed with consideration given to the costs and technological feasibility of reducing contaminant levels in water to meet those standards.

The 2000 Human Health Methodology states that EPA will publish its national 304(a) water quality criteria at a 10^{-6} risk level, which we consider to be appropriate for the general population. Again, consistent with the 1999 draft revised cancer guidelines, there are no more alphanumeric categories. We will only quantify those considered ''carcinogenic to humans'' or ''likely to be carcinogenic to humans.'' We are increasing the degree of consistency between the drinking water and ambient water programs, given somewhat different requirements of the CWA and SDWA. We will use the same hazard characterizations of dose-response.

B. What Specific Scientific Advances Have Occurred Since 1980?

Since 1980, EPA risk assessment practices have evolved significantly in all of the major Methodology areas: cancer and noncancer risk assessments; exposure assessments; and bioaccumulation. EPA first published guidelines on cancer risk assessment in 1986. EPA published Proposed Guidelines for Carcinogen Risk Assessment in 1996 (hereafter ''1996 proposed cancer guidelines''; USEPA, 1996a). These were recently revised following review by the Agency's Science Advisory Board (SAB) and receipt of their comments in May 1999. The most recent document is the July 1999 draft revised cancer guidelines (USEPA, 1999a). The 1999 draft revised cancer guidelines discuss the use of mode of action (MOA) information to support both the identification of carcinogens and the selection of procedures to characterize risk at low, environmentally relevant exposure levels. They also address the development of new procedures to quantify cancer risks at low doses to replace the current default use of the linearized multistage (LMS) model. In noncancer risk assessment, we are moving toward the use of the benchmark dose (BMD) and other dose-response methodologies in place of the traditional NOAEL approach to estimate an RfD concentration or other point of departure (POD) divided by an uncertainty factor (UF). In addition, several risk assessment guidelines have been published. For example, in 1986 EPA published Guidelines for Mutagenicity Risk Assessment (USEPA, 1986b). In 1991, EPA published the Guidelines for Developmental Toxicity Risk Assessment (USEPA, 1991a), and in 1996, it published the Guidelines for Reproductive Toxicity Risk Assessment (USEPA, 1996b). In 1998, EPA also published the Guidelines for Neurotoxicity Risk Assessment (USEPA, 1998a). In May 1999, EPA published the Draft Guidance for Conducting Health Risk Assessment of Chemical Mixtures (USEPA, 1999b). In addition, the Agency is developing a framework for cumulative risk assessment, and the Office of Pesticide Programs has developed draft guidance for assessing cumulative risk of common mechanism pesticides and other substances.

In 1986, EPA made available to the public the Integrated Risk Information System (IRIS). IRIS is a database that contains risk information on the cancer and noncancer effects of chemicals. The IRIS assessments represent EPA scientific consensus positions across the Agency's program offices and regional offices.

In exposure analysis, several new studies have addressed water consumption and fish tissue consumption. These exposure studies provide a more current and comprehensive description of national, regional and special population consumption patterns that we reflected in the 1998 Draft Water Quality Criteria Methodology: Human Health (hereafter ''1998 draft Methodology revisions''; USEPA, 1998c). In addition, more formalized procedures are available to account for human exposure to multiple sources when setting health goals such as AWQC that have previously addressed only one exposure source. The Exposure Factors Handbook was updated in 1997 (USEPA, 1997a). In 1992, we published the revised Guidelines for Exposure Assessment (USEPA, 1992a), which describe general concepts of exposure assessment, including definitions and associated intake rate parameters, and provide guidance on planning and conducting an exposure assessment. In 1986, the Agency published the Total Exposure Assessment Methodology (TEAM) Study: Summary and Analysis, Volume I, Final Report (USEPA, 1986c), which presents a process for conducting comprehensive evaluation of human exposures. The Agency has recently developed a revised relative source contribution (RSC) policy for assessing total human exposure to a contaminant and apportioning the RfD among the media of concern for use in deriving or revising AWQC. In 1997, we developed Guiding Principles for Monte Carlo Analysis (USEPA, 1997b). Also in 1997, we published the Policy for Use of Probabilistic Analysis in Risk Assessment (USEPA, 1997c; see *http://www.epa.gov/ncea/mcpolicy.htm*). The Monte Carlo guidance document can be applied to exposure assessments and risk assessments. The Agency has moved toward the use of a bioaccumulation factor (BAF) to reflect the uptake of a contaminant from all sources (*e.g.*, ingestion, sediment) by fish and shellfish, rather than just from the water column as reflected by the use of a bioconcentration factor (BCF) in the 1980 Methodology. We have developed detailed procedures and guidelines for estimating BAF values for use in deriving or revising AWQC.

C. What Process Did EPA Follow in Revising the Methodology?

We began by developing (along with other Federal agencies, State health organizations, Canadian health agencies, academies, environmental and industry groups, and consulting organizations) an issues paper that described the 1980 Methodology, discussed areas that needed strengthening, and recommended revisions. The paper was distributed for review and comment and was examined at a national workshop, where more than 100 participants discussed critical issues. Based on individual expertise, attendees were assigned to specific technical workgroups. The workgroups' topics included cancer risk, noncancer risk, exposure, microbiology, minimum data and bioaccumulation in fish.

A summary document based on the workshop recommendations was submitted for review and comment by the EPA SAB. Once final comments and

revisions were received from the SAB, the recommendations were again reviewed at a meeting of the Federal-State Toxicology and Risk Analysis Committee, where state representatives presented their opinions on the preliminary draft recommendations. (A more detailed chronology of this process was provided with the 1998 draft Methodology revisions.)

EPA subsequently developed the 1998 draft Methodology revisions (USEPA, 1998c) and the Ambient Water Quality Criteria Derivation Methodology Human Health Technical Support Document (TSD) (USEPA, 1998d) that provides greater detail on the Methodology guidance—including case study examples, data tables, and other supporting information. These were published in the **Federal Register** in August 1998. A four-month public comment period followed. In May of 1999, a fifteen-member independent peer review workshop was held, and a public stakeholder meeting followed. The 2000 Human Health Methodology reflects, in part, the input received from the public and peer review experts, in addition to more recent scientific information and science policies since the 1998 draft publication.

F. What Are the Major Revisions to the Methodology?

The major revisions are in four assessment areas: Noncancer, cancer, exposure and bioaccumulation. Equations have been developed for deriving AWQC, which include parameters relevant to those four assessment areas. These parameters are derived from scientific analysis, science policy and risk management decisions.

For noncarcinogens, the process for deriving a level of exposure considered to be without appreciable risk of effect—known as the Reference Dose (RfD) value—has evolved over time.

- EPA has developed guidance on assessing noncarcinogenic effects of chemicals and for the RfD derivation.
- The Methodology revisions recommend consideration of other issues related to the RfD process including integrating reproductive/developmental, immunotoxicity, and neurotoxicity data into the calculation.
- EPA is recommending the use of quantitative dose-response modeling for the derivation of RfDs.
- EPA has provided additional guidance (in its Risk Assessment TSD) to allow States and authorized Tribes greater flexibility in conducting their own risk assessments.

For carcinogen (cancer) risk assessment, more sophisticated methods for determining the likely mechanism that causes human carcinogenicity are being recommended, as well as consideration of all biological information (rather than just tumor findings) and full risk characterization for the general population as well as sensitive groups such as children.

Changes in the area of exposure assessment include the following.

- States and authorized Tribes are encouraged to use local studies on fish consumption that better reflect local intake patterns and choices.
- EPA will recommend default fish consumption values for the general population, recreational fishers and subsistence fishers.
- A factor to account for other sources of exposure, such as food and air, is included when deriving AWQC for noncarcinogens and for carcinogens based on a nonlinear low-dose extrapolation (*i.e.*, water and fish consumption are not the only exposures considered).

The 2000 Human Health Methodology places greater emphasis on the use of BAFs compared to the 1980 Methodology for estimating potential human exposure to contaminants via the consumption of contaminated fish and shellfish.

- BAFs reflect the accumulation of chemicals by aquatic organisms from all surrounding media (water, food, sediment). Compared with BCFs, which reflect chemical accumulation by aquatic organisms from water only, BAFs are considered to be better predictors of chemical accumulation by fish and shellfish for chemicals where exposure from food and sediment is important (*e.g.*, highly persistent, hydrophobic chemicals).
- EPA gives preference to the use of high quality field data over laboratory or model-derived estimates of BAFs, since field data best reflect factors that can affect the extent of bioaccumulation (*e.g.*, chemical metabolism, food web structure).

G. How Will EPA Use the Human Health Methodology?

Our future role in developing AWQC for the protection of human health will include the following.

- Further refinement of the Methodology as the science and EPA's science policies evolve;
- Development of revised AWQC for pollutants of high priority and national importance (including, but not limited to chemicals that bioaccumulate, such as PCBs, dioxin, and mercury); and
- Development or revision of AWQC for some additional priority pollutants.

We plan to fully update the most environmentally important criteria developed in 1980 (or those updated as part of the 1992 National Toxics Rule (NTR)). Partial updates of substantially more criteria may be warranted. We encourage States and authorized Tribes to use the 2000 Human Health Methodology to develop or revise AWQC to reflect local conditions. EPA believes that AWQC inherently require several risk management decisions that are, in many cases, better made at the State or Tribal level (*e.g.*, selection of specific fish consumption rates or target risk levels). We will continue to develop and update necessary toxicology and exposure data needed for the derivation of AWQC that may not be practical for the States or Tribes to obtain. More information on implementation issues and the effect of the 2000 Human Health Methodology on States and authorized Tribes is discussed below.

II. Implementation Issues

Water quality standards consist of designated uses, water quality criteria to protect those uses, a policy for antidegradation, and general policies for application and implementation. As part of the water quality standards triennial review process defined in section 303(c)(1) of the CWA, States and authorized Tribes are responsible for maintaining and revising water quality standards. Section 303(c)(1) requires States and authorized Tribes to review, and modify if appropriate, their water quality standards at least once every three years.

A. How Does EPA Use Its Recommended 304(a) Water Quality Criteria?

EPA's recommended 304(a) water quality criteria form the basis for Agency decisions, both regulatory and nonregulatory, until superseded by EPA publication of new or revised 304(a) water quality criteria. For example, these criteria are used in the following ways: (1) As guidance to States and authorized Tribes in adopting water quality standards; (2) as guidance to EPA in promulgating Federal water quality standards; (3) in establishing National Pollutant Discharge Elimination System (NPDES) water quality-based permit limits, where the criteria have been adopted by a State or authorized Tribe or promulgated by EPA; and (4) for all other purposes of Section 304(a) criteria under the Act. It is important to emphasize again two distinct purposes which are served by the 304(a) criteria. The first is as guidance to the States and Tribes in the development and adoption of water quality criteria which will protect designated uses. The second is as the basis for promulgation of Federal water

quality standards for States or authorized Tribes when such action is necessary.

B. What Water Quality Criteria Must a State or Authorized Tribe Adopt Into Its Water Quality Standards?

States and authorized Tribes must adopt water quality criteria that protect designated uses. Such criteria must be based on sound scientific rationale and must contain sufficient parameters or components to protect the designated uses. Criteria may be expressed in either narrative or numeric form. States and authorized Tribes have four options when adopting water quality criteria for which EPA has published 304(a) criteria. They can establish numerical values based on 304(a) criteria, 304(a) criteria modified to reflect site-specific conditions, other scientifically defensible methods, or establish narrative criteria where numeric criteria cannot be determined. (See 40 CFR 131.11.)

EPA's recommended 304(a) water quality criteria for States and authorized Tribes to use as guidance in adopting water quality standards consistent with Section 303(c) of the Act and the implementing Federal regulations at 40 CFR part 131 are contained in EPA's last compilation of National Recommended Water Quality Criteria (USEPA, 1998e) (corrected in USEPA, 1999c). In the future, we will be publishing new and revised 304(a) water quality criteria based upon the 2000 Human Health Methodology for pollutants of high priority and national importance. Because the revision of existing 304(a) human health criteria to reflect the 2000 Human Health Methodology will take time, EPA encourages States and authorized Tribes to make appropriate changes to their existing numerical, pollutant-specific criteria in their water quality standards to reflect this new Methodology prior to publication of a revised 304(a) criteria where they determine that such actions are necessary. For example, a pollutant of concern in a particular State may not be a high priority on the national level and revision of the national 304(a) criteria may not occur for several years. In this case, the State or a group of States, might choose to use this new Methodology to revise their water quality standards prior to EPA publication of a revised 304(a) criteria for that pollutant. EPA will recognize criteria that are revised pursuant to the 2000 Human Health Methodology as scientifically defensible and promptly approve such revised criteria as enforceable elements of State or Tribal water quality standards.

Once a new or revised 304(a) criteria reflecting this new Methodology is published, EPA expects States and authorized Tribes to reassess their water quality standards and, where necessary, establish new or revised water quality criteria consistent with one of the four options described above. Because of the critical role that human health ambient water quality criteria play in protecting human health, EPA will work with States and authorized Tribes to revise existing water quality standards promptly following EPA publication of revised section 304(a) criteria.

C. May States and Authorized Tribes Adopt Water Quality Criteria Based on Local Conditions?

In keeping with their primary responsibility in establishing water quality standards, we encourage States and authorized Tribes to develop and adopt water quality criteria to reflect local and regional conditions. States and authorized Tribes will have access to EPA regional, laboratory, and headquarters staff when help is needed to interpret today's Human Health Methodology and to make critical risk assessment decisions. For the purpose of deriving criteria based on the 2000 Human Health Methodology, EPA is publishing default values for risk level, fish intake, drinking water intake, and body weight. Default BAF values and RSC factor values will be published as chemical-specific criteria are developed or revised. (Other RSC estimates will be made when data are adequate to make them.) We believe these default values result in water quality criteria protective of the general population, and we will use these values when deriving 304(a) criteria. States and authorized Tribes may use other values more representative of local conditions if data have been collected supporting the alternative values. However, when establishing a numerical value based on a 304(a) criterion modified to reflect site-specific conditions, or water quality criteria based on other scientifically defensible methods, we strongly caution States and authorized Tribes not to selectively apply data in order to ensure water quality criteria less stringent than EPA's 304(a) criteria. Such an approach would inaccurately characterize risk.

D. What Cancer Risk Level Should States and Authorized Tribes Use When Establishing Water Quality Criteria?

In deriving 304(a) criteria based on the 2000 Human Health Methodology or when promulgating Federal water quality standards under section 303(c) of the CWA, EPA intends to use a 10^{-61} cancer risk level, which we believe reflects an appropriate target risk level for the general population. EPA acknowledges that at any given cancer risk level for the general population, those segments of the population that are more highly exposed face a higher relative risk. For example, if fish are contaminated at a level allowed by criteria derived on the basis of a risk level of 10^{-6}, individuals consuming up to 10 times the assumed fish consumption rate would still be protected at a 10^{-5} risk level. States and authorized Tribes have the flexibility to adopt water quality criteria that result in a risk level higher than 10^{-6}, up to the 10^{-5} level. EPA recommends adoption of such criteria if the State or Tribe has identified the most highly exposed subpopulation within the State or Tribe, has demonstrated that the chosen cancer risk level is protective of the most highly exposed subpopulations, and has completed all necessary public participation. EPA notes that special scientific circumstances and assessment of natural contaminants may lead to numbers outside the 10^{-6} to 10^{-5} risk range. (For additional discussion on this issue, including restrictions on selection of a cancer risk level, refer to the response on the comment for cancer risk ranges summarized in Section III of this Notice, below.)

E. How Does the Review and Approval of State and Tribal Water Quality Standards Rule Affect Water Quality Criteria Adopted by States and Authorized Tribes?

Consistent with the Review and Approval of State and Tribal Water Quality Standards rule revision (USEPA, 2000a), water quality criteria adopted into law or regulation by States and authorized Tribes prior to May 30, 2000, are in effect for CWA purposes unless superseded by replacement Federal water quality standards (see, for example, the National Toxics Rule, 40 CFR 131.35; Water Quality Standards for Idaho, 40 CFR 131.35). Water quality criteria adopted into law or regulation by States and authorized Tribes after May 30, 2000, are in effect for CWA purposes only after EPA approval of any new or revised water quality standards.

F. While EPA is Re-Evaluating a 304(a) Criterion, What Criterion Is in Effect?

Until such time as EPA reevaluates the 304(a) criteria, subjects the criteria to appropriate peer review, and subsequently publishes revised 304(a) criteria, the existing 304(a) criteria remain in effect for the purposes of EPA review of State and Tribal water quality standards under section 303(c). Where EPA has not published a revision of a

304(a) criteria reflecting the 2000 Human Health Methodology, EPA will not require the revision of State water quality standards to reflect this new Methodology. As noted above, however, EPA will assist those States or Tribes that choose to use the new Methodology to revise their existing water quality standards prior to publication of a revised criteria under section 304(a).

G. What Design Stream Flow Should Be Used to Implement Human Health Criteria?

Human health criteria represent ambient pollutant concentrations that are acceptable based on a lifetime (70 years) of exposure. Accordingly, discharges of pollutants should be regulated such that criteria will not be exceeded under stream conditions that represent long-term average conditions. Current EPA guidance recommends the use of the long-term harmonic mean flow to implement criteria for carcinogens and the 30Q5 flow to implement criteria for noncarcinogens (USEPA, 1991b). The harmonic mean flow is the sum of the reciprocals of individual flow measurements divided into the total number of individual flow measurements, and the 30Q5 flow is defined by the lowest 30-day average that has an expected return frequency of once every five years. With today's Human Health Methodology, EPA is revising its guidance to recommend harmonic mean flow be used to implement both carcinogen and noncarcinogen human health criteria. Harmonic mean flow should be used to implement human health criteria because, by and large, human health criteria are designed to protect an individual over a lifetime of exposure. As stated in the 1998 draft Methodology revisions, we are not recommending the development of additional water quality criteria similar to the drinking water health advisories that focus on acute or short-term effects. These are not seen as routinely having a meaningful role in the water quality criteria and standards program because the chronic health effects associated with chemical contaminants are usually the most sensitive health endpoint. Human health criteria based on cancer potencies and risk levels are based on models that extrapolate animal data to a human lifetime. Similarly, a human noncancer criterion is based on an RfD, which is an acceptable daily exposure over a lifetime. Therefore, we have attempted to match the longest stream flow averaging period (using harmonic mean) with the criterion which is protective over a human lifetime.

In rare instances where a human health criterion or value is based on a short-term toxicological effect (*i.e.*, the critical effect upon which the criterion/value is based is significantly less than lifetime and may be an acute effect), the design flow should be adjusted accordingly. This does not pertain to RfDs in which a short-term study has been used as the RfD basis and an uncertainty factor has been used to account for less than lifetime study results; that is, the short-term study has been used to estimate a lifetime RfD value. This pertains only to those situations where the critical effect is a short-term effect (and where no additional uncertainty factor has been used to account for less than lifetime exposure). A good example of this is EPA's RfD for nitrate. The critical effect, upon which the RfD is based, is toxicity to infants after a short-term exposure. In this case, harmonic mean flow would be an inappropriate design flow for such a short-term effect. In this case, a 7Q10 or a 4Q3 design flow may be more appropriate.

H. What Is the Relationship Between the Agency's Recommended Section 304(a) Water Quality Criteria and Drinking Water Standards?

EPA recommends that States and authorized Tribes use this 2000 Human Health Methodology to develop their own AWQC for all pollutants of concern using the latest scientifically defensible data and principles. Sources of scientifically defensible data include published toxicological literature or recent EPA assessments, including those that underlie IRIS values, the most recently published recommended Section 304(a) water quality criteria or the most recently promulgated SDWA MCLGs.

When adopting water quality criteria to protect CWA Section 101(a) fishable uses, States and authorized Tribes need to ensure such criteria adequately address fish consumption as an exposure route.

When States and authorized Tribes do not develop their own AWQC, EPA recommends that States and authorized Tribes use the most recently published recommended Section 304(a) water quality criteria for ''water and organisms'' based on this new Human Health Methodology to protect CWA Section 101(a) fishable uses and waters designated for drinking water. This ensures that the water quality criteria adequately address fish consumption, bioaccumulation and drinking water uses.

When EPA publishes the annual compilation of new and revised national recommended Section 304(a) water quality criteria, those criteria represent the Agency's most current recommended Section 304(a) water quality criteria and should be used by States and authorized Tribes when reviewing their water quality standards.

When States and authorized Tribes do not develop their own AWQC, and there are no recommended Section 304(a) water quality criteria for a pollutant of concern, or the recommended Section 304(a) water quality criteria have not yet been revised based on this new Human Health Methodology [1]:

1. For a pollutant for which EPA has published a recommended Section 304(a) water quality criterion for ''water and organisms'' based on the 1980 Methodology and for which EPA has not promulgated an MCLG, EPA will recognize the current Section 304(a) water quality criterion, or a criterion that is developed or revised pursuant to the 2000 Human Health Methodology and approved by EPA.

2. For a pollutant for which EPA has published a recommended Section 304(a) water quality criterion for ''water and organisms'' based on the 1980 Methodology and for which EPA has more recently promulgated an MCLG, EPA generally recommends the MCLG for noncarcinogenic pollutants, or a criterion derived by recalculating the MCLG at an acceptable cancer risk level (*i.e.*, a level within the range of 10^{-6} to 10^{-5}, as specifically discussed in Section II.D, which notes that special scientific circumstances and assessment of natural contaminants may lead to numbers outside the to 10^{-6} to 10^{-5} risk range).

3. For a pollutant for which EPA has not published a recommended Section 304(a) water quality criterion for ''water and organisms'' and for which EPA has promulgated an MCLG, EPA generally recommends the MCLG for noncarcinogenic pollutants, or a criterion derived by recalculating the MCLG at an acceptable cancer risk level (*i.e.*, a level within the range of 10^{-6} to 10^{-5}, as specifically discussed in Section II.D, which notes that special scientific circumstances and assessment of natural contaminants may lead to numbers outside the 10^{-6} to 10^{-5} risk range).

EPA no longer recommends that an MCL be used where consideration of available treatment technology, costs, or availability of analytical methodologies

[1] New criteria and criteria revised under this new Methodology are published annually as the ''Compilation of National Recommended Water Quality Criteria and EPA's Process for Deriving New and Revised Criteria'' at www.epa.gov/ost/standards/.

has resulted in an MCL that is less protective than an MCLG.

States and authorized Tribes continue to have the flexibility to adopt water quality criteria that are more protective than EPA's recommendations, as long as such criteria are protective of the designated uses and scientifically defensible.

I. How Are Health Risks to Children Considered in the Methodology?

In recognition that children have a special vulnerability to many toxic substances, EPA's Administrator directed the Agency in 1995 to explicitly and consistently take into account environmental health risks to infants and children in all risk assessments, risk characterizations and public health standards set for the United States. On April 21, 1997, President Clinton signed Executive Order 13045, ''Protection of Children From Environmental Health Risks and Safety Risks,'' which assigned a high priority to addressing risks to children. In May 1997, EPA established the Office of Children's Health Protection to ensure the implementation of the President's Executive Order (E.O.). Circumstances where risks to children should be considered in the context of the 2000 Human Health Methodology are discussed in the Noncancer Section (in terms of developmental and reproductive toxicity) and in the Exposure Section (for appropriate exposure intake parameters).

All of EPA's risk assessment guidelines should be consulted when conducting a risk assessment to ensure that information from studies on carcinogenesis and other health effects are considered together in the overall characterization of risk. This is particularly important in the case in which a precursor effect to tumor is also a precursor or endpoint of other health effects and is used in dose-response assessment. The overall characterization of risk will be the basis for carrying out assessments of instances in which fetuses, infants, or children are at risk.

III. Summary of Comments Received on the 1998 Draft Methodology Revisions and EPA's Responses

A. Implementation

1. Application of Human Health Water Criteria Within Mixing Zones

C*omments*—Commenters stated that human health criteria should start with the local relevant fish consumption rates and then make adjustments to reflect the actual relevant fish consumption rate related to the discharge and the mixing zone. It was also suggested that implementation in the NPDES program inherently needs a translator mechanism to adjust the standards to reflect actual consumption associated with allowed mixing zones.

Response—Application of human health water criteria within a mixing zone is not within the scope of this Methodology. At this time, EPA's current recommendations regarding the application of human health criteria within mixing zones are contained in the Technical Support Document for Water Quality-Based Toxics Control (USEPA, 1991b) and the Water Quality Standards Handbook (USEPA, 1994). We also note that mixing zones are an optional policy that not every State and authorized Tribe has adopted into their water quality standards. For States and Tribes that have authorized mixing zones, the designated uses of a waterbody as a whole must be maintained and protected.

2. Application of Human Health Water Quality Criteria to Marine Waters

Comment—A question was raised as to whether human health water quality criteria are applicable to marine waters, given the vastness of most marine waters.

Response—EPA believes human health water quality criteria should be applied to near-shore waters (specifically within a three-mile limit) wherever dischargers are located to protect aquatic food organisms, but not to include the drinking water consumption parameter. These water quality criteria are then used to derive permit limits that will ensure water quality criteria are not exceeded within the vicinity of an outfall. This protects organisms that are sessile and other organisms that may be attracted to the effluent and that are food sources. In the absence of data specific to the coastal site indicating that particular marine species are impacted by those discharges, we recommend our human health criteria to protect coastal waters. [Note: EPA's recommended national default fish intake value, which excludes marine species, supports this position. Estuarine species that are more likely to be found in near-shore waters are included in the default intake value. Potential exposure from open-ocean marine species are not ignored; the marine species exposure pathway can be accounted for as part of the RSC factor.]

3. Cancer Risk Range

Comments—Many comments were received on the appropriateness of the cancer risk range. Numerous commenters stated that the permissible range and recommended default of 10^{-6} are appropriate and approved of the range's consistency with other Agency programs. EPA was asked to reconcile the statements that both 10^{-6} and 10^{-5} are acceptable for the general population, that 10^{-6} is appropriate for promulgation of Federal water quality standards under Section 303(c) given that we have said 10^{-5} is appropriate for the Great Lakes, and that a 10^{-5} risk level along with a 17.8 g/day fish intake assumption will protect the highest consumers at a 10^{-4} risk level. Other comments are listed as follows.

- The Methodology should use a 10^{-5} risk level.
- 10^{-6} represents a change in the acceptable risk level.
- The 10^{-6} risk level represents a binding regulatory constraint that will provide no State flexibility.
- 10^{-5} is used by most States, and EPA should retain this default because the Agency has not determined that it is inadequate.
- A range of 10^{-4} to 10^{-5} is advocated.

In addition, we received comments that allowing highly exposed groups to potentially experience cancer risks an order of magnitude higher than the general population is unjust and disregards Native American treaty rights. A commenter supported the idea that a 10^{-4} risk level can be protective and believed highly exposed populations are few in number. Another stated that the cancer risk range should apply to total contaminants (*i.e.*, a cumulative cancer risk ceiling). It was cautioned that the concept of relative risk could result in selection of inappropriate target populations and intake rates. Others agreed that States and authorized Tribes should have the flexibility to select cancer risk levels as risk management decisions and requested that EPA explicitly state that it will support risk levels chosen by a Tribal authority, while another requested the flexibility without requiring involved demonstrations specific to the subpopulation at issue. A commenter recommended changes in EPA's Methodology to ensure that the resulting water quality criteria are more applicable to exposed populations. Others asked EPA to indicate the percentile of the exposed population that would meet the 10^{-6} risk level.

Response—With the 1980 Methodology, EPA presented three separate 304(a) criteria for carcinogens at risk levels corresponding to 10^{-7}, 10^{-6}, and 10^{-5} for States and authorized Tribes to choose from. However, the 10^{-7} risk level has not been used by any State or authorized

Tribe when adopting water quality standards. Furthermore, since that time, EPA's guidance and regulatory actions have utilized a 10^{-6} risk level as an appropriate target risk for the general population.

With the 2000 Human Health Methodology, our position is that both 10^{-6} and 10^{-5} are appropriate targets for health protection of the general population and that highly exposed populations should not exceed a 10^{-4} risk level. We also note that special scientific circumstances and assessment of natural contaminants may lead to numbers outside the 10^{-6} to 10^{-5} range. However, we are not automatically assuming that 10^{-5} will protect ''the highest consumers'' at the 10^{-4} risk level. One commenter referred to specific data indicating high intake levels that would not satisfy such an assumption. Nor are we advocating that States and authorized Tribes automatically establish criteria based on assumptions for highly exposed population groups at the 10^{-4} risk level. We acknowledge that fish consumption rates vary considerably, especially among subsistence populations, as is evident from the studies summarized in the Exposure TSD. Indeed, it is the variation of fish consumption among these population groups that could make either 10^{-5} or 10^{-6} protective of those groups at a 10^{-4} risk level. Specifically, if a State adopted a criterion based on a 10^{-5} risk level and a 17.5 g/day consumption rate, a high-end subsistence consumption of 1,750 g/day would exceed a 10^{-4} risk level.

It is important to understand that criteria for carcinogens are based on chosen risk levels that inherently reflect, in part, the exposure parameters used to derive those values. Therefore, changing the exposure parameters will also change the risk. Specifically, the incremental cancer risk levels are *relative*, meaning that any given criterion associated with a particular cancer risk level is also associated with specific exposure parameter assumptions (*i.e.,* intake rates, body weights). When these exposure values change, so does the relative risk. As we have previously indicated for a criterion derived on the basis of a cancer risk level of 10^{-6}, individuals consuming up to 10 times the assumed fish intake rate would not exceed a 10^{-5} risk level. Similarly, individuals consuming up to 100 times the assumed rate would not exceed a 10^{-4} risk level. Thus, for a criterion based on EPA's default fish intake rate (now 17.5 g/day, based on the most recent survey data) and a risk level of 10^{-6}, those consuming a pound of fish per day would potentially experience between a 10^{-5} and a 10^{-4} risk level (closer to a 10^{-5} risk level). Even if a criterion were based on high-end intake rates and the relative risk of 10^{-6}, then an average fish consumer would not exceed a cancer risk level of approximately 10^{-8}. The point here is that the risks for different population groups are not the same.

EPA believes that the adoption of a 10^{-6} or 10^{-5} target risk level, both of which States and authorized Tribes have historically chosen, represents a generally acceptable health protection decision, noting again that special scientific circumstances or assessments of natural contaminants may necessitate additional considerations. EPA recommends adoption of water quality standards that include water quality criteria based on either the 10^{-5} or 10^{-6} risk level if the State or authorized Tribe has identified the most highly exposed subpopulation, has demonstrated that the chosen risk level is adequately protective of the most highly exposed subpopulation, and has completed all necessary public participation. States and authorized Tribes also have flexibility in how they demonstrate this protectiveness and obtain such information. A State or authorized Tribe may use existing information as well as collect new information in making its determination as to an appropriate level of protection. In addition, if a State or authorized Tribe does not believe that the 10^{-6} risk level adequately protects highly exposed subpopulations, water quality criteria based on a more stringent risk level may be adopted. However, we are now adding that a generally specific analysis should be made and presented to ensure that highly exposed groups do not exceed a target 10^{-4} risk level. In cases where fish consumption among highly exposed population groups is of a magnitude that such a 10^{-4} risk level would be exceeded, a more protective risk level should be chosen. These determinations should be made by the State or authorized Tribe and are subject to EPA's review under Section 303 of the CWA. Guidance on choosing appropriate exposure parameters is discussed in both the 2000 Human Health Methodology and the Exposure Assessment TSD.

Given the relatively significant variation in fish consumption rates, EPA intends to derive Section 304(a) criteria at the 10^{-6} risk level, based on an intake rate of 17.5 g/day. We believe that basing our 304(a) criteria on general U.S. population exposures is most appropriate, given their use as a default value for the nation as a whole. Most States have, in fact, already adopted a 10^{-6} risk level with their criteria for carcinogens, not the 10^{-5} risk level claimed by one commenter. This default would, in turn, be protective for fish intakes of up to 1,750 g/day at the 10^{-4} risk level. However, in the Exposure Assessment TSD, EPA has recommended that States and authorized Tribes give priority to identifying and adequately protecting the most highly exposed population by adopting more stringent criteria, if the State or authorized Tribe determines that the highly exposed population would not be adequately protected by criteria based on protecting the general population. States and authorized Tribes have the option to derive their criteria at a 10^{-6} risk level, as EPA will do with its 304(a) criteria. They also have the flexibility to combine the 10^{-6} risk level with fish consumption rates for highly exposed population groups. Thus, States and authorized Tribes may choose to adopt criteria that are more protective than EPA's 304(a) criteria. We intend to support the health protection decisions made by States and authorized Tribes as long as they use the risk range that EPA has stated here and in the 2000 Human Health Methodology. EPA has made reasonable and conservative assumptions in choosing exposure parameters with the goal of protecting the majority of the population. However, we do not believe it is possible to calculate the exact percentile of the population that would be protected at a given risk level in terms of the overall combination of exposure parameters. We emphasize that the criteria are derived to be protective, not predictive of an exact percentile of the total population that is protected.

Regarding the use of a 10^{-5} risk level in the Great Lakes Water Quality Initiative (GLI), the criteria values were based on fish consumption estimates that reflected intake data among sportfishers, a group that consumes more fish than the general population. Again, we recommend that States and authorized Tribes base their criteria on more highly exposed population groups, if they would not be adequately protected by criteria based on intake rate estimates for the general population. Regarding the application of a cumulative cancer ceiling, the commenter has misunderstood EPA's policy when setting 304(a) criteria for carcinogenic effects based on linear low-dose extrapolation. With these carcinogens, the AWQC are set with respect to the incremental lifetime risk posed by the substance in water and are

not being set on an individual's total cancer risk from all sources of exposure.

4. Coordinating the Human Health Methodology With Other EPA Programs

Comments—Numerous commenters recommended that the Methodology revisions be coordinated with the drinking water program (specifically, MCLs/MCLGs required under the SDWA) and believed that the drinking water portion of AWQC and MCLGs should be equivalent. Several commenters stated that the burden of achieving health goals should be borne by dischargers and other polluters, not by water users or the environment. Commenters also recommended that EPA use MCLs when AWQC are less protective or for chemicals when AWQC do not exist. Another recommended that an additional margin of safety be included if the MCL were used, in particular for chemicals not effectively removed by conventional drinking water treatment, and also stated that neither the availability of MCLs or MCLGs should deter development of AWQC. Some commenters believed that the use of an MCLG is an acceptable alternative for chemicals of drinking water concern because, like the AWQC, it is a health-based value. However, others recommended that MCLGs not be used when they are more stringent than AWQC because they are not regulatory standards. Two commenters stated that EPA should not abandon its policy of setting AWQC for carcinogens at zero for ''maximum protection of human health'' and recommended that the ''Group C'' chemicals also have AWQC set at zero (referring to non-zero MCLs as inconsistent with the intent of a zero MCLG). However, other commenters recommended that AWQC be set at one-half of the MCL when the MCLG is zero, at a 10^{-6} risk level, or by calculating both and choosing the lower of the two. Two commenters urged EPA to unify the national Human Health Methodology with the GLI guidance. Another discussed microbial pathogens and, in addition to recommending development of criteria for specific microbial contaminants, recommended coordination with the drinking water program [i.e., the SDWA's Candidate Chemical List (CCL)] and stated that microbial criteria need to be set for more than recreational waters.

Response—EPA intends to continue deriving AWQC that include a drinking water pathway, applicable to waters that are potential sources of drinking water, and agrees that the drinking water component of AWQC should be consistent with the MCLG (if one has been established). Therefore, we intend to use a similar methodology for deriving AWQC and MCLGs. We also intend to coordinate with the Agency's safe drinking water program when prioritizing chemicals for AWQC derivation/revision (see also response to Comment A.11, Proposed Chemical List). Regarding the relationship between AWQC and the drinking water MCLs and MCLGs, we have clearly stated our position in the **Federal Register** Notice for the 1998 draft Methodology revisions (USEPA, 1998c) on this relationship and our approach to considering when an MCL or MCLG may be appropriate to use in lieu of AWQC. That discussion is excerpted in the 2000 Human Health Methodology document, along with clarification of our policy on the circumstances and limitations under which either should be used. We do not necessarily assume that a chemical's concentrations in ambient waters and drinking water are equivalent but are aware that chemicals may not be effectively removed by conventional drinking water treatment.

Commenters who referred to EPA's abandonment of its policy of setting AWQC for carcinogens at zero have substantively misstated our policy based on both the 1980 Methodology for deriving AWQC and our 1998 draft Methodology revisions, and are directed to the **Federal Register** Notice cited above. We did state in our 1980 Methodology that for the maximum protection of human health from potential carcinogenic effects, the ambient water concentration should be zero, based on an assumption of a linear dose-response relationship at low doses. The 1980 Methodology also indicated that zero levels may not have been attainable at that time. This remains the case at present. The combination of background levels of carcinogens from natural sources and global background levels from anthropogenic sources make attainment of zero levels for many potential carcinogens impossible. In addition, more recent and sophisticated toxicological information on carcinogenicity suggests modes of action for carcinogens that would lead to nonlinear low-dose extrapolation. Note that the 1980 Methodology preceded the Agency's original 1986 cancer guidelines, which are now being revised. We are maintaining our policy to derive AWQC for carcinogens to correspond to incremental lifetime cancer risk levels, applying a risk management policy that ensures a reasonable level of protection for the general population.

When EPA developed the methodology to derive human health criteria for the waters of the Great Lakes System, the Agency was mindful of the need for consistency with the planned changes in the Human Health Methodology presented today for deriving national AWQC for the protection of human health. Throughout the 1998 draft Methodology revisions, references were made to comparisons of the two methodologies, especially whenever differences occur due to regional exposure assumptions made for the Great Lakes System. The GLI guidance consisted of water quality criteria, detailed methodologies to develop criteria for additional pollutants, implementation procedures, and antidegradation policies and procedures tailored to the Great Lakes system; these reflected the unique nature of the Great Lakes ecosystem. Those States and authorized Tribes are to use the GLI methodology to establish criteria for the waters of the Great Lakes system, which allows appropriate flexibility to States and authorized Tribes to develop equitable strategies to control pollution sources and to promote pollution prevention practices. The 2000 Human Health Methodology is undertaken pursuant to Section 304 of the CWA, and is independent of, and does not supersede, the GLI. Although consistency in State water quality standards programs is an important goal for EPA, we also recognize that it is necessary to provide appropriate flexibility to States and Tribes, both Great Lakes States and non-Great Lakes States, in the development and implementation of place-based water quality programs. Recognition of a general need for flexibility is not incompatible with the requirements for the Great Lakes States and Tribes established in Section 118(c)(2) of the CWA. We have harmonized the two, where appropriate, while maintaining parameters and provisions that are appropriate for Great Lakes-specific criteria.

EPA has identified development of microbial water quality criteria as part of its strategy to control waterborne microbial disease, by controlling pathogens in waterbodies and by protecting designated uses, such as recreation and public water supplies. The program fosters an integrated approach in order to protect both ground-water and surface water sources. EPA plans to conduct additional monitoring for *Cryptosporidium parvum and Escherichia coli*, and determine action plans in accordance with the results of this monitoring.

5. Designated Uses

Comments—Commenters indicated that designated uses for waterbodies

that cross State boundaries and that fail to take into account downstream uses may effectively prohibit downstream waters from being used as a water supply; the AWQC should reflect the use of a waterbody as a drinking water source unless the use patterns of the entire waterbody indicate that this is not a current or future possibility.

Response—EPA regulations at 40 CFR 131.10(b) state:

> In designating uses of a water body and the appropriate criteria for those uses, the State shall take into consideration the water quality standards of downstream waters and shall ensure that its water quality standards provide for the attainment and maintenance of the water quality standards of downstream waters.

We believe this requirement is sufficient to address the concerns raised by the commenter and to ensure downstream uses are maintained and protected.

6. Developing National 304(a) Criteria

Comments—Commenters stated that EPA should not derive national 304(a) AWQC and stated their preference for regional measurements, and that national 304(a) criteria could be overly stringent or underprotective from State to State. Instead, they recommended that EPA simply provide specific ''algorithms'' to force States to develop their own criteria. However, they also said that EPA should develop a single criterion for each chemical based on the most relevant toxic endpoint and appropriate target population. A commenter recommended that EPA develop criteria for both cancer and noncancer endpoints because their comparative protectiveness may not be clear until permit limit design flows are determined. Another commenter stated that relying on default parameter values would inhibit the process for developing criteria/implementing standards because the regulated community will not accept such criteria. Two commenters stated that the amount of information on adverse impacts to water quality, fish, birds, wildlife, and human health warrants regulatory action to eliminate those toxicants. They recommended that EPA include all biotic pathways using the water source, including wildlife and plant life, and advocated protecting cultural and religious uses. A commenter stated that limited information exists for development of criteria in arid regions and that resources would be better spent gaining knowledge on the impacts of chemicals in regional watersheds. Another questioned how AWQC can be derived when ambient levels are below analytical detection limits. Several commenters supported the derivation of fish tissue criteria.

Response—Section 304(a) of the CWA requires EPA to develop national water quality criteria recommendations for States and authorized Tribes to use as guidance in adopting water quality standards. It is not an option for EPA to ignore this requirement. As such, the national 304(a) criteria that EPA periodically publishes are generally applicable to the nation's waters. Although we encourage States and authorized Tribes to use the Methodology to develop criteria based on local/regional information and believe that water quality criteria reflecting such local conditions are desirable, we have not abandoned our obligations under the CWA. The commenter should be aware that States have adopted EPA's recommended 304(a) criteria. Furthermore, in contrast to another commenter's suggestion, under the CWA, 304(a) criteria are not enforceable regulations; these criteria are guidance and do not impose legally binding requirements.

States and Tribes always have the option to undertake their own evaluations to develop water quality criteria, as long as such criteria are consistent with the CWA and the implementing Federal regulations. States have derived water quality criteria for their waters in the absence of EPA guidance and may continue to do so. However, the recommended criteria serve as guidance to States and authorized Tribes, and EPA cannot force States or Tribes to conduct their own evaluations. We are well aware that the resources and expertise within States and Tribal authorities vary greatly and, while encouraging them to pursue their own criteria development programs, we anticipate that many will continue to rely on our expertise and recommended 304(a) criteria. We included guidance on site-specific modifications for States and authorized Tribes to derive their own water quality criteria and will expand this information as part of the TSD volumes for the 2000 Human Health Methodology.

Although we have provided numerous default parameter values for different population groups, we intend to derive or revise AWQC based on the most sensitive health endpoint and the population group most relevant for that endpoint. Regarding measurable levels of chemicals in the water column, the CWA clearly states that limitations in analytical methods will not be considered when deriving AWQC. Rather, the AWQC represent health-based considerations only. However, analytical method limitations are taken into account in the implementation of water quality standards. We believe that deriving AWQC based on fish tissue concentrations may be appropriate in some instances to overcome this problem when there is a health concern for that chemical (for greater discussion of fish tissue criteria, see response to Comment F.7). Regarding cancer versus noncancer endpoints, it is EPA policy to develop criteria for the most sensitive endpoint in order to be protective of both potentially relevant cancer and noncancer effects. EPA intends to continue this practice. Regarding design flows, see the response on this issue under Comment A.9. Finally, these Methodology revisions apply to the protection of human health only. Other EPA efforts to develop methods and criteria for the protection of birds or other wildlife are not part of this guidance and will not be addressed here. Considerations such as religious or cultural uses cannot be quantitatively factored into the AWQC equation for setting pollutant criteria values.

7. Developing Organoleptic Criteria

Comments—Commenters suggested that EPA should provide guidance for States to develop organoleptic criteria for ambient waters that are sources of drinking water, and develop specific organoleptic criteria. Taste and odor are strongly associated with consumer perceptions and confidence in water quality. They suggested that EPA should provide organoleptic criteria and allow States to make decisions about their use. Others stated that organoleptic criteria should not be developed because they are not relevant to protection of human health and because they should only be considered for drinking water standards.

Response—The 2000 Human Health Methodology is focused on deriving toxicity-based criteria because they, not organoleptic criteria, are directly related to potential adverse human health effects. We have received much support for our position on this issue since initiating the Methodology revisions. EPA acknowledges that if organoleptic effects (*i.e.,* objectionable taste and odor) cause people to reject the water and its designated uses, then the public is effectively deprived of the natural resource. EPA encourages the development of organoleptic criteria when States and Tribes believe they are needed to protect designated uses and have indicated this in the 2000 Human Health Methodology.

8. Establishing EPA's Most Recent Federally Recommended Water Quality Criteria

Comment—A commenter stated that the proposed California Toxics Rule (CTR) established EPA's most recent federally recommended water quality criteria, and because EPA did not propose to promulgate arsenic in the CTR, there is no federally recommended water quality criterion for arsenic.

Response—With regard to arsenic and the Agency's policy on applicable 304(a) criteria, EPA clearly stated in the 1998 draft Methodology revisions that until such time as the Agency re-evaluates a chemical and subsequently publishes revised chemical-specific 304(a) criteria, the existing criteria remain in effect. Although the 2000 Human Health Methodology represents improvements to the 1980 Methodology, EPA believes that the existing 304(a) criteria are fundamentally sound from a scientific standpoint. We have long supported this position. Our recommended water quality criterion for arsenic remains the value published in EPA's Goldbook in 1986 (USEPA, 1986d) and promulgated in 1992 as part of the NTR. Federal promulgations for individual States take into account the needs of the individual State and site-specific conditions of waterbodies within the State. Federally promulgated water quality standards for a State may not always result in water quality criteria that are nationally applicable. We understand there has been some confusion regarding the current recommended water quality criteria in light of State-specific promulgations, and as a result, in 1998, we published National Recommended Water Quality Criteria (USEPA, 1998b) to clarify our national recommendations. This list will be updated approximately on an annual basis to contain our most current recommended water quality criteria for States and authorized Tribes to use as guidance in adopting water quality standards.

9. Flows

Comment—Comments received suggested that EPA should adequately consider and account for regional differences, such as highly variable flows, lower exposures, and lack of fish habitat due to no-flow conditions in many Southwestern washes (*i.e.*, waterbody flow only following a storm event).

Response—EPA believes there is sufficient flexibility in the current regulatory program for States to modify designated uses and water quality criteria to protect those uses to address the conditions that exist in waterbodies such as intermittent streams and washes. Modifications to the water quality standards program are unwarranted at this time.

10. Implementation on a Waterbody Basis

Comment—Commenters stated that human health criteria should be met within the waterbody on a long-term average basis instead of short-term maximums never to be exceeded. It was recommended that States be able and even encouraged to develop site-specific standards for waterbodies to reflect relevant fish consumption rates.

Response—The 2000 Human Health Methodology incorporates long-term exposure into the development of water quality criteria. Determination of when human health criteria are met within the waterbody is beyond the scope of this document. However, EPA guidance addresses this issue (USEPA, 1991b). We recommend harmonic mean flow to calculate permit limits and taking the geometric mean of ambient water samples to determine attainment. Both of these recommendations account for the long-term exposure effects of chemical water quality criteria.

EPA recommends that States develop site-specific water quality criteria to reflect relevant fish consumption rates. We have published default fish consumption rates in the Methodology as recommendations to States and Tribes in adopting water quality standards when a State or Tribe lacks information on local fish consumption rates. EPA's preference, however, is that States and Tribes adopt human health criteria reflecting local fish consumption rates.

11. Proposed Chemical List

Comments—Commenters suggested that EPA integrate the AWQC prioritization process with the drinking water program (*i.e.,* with the Candidate Contaminant List). Other comments suggested that EPA's short list of pollutants (for revision) would result in a greater burden for States that will need to develop more criteria. EPA was asked to strengthen efforts to develop criteria for persistent chemicals and to add endocrine disruptors. It was pointed out that the short priority list published in the 1998 draft Methodology revisions includes numerous banned pesticides. Additional chemicals and microbial contaminants for EPA to consider in its prioritization of criteria to revise/develop are suggested, as follows:

Atrazine
Benzo(a)pyrene
Chlordane
Cryptosporidium parvum strains
Cyanazine
Endrin
Giardia lamblia
Heptachlor
Heptachlor epoxide
Hexachlorobenzene
Methyl-tertiary-butyl-ether (MTBE)
Lead
Other PAHs (specifically advocated use of Relative Potency Factors)
Total Organic Carbon (TOC)
Toxaphene

Response—We will evaluate all suggested pollutants based on the following factors: relative toxicity; occurrence in fish tissue, water, and sediments (frequency as well as concentration levels); and for chemicals, information on the chemical's bioaccumulation. This strategy, previously published in the 1998 draft Methodology revisions, received general support, and we will consider these suggestions along with priorities identified by both the Office of Pesticide Programs and the Office of Ground Water and Drinking Water, and other input received from States and Tribes. Regarding a State's need to revise more criteria, see the response to Comment A.13, Revising Existing 304(a) Criteria.

12. Publishing Existing 304(a) Criteria Information

Comments—EPA received support for its proposal to occasionally publish a list of its criteria and information on revisions or new criteria in progress. Some commenters stated that EPA should publish a list in the **Federal Register** annually, and one suggested that EPA post any changes during the interim on the Agency's website. It was also suggested that EPA should identify which criteria were changed and why. One commenter stated that a timeframe of 3 to 5 years is more appropriate because little is likely to change in just one year. Another commenter expressed support for publishing an annual list of EPA drinking water regulations and health advisories.

Response—EPA believes that regular updates on its website are the most efficient way to make accurate information available to the public. We hope this will be helpful for States and authorized Tribes in reviewing and revising their water quality standards during the triennial reviews required under 40 CFR 131. We will consider further the circumstances and frequency with which **Federal Register** publications may be used. The commenter who referred to drinking water standards and health advisories misunderstood EPA's intention, which is to publish a list annually on the

304(a) water quality criteria similar to that done for the drinking water program.

13. Revising Existing 304(a) Criteria

Comments—EPA received support for revising its Methodology and for providing clear indication of the scientific components versus the science policy components. Commenters supported the idea of EPA revising criteria based on partially updated components of the criteria equations. One expressed a preference for comprehensive revisions but also stated that partial updates should be done as soon as possible, referring to components such as fish consumption rates and ''interspecies conversion of doses'' as those that can automatically be inserted, thereby enabling revision of all criteria within a week of effort. [**Note:** It is unclear whether the commenter is referring to the new body weight/surface area scaling factor or something else by the term ''interspecies conversion of doses,'' because it is not specified.] A commenter stated that as any component is updated, so should the criteria. Another suggested that EPA partially revise all criteria for the components that current information would allow. On the other hand, a commenter stated that EPA should not revise criteria based on the new scaling factor or other pieces of data, but should conduct literature searches for new available data applicable to the Methodology. Other comments were that priority should be given to chemicals with significant new toxicity information; the use of partial updates is not scientifically sound, will produce overly conservative criteria, and restricts the public's right to comment; and all revision actions should be subject to public review and comment.

Response—EPA ideally seeks to conduct re-evaluations of every component used in the derivation of 304(a) criteria before revising any criteria. However, we have discussed updating a limited number of 304(a) criteria over the course of the next several years based on one or more components of the criteria equation (a ''partial update'') rather than a complete set of components, realizing that updating some of these (*e.g.,* the BAF, the exposure parameters) is not as time- or resource-intensive as completing a toxicological evaluation. Recent actions taken by EPA represent this option; both the NTR and the GLI were partial updates. We intend to focus our limited resources on revising (either partially or completely) those pollutants that we consider highest priority in terms of both toxicological concern and frequency of occurrence.

EPA has indicated that it does not believe it is desirable to revise criteria based on piecemeal information, such as the interspecies scaling factor, when there may be other information (*e.g.,* new toxicity studies) that could also change the risk assessment and, thus, the criteria. We have also cautioned the States and Tribes not to selectively apply data or methods that would inaccurately characterize risk (*e.g.*, in order to ensure a water quality criterion that is less stringent than an EPA 304(a) criterion). For a water quality criterion revision based on a partial update to be considered acceptable to EPA, a component of the criterion (*e.g.*, the toxicological risk assessment) would need to be comprehensive (*e.g.*, a new or revised RfD or cancer dose-response assessment, as opposed to simply a new scaling factor), should stand alone and be based on new national or local data. A toxicological update should be on a weight-of-all-of-the-evidence basis, as called for under EPA's risk assessment guidelines. This should incorporate the latest published toxicological literature and risk assessment approaches. States or authorized Tribes seeking to establish ambient water quality criteria are urged to continue using the IRIS noncancer and cancer risk assessments if they cannot conduct a complete evaluation to update toxicological values.

The Agency has developed an improved process that it intends to use when deriving new criteria or conducting a major reassessment of existing criteria. The process is intended to provide expanded opportunities for public input and to make the process more efficient. When deriving new criteria or when initiating a major reassessment of existing criteria, we will publish a notice in the **Federal Register** and on the EPA website announcing our assessment or reassessment of the pollutant. References relied on will be provided, and we will solicit additional data or information useful in deriving new or revised criteria. After input is received and evaluated, we will develop draft recommended water quality criteria. Next, EPA will initiate an independent external peer review of the draft criteria. The public will also be able to submit views on issues of science pertaining to the information used in deriving the draft criteria. We will then revise the draft criteria as necessary, incorporating peer review and public input, and announce the availability of the final water quality criteria in the **Federal Register** and on the EPA website. In addition to developing new criteria and conducting major reassessments of existing criteria, EPA also from time to time will partially revise criteria based on new information pertaining to individual, stand-alone components of the criteria. Because such recalculations normally result only in changes to single parameters of the criteria (not in the underlying scientific methodologies) and reflect peer-reviewed data, EPA will typically publish such recalculated criteria directly as the Agency's recommended water quality criteria. If substantial revision is done, we will follow the process of peer review and public input outlined above. Further discussion of this process can be found in the **Federal Register** Notice compilation of recommended water quality criteria and notice of process for new and revised criteria (USEPA, 1998e).

14. State Evaluation of Data Supporting Criteria

Comment—One commenter asserted that ''states should be allowed to critically evaluate all data and disregard data that, for one reason or another, are unrepresentative or unreliable'' and further asserted that States should be allowed to critically review EPA's published 304(a) criteria and to decline to adopt any criteria they feel are inappropriate.

Response—EPA disagrees with underlying assumptions of the comment. EPA's 304(a) criteria are guidance. States and authorized Tribes may develop their own scientifically defensible, peer-reviewed criteria. Moreover, States and any other interested parties have the opportunity to participate in development of water quality criteria published under Section 304(a) of the Act. Prior to publishing any new or revised 304(a) criteria, EPA provides stakeholders with an opportunity to review and provide scientific views. EPA maintains that at the time of publishing of new or revised 304(a) criteria, the criteria are scientifically defensible and establish guidance to States for adopting water quality standards under section 303(c) of the Act. Under 40 CFR 131.11, States continue to have the option of adopting water quality criteria based on 304(a) criteria modified to reflect site-specific conditions, or other scientifically defensible methods.

15. Streamlined Approach to Developing Criteria Documents

Comment—EPA received support for the streamlined format used in the example criteria documents published in 1998.

Response—We acknowledge this support.

16. Treaty Rights and Trust Obligations/ Government-to-Government Relations

Comments—Commenters recommend EPA fully incorporate treaty rights and Federal trust obligations to Indian tribes in its national AWQC guidelines. It was reiterated that EPA has an obligation to maintain government-to-government relations with Tribal Governments.

Response—As stated in the 1998 draft Methodology revisions, ''risk levels and criteria need to be protective of tribal rights under federal law (*e.g.*, fishing, hunting, or gathering rights) that are related to water quality.'' We believe the best way to ensure that Tribal treaty and other rights under Federal law are met, consistent with Federal trust responsibility, is to address these issues at the time EPA reviews water quality standards submissions.

B. General Policy

1. AWQC Derivation Equation Errors

Comments—Commenters pointed out that the term ''RSC'' (relative source contribution) in the Linear Cancer Effects equation of the 1998 draft Methodology revisions was incorrect and should have been ''RSD'' (risk-specific dose).

Response—The commenters are correct; this was a misprint and should have been RSD for the linear equation.

2. Chronic Human Health Effects Assumption

Comments—EPA received support for its assumption that, by and large, AWQC are set to protect against long-term (chronic) human health effects.

Response—We acknowledge the commenter's support.

3. Protectiveness of the Methodology

Comments—A commenter stated that inherent uncertainties in EPA's risk assessments make them useless and that EPA must adopt the most conservative methodologies in order to protect human health, while also acknowledging the presence of uncertainties in assessing adverse health impacts. They suggested that EPA should tighten regulations for chemicals of national priority, develop criteria for additional priority chemicals, and take the most conservative approach regarding reproductive and developmental effects. Other commenters advocated that EPA incorporate pollution prevention policies into its risk assessment methodologies. One commenter asked EPA to provide guidance to States for developing AWQC less restrictive than AWQC for the general public, and suggested that engineering and administrative controls could reduce exposures. Another stated that the population groups identified represent appropriate categories and that the corresponding default parameter values are reasonable. The same commenter advocated use of the same percentile value for each default parameter (''*e.g.*, 95th percentile''). Another commenter recommended that EPA determine distributions of exposure in order to assess whether a significant subgroup is more highly exposed than the general population, especially in the context of the chosen exposure parameter values. Others stated that the general population should not be targeted and that EPA should instead target the population group most at risk, or that protection of health should apply to all humans. Commenters also expressed uncertainty over the segment of the population that the AWQC are designed to protect, and questioned whether EPA would evaluate all subpopulations for all chemicals. Two commenters requested an analysis of the overall impact that each parameter has on the criteria and how that relates to the conservativeness of the estimated risk, with one criticizing EPA for not conducting probabilistic analyses of exposures or other methods to evaluate the interaction of exposure parameters. This commenter stated that the Agency has used ''high confidence-level'' values for all parameter values and, therefore, the AWQC are ''inordinately conservative.'' Furthermore, EPA should specify the level of protection within the high-end proportion of the general population (*e.g.*, ''the 95% level'') and adjust the exposure parameter values within ''their defined distributions.'' Concern was expressed that the flexibility regarding infants and children (*i.e.,* for developmental effects) conflicted with the fact that chronic lifetime effects cover persons when they are children and adults. A commenter recommended consideration of tissue effects, as well as organ-level effects. Another stated that increasingly strict criteria/discharge limits represent regulatory environmental injustice, and that discharges in effluent-dependent streams are necessary for trees, vegetation, and wildlife.

Response—EPA believes that it has made appropriately conservative assumptions in conducting risk assessments where uncertainties exist. Furthermore, for this effort we will rely on the Agency's peer-reviewed, published risk assessment methodologies, which incorporate procedures to address uncertainties in the risk assessments. We will continue to make the most appropriate risk management decisions when developing or revising criteria, including determining pollutants of high priority. EPA does consider tissue-level effects in addition to organ-level effects when conducting its risk assessments. We acknowledge the comment regarding integrating pollution prevention policies with our risk assessment methodologies and specifically discuss this in the context of CWA goals in the 2000 Human Health Methodology. We also believe that we have selected appropriate default parameter values. Regarding the idea of criteria that are less restrictive than EPA's 304(a) criteria, a State or authorized Tribe would have such flexibility as long as it could clearly demonstrate that the criteria it calculated would be protective of its population. Such alternate assessments and the resulting proposed State or Tribal standard would be subject to EPA's triennial review process. Furthermore, the AWQC are health-based criteria, and therefore potential effects of engineering and administrative controls are not part of criteria.

By and large, the AWQC are derived to protect most of the overall population from chronic adverse health effects. However, States and authorized Tribes also need to understand that there are RfD's based on developmental or other short-term adverse health effects, perhaps where an exposure of one day could result in the effect. Long-term averaging of exposure would not be appropriate in such circumstances. States and authorized Tribes are also encouraged to consider protecting population groups that they determine are at greater risk and, thus, would be more protected using alternative exposure assumptions. We do not intend to derive multiple criteria for all subpopulation groups for every chemical. The commenter who discussed probabilistic analyses has misunderstood EPA procedures. We have used median and mean values, and percentile estimates, not high confidence-level values, as suggested by the commenter. We also disagree that the resulting criteria represent inordinately high levels of conservativeness. In general, we are doing what the commenter recommended about targeting the overall protection at the high end of the general population, even though the criteria have not been subjected to an assessment of whether a 95% level has been achieved (as recommended by the commenter). Although we have not subjected the parameter values chosen

to a rigorous analysis, we have not used high-end percentiles for all parameters. The assumed body weight value used is an arithmetic mean, as are the RSC intake estimates of other exposures, when data are available. The BAF component data values are based on median (*i.e.,* 50th percentile) values. The drinking water and fish intake values are 90th percentile estimates. We believe this will result in water quality criteria that will be protective of a majority of the population. That is our goal. The commenter has not provided a method that would allow us to determine the overall percentile associated with the criteria calculations. EPA has provided additional language in the 2000 Human Health Methodology to clarify the population the AWQC are intended to protect.

Finally, if EPA determined that pregnant mothers/fetuses or young children are the population basis of a chemical's RfD or POD/UF, then we would derive our 304(a) criteria using exposure parameter values for that subgroup. This would be relevant only for less-than-lifetime exposure situations and, therefore, does not conflict with the fact that chronic health effects potentially reflect a person's exposure during both childhood and adult years.

4. Setting Criteria to Protect Both Fish and Drinking Water Versus Fish Only

Comments—EPA received strong support for deriving one AWQC value to protect both drinking water and fish intakes and another to protect for fish intakes only, given that the designated uses of waterbodies vary and drinking water may not be a designated use. One commenter stated that in addition to these two types of criteria, EPA should also develop criteria for water ingestion only. They indicated that waters may exist where fishing and consumption of fish are not relevant but water ingestion is relevant. Furthermore, they pointed out that EPA's Advanced Notice of Proposed Rulemaking for Water Quality Standards discussed protection for aquatic life and, therefore, stated that flexibility is needed so that fish consumption is not inappropriately applied to all waters. A commenter questioned whether ambient waters that are fished are also sources of drinking water, and whether contaminant levels in the two water types could be equivalent. Others stated that the drinking water pathway should not be included in the AWQC, given the way AWQC are implemented (*e.g.*, AWQC apply to waste water discharges and MCLs apply to public drinking water system exposures) and that MCLs may consider affordability and treatability. A commenter stated that AWQC to protect fish/shellfish are not justified and should be dealt with under other regulatory programs (*e.g.*, the Food Quality Protection Act).

Response—EPA believes that AWQC should include a drinking water pathway to protect waters designated as potable water sources. (Also see EPA's response to Comment A.4 regarding the relationship between MCLs/MCLGs and AWQC, Coordinating the Human Health Methodology With Other EPA Programs.) EPA strongly disagrees that AWQC to protect humans exposed through consumption of fish/shellfish should not be developed. Ensuring the protection of human health from consumption of contaminated fish and shellfish is clearly within the requirements of the CWA. We do not believe that 304(a) criteria to protect drinking water uses only are particularly useful, because by and large, State and Tribal standards for human health are set to protect waters with multiple designated uses, not merely drinking water use. The water quality standards program also protects aquatic life. The 2000 Human Health Methodology will not change our requirement to apply aquatic life criteria to protect aquatic species where they are more sensitive (*i.e.*, when human health criteria would not be protective enough) or where human health via fish or water ingestion is not an issue.

5. Setting Criteria to Protect Against Multiple Exposures From Multiple Chemicals

Comments—Several commenters thought EPA should consider multiple chemical exposures when setting AWQC and consider these exposures additive, at a minimum, while using information on synergistic impacts from the combination of chemicals. Commenters also suggested that certain Native American Tribes may have significant confounding factors (not specified) to be considered with any synergistic assessment. A commenter suggested that the cancer risk range apply to total contaminants or that a cumulative cancer ceiling be established. Another stated that the suggested alternate approach to account for inhalation and ingestion exposures (via the RfD and RfC equation) regardless of the target organ/endpoint was inconsistent with EPA's guidance on the use of hazard indices (HIs) and hazard quotients (HQs) to evaluate multiple noncarcinogenic toxicants. Commenters also questioned whether all exposure routes exhibit the same toxicity or stated that inhalation exposures should be disregarded if the pollutant in question does not affect the same endpoint.

Response—Assuming that all multiple exposures from multiple chemicals are additive, as the commenters suggest, is not scientifically sound unless they exhibit the same toxic endpoints and modes of action. We are aware of the complex issues and implications of cumulative risk and are developing an overall approach at the Agency-wide level. In particular, the Agency's program offices are engaged in ongoing discussions on how to address the great complexities, methodological challenges, data adequacy needs, and other information gaps, as well as the science policy and risk management decisions that will need to be made, as we pursue developing a sound strategy and, eventually, specific guidance for addressing cumulative risks. As previously indicated, the Agency is developing a framework for cumulative risk assessment, and the Office of Pesticide Programs has developed draft guidance for assessing cumulative risk of common mechanism pesticides and other substances. We have added discussion about the concept of cumulative risk and the state of the science in the 2000 Human Health Methodology and its TSDs. As a matter of internal policy, we are committed to refining the Methodology as advances in relevant aspects of the science improve. Regarding the alternate approach to use the HI/HQ equation (combining RfDs and RfCs), we do not intend to use this approach to combine chemicals when deriving criteria at this time. We requested comment on this as an alternate method to consider inhalation exposures for a given chemical, but would not consider its use in situations where existing information indicates that ingestion exposures and inhalation exposures affect different target organs. EPA intends to consider the comparative toxicity between exposure routes for Section 304(a) water quality criteria and has encouraged States and Tribes to do so. For the recommended national 304(a) criteria, cumulative risk approaches will not work since the mixture of pollutants present in water is inherently site-specific.

6. Uncertainty with the Derivation of 304(a) Criteria

Comment—Comments suggested that cumulative uncertainty guidance should be included in the Methodology, including a maximum acceptable uncertainty level.

Response—Establishing a maximum level of acceptable uncertainty is not part of the Methodology and will not be

factored into the decision of whether to develop or revise 304(a) criteria. However, issues regarding uncertainties with the risk assessments, exposure assessments, and bioaccumulation assessments will be addressed in the risk characterization sections of future criteria documents.

7. Toxicity Equivalency Factors (TEFs) for Dioxin-like Compounds

Comments—Several commenters addressed the use of TEFs for dioxin-like and other mixtures and classes of compounds. They believed the TEF approach has only limited application in risk assessment. Commenters indicated that complexities of the biology argue strongly against any more than limited and very cautious use of the TEF approach for assessment of human health from exposure to dioxin-like compounds.

Response—EPA agrees that there is a limitation to TEF use and that caution should be exercised when using it. More guidance can be found in the Guidance for Conducting Health Risk Assessment of Chemical Mixtures (USEPA, 1999b) and the Health Assessment for 2,3,7,8–Tetrachlorodibenzo-p-dioxin (TCDD) and Related Compounds, Internal Review Draft, February 14, 2000; Part II, Chapter 9: Toxicity Equivalency Factors (TEFs) for Dioxin and Related Compounds (USEPA, 2000b).

C. Cancer

1. Acceptable Risk Level for Carcinogens

Comments—Comments were received suggesting that regulations should be tightened or that AWQC for all carcinogens including the Groups C compounds (possible human carcinogens) should be set at zero, while others believed that cancer potency factors may overestimate actual risk. Some suggested the actual risk may be much lower, perhaps as low as zero, particularly for chemicals for which human carcinogenicity information is lacking. Comments also addressed the EPA cancer risk range for deriving AWQC.

Response—Regarding the permissible cancer risk range, see response to Comment A.3, Cancer Risk Range.

2. ED10 (central estimate) versus LED10 (lower bound on dose)

Comments—Several commenters preferred the use of ED10 over LED10 as the POD or BMD.

Response—The 1999 draft revised cancer guidelines provided a rationale for the selection of PODs. EPA's 1999 draft revisions provide for the use of the LED10. The EPA Science Advisory Board (SAB) suggests harmonization of the LED10 between the BMD approach for noncancer assessments and cancer assessments. The SAB also recommends reporting both the LED and ED (see USEPA, 1999d).

3. Group C Contaminants

Comments—One commenter stated that Group C compounds are treated differently under the SDWA and the CWA and wanted clarification on development of AWQC for Group C contaminants. Also, an ''integrated approach'' was suggested in evaluating nonlinear carcinogen and noncarcinogen assessments. However, the commenter's approach was to determine tentative AWQC for the contaminant as both a noncarcinogen and a carcinogen at 10^{-6} risk, and then choose the lower of the two values (*i.e.,* RfD vs. 10^{-6} risk) for setting the AWQC. Another commenter stated that integrating nonlinear and noncarcinogen assessments proposed by EPA is reasonable and it may be possible to replace this in the future with the categorical regression approach.

Response—The 1999 draft revised cancer guidelines require risk assessors to use the best science and consider mode of action in selecting an appropriate model to use. Under the 1999 draft revised cancer guidelines, Group C will no longer exist. The linear approach is used when there is insufficient information on mode of action, or the mode-of-action information indicates that the dose-response curve at the low dose is or is expected to be linear. The default approach for nonlinearity is to use a margin of exposure analysis. However, when the mode of action suggests both linear and nonlinear approaches, then both methods will be applied and considered. As for the integrated approach, EPA currently is working to increase the harmonization of both cancer and noncancer risk assessments. In the 2000 Human Health Methodology, we will only quantify cancer risks for those chemicals considered ''carcinogenic to humans'' or ''likely to be carcinogenic to humans.''

4. Guidance on Carcinogen Risk Assessment

Comments—Several commenters supported EPA's 1996 proposed cancer guidelines. They endorsed the proposed guidelines for considering all scientific data and using the latest information, including weight of evidence, mode of action, margin of exposure, and a nonlinear approach for certain contaminants. They thought the new approach is more in line with recent advances in understanding carcinogenesis. However, they requested more guidance on how and when to apply the cancer guidelines.

Response—We will provide more guidance when the guidelines are finalized.

5. Hexachlorobutadiene (HCBD)

Comments—Comments stated that EPA should not propose AWQC for HCBD before the 1999 draft revised cancer guidelines are final. Furthermore, for HCBD, there is inconsistency between the statement in the 1998 **Federal Register** (Appendix VI) and that in the example HCBD criteria document.

Response—The Agency is considering the comment and will postpone completion of the AWQC for HCBD until more recent data can be incorporated. In reference to the risk assessment of the chemical, the discrepancy is minor. The 1998 Methodology states that both linear and nonlinear approaches will be used by EPA. The criteria document presents both approaches.

Note: EPA also will postpone completion of the criteria for 1,3-dichloropropene. Because of the large volume of new scientific information available for acrylonitrile, additional effort will be necessary to review the material. Therefore, EPA will not complete the criterion for acrylonitrile at this time. For the same reason, we are not addressing the comments on this chemical at the present time.

6. Integration of Analyses for Cancer and Noncancer Effects

Comments—Commenters supported integration and harmonizing procedures for risk assessment of cancer and noncancer effects in ambient water and drinking water programs.

Response—EPA agrees that it is a good idea to use an integrated approach to assess both cancer and noncancer effects. Currently, EPA has Agency-wide efforts to investigate harmonization of cancer and noncancer risk assessments.

7. Margin of Exposure (MOE) Analysis

Comments—Commenters requested that EPA provide more guidance on how to do MOE analysis and how to select the MOE. They also requested a comparison of the BMD with the LED10.

Response—Guidance will be provided either in the final Guidelines for Carcinogen Risk Assessment or in a separate document from the Agency's Risk Assessment Forum in the future.

8. MOE Approach to Applying Uncertainty Factors (UFs)

Comments—A commenter disagreed with the proposal to apply a UF to account for the severity of a precursor effect. Another commenter opposed applying a UF of no less than 0.1 when humans are less sensitive than animals.

Response—The Agency will develop more specific guidance on the MOE approach, as recommended by the SAB in 1999. The guidance will be peer reviewed and published separately as part of the Agency's implementation activity for these guidelines.

9. MOE and MOP

Comments—Commenters seemed confused regarding MOE and MOP (''margin of protection,'' as defined by a commenter). They defined MOE = MOP = POD/RfD and claimed that the calculated MOEs for chemicals based on nonlinear low-dose extrapolation are 100 times higher than those for carcinogens based on linear low-dose extrapolation, and claimed that the MOE is implicitly linear and, thus, is an inadequate approach to dealing with ''nonlinear'' carcinogens.

Response—There is a significant misunderstanding on the part of the commenters. The MOE is defined as the POD (*i.e.,* NOAEL or LOAEL or LED10) divided by the environmental level of interest (actual exposure or possible criterion). The MOE approach is recommended for chemicals that have a nonlinear low-dose response. For carcinogens with a linear low-dose response, we estimate the slope of the line drawn between zero and the LED10, and use the equation presented in the Methodology to estimate the concentration in water for human heath protection (10^{-6} is the recommended risk level). EPA does not recommend using any formula such as the one presented [*i.e.,* MOE = (POD) /(RfD)] to estimate MOE for carcinogens with a linear low-dose response.

10. Oral Scaling Factor for Dose Adjustment

Comments—Several commenters endorsed EPA's use of the body weight raised to the three-quarters power as the scaling factor. It was also suggested that, if available, chemical-specific data should take precedence over the generic default scaling factor.

Response—EPA agrees.

11. Toxic Endpoints

Comments—A commenter stated that EPA should make clear in its Methodology that it intends to take into consideration the toxic actions of the individual chemicals for which criteria are being established so that an appropriate target population and consumption rate can be selected. The commenter suggested that if the critical toxic endpoint of a chemical is cancer or other chronic disease, then use of the adult population and long-term consumption rates are appropriate to develop the AWQC. However, if the most sensitive toxic endpoint of a chemical of interest is acute reproductive effects, it may be more appropriate to use short-term consumption rates and exposure parameters that are relevant for women of childbearing age in developing the AWQC.

Response—EPA agrees.

12. Weight-of-Evidence Narrative and Classification System

Comments—A commenter expressed support for the use of narrative statements, but found the guidance on the weight-of-evidence narrative to be overly general and confusing. They suggested that some sort of classification system such as the alphanumeric should be retained. They also stated that without such a system, practical use of the weight-of-evidence approach will be more difficult, particularly for States that do not have strong expertise and sufficient resources in the application of health-based risk assessment.

Response—Current revisions to the cancer guidelines and the use of descriptors and narratives have been endorsed by the SAB and other commenters and will be included in assessments and final guidelines because they provide important information to the risk manager that a number or letter cannot convey.

D. Noncancer

1. Benchmark Dose Methodology

Comments—Commenters supported the flexibility of having the NOAEL/LOAEL/UF, categorical regression, and benchmark options for derivation of an RfD but pointed out a variety of concerns or factors for EPA to consider as it revises the BMD guidance.

Commenters suggested that the BMD methodology will eventually have a prominent role in risk assessment, but checks and balances need to be set to ensure that it is applied intelligently and with a healthy scepticism for its results, especially those that vary significantly from the results of the conventional NOAEL/LOAEL approach. The following specific recommendations were presented for EPA's consideration:

- Prohibit extrapolations without some mechanistic foundation. Permit interpolation only within the experimental dose range, for example, between NOAELS and LOAELS.
- Present a range of BMD estimates from the use of multiple-dose models, including models with thresholds just below LOAELS; estimates with the high-dose results dropped sequentially from the analysis; and multiple response rates (*i.e.,* 1%, 5%, and 10% response rates as well as the response rate associated with the experimental detection limit).
- Estimate the BMD using several confidence bounds.
- Compare the results of the alternative modeling approaches and reconcile discrepancies.

Other comments are summarized in the following paragraphs.

The BMD methodology lacks a mechanistic basis. There is no connection between the mechanisms of action that underlie the observed responses. Because the methodology is devoid of a mechanistic basis, its use needs to be restricted to the observable range. Extrapolations below the lowest nonzero dose of a study have no scientific foundation. However, it is acknowledged that some extrapolation of the data below the observable range is inevitable.

An additional critique was that high-dose effects influence low-dose estimates. The curve fitting involved in estimation of the mathematical dose-response relationship permits the responses at the high end of the dose range to influence the estimated responses at the low end of that range. This will occur whether or not the high-dose observations are mechanistically related to the responses at low doses. Furthermore, response and dose estimates are model dependent. In some cases, both central estimates and lower-bound estimates of doses associated with various response rates are known to be highly unstable and fluctuate significantly in response to minor data manipulations or assumptions.

More research is needed on implementation of the benchmark model. Guidelines for selecting appropriate models/benchmark responses, handling lack of fit, or selecting a single benchmark dose when more than one is calculated should be developed by EPA to assist States and other users in implementing this methodology.

The central estimate rather than the lower bound on dose should be used as the POD for benchmark modeling. Such an approach provides greater opportunity to compare effect doses among chemicals. Uncertainty associated with wide confidence limits

can be accommodated in other portions of the risk assessment process. Furthermore, the most recent peer review of the BMD methodology (USEPA, 1996c) recommended use of the ED10 rather than the LED10.

Use of the benchmark model could introduce additional conservatism into the derivation of an RfD. Certain benchmark models as applied to developmental toxicity endpoints are substantially more conservative, on average, than the corresponding NOAELs. Using the benchmark approach in such a circumstance will introduce additional unjustified conservatism in the standard-setting process.

Caution should be taken when using different methods for RfD determination; that is, the degree of human health protection should be comparable from different methods. Because the BMD and categorical regression are relatively new methods, more studies are needed to compare the RfDs derived using the typical NOAEL/UF approach and those derived using the BMD and categorical regression methods.

EPA should closely coordinate adopting BMDs for noncancer endpoints under the Human Health Methodology with other Agency programs so that the policy is implemented identically throughout the Agency. However, because the benchmark approach makes better use of all data, the Agency should continue to work on its development.

Response—EPA agrees with the concerns regarding widespread application of the benchmark approach without consideration of the many factors addressed by commenters. The AWQC guidelines do not prescribe use of the benchmark approach in the derivation of an RfD. The guidelines allow the use of either the NOAEL/UF, benchmark, or categorical regression approaches. The risk assessor can select the approach most suitable to the available data. Accordingly, if the data do not support derivation of a BMD, then the NOAEL/UF approach can be selected for the RfD derivation rather than the benchmark approach. In addition, when selecting the appropriate equation for derivation of the BMD, one should consider goodness-of-fit along with the impact of high doses on the model results, confidence interval domains, and consistency of the dose-response pattern with the mode of action.

We do not anticipate that either of the new approaches, benchmark or categorical regression, will soon completely replace the NOAEL/UF approach. Both of the new approaches require more extensive data than the NOAEL/UF approach, and in many cases the data required to apply the methodology will not be available.

EPA is developing technical guidance that will assist in determining whether or not a particular data set is compatible with the BMD approach. Use of BMD methods involves fitting mathematical models to dose-response data obtained primarily from toxicology studies. When considering available models to use for a BMD analysis, it is important to select the model that best fits the data and is the most biologically appropriate. EPA has developed software following several years of research and development, expert peer review, public comment, subsequent revision and quality assurance testing. The software (BMDS, Version 1.2) can be downloaded from *http://www.epa.gov/ncea/bmds.htm.* BMDS facilitates these operations by providing simple data-management tools, a comprehensive help manual and online help system, and an easy-to-use interface to run multiple models on the same dose-response data.

As part of this software package, EPA has endorsed sixteen (16) different models that are appropriate for the analysis of dichotomous (quantal) data (Gamma, Logistic, Log-Logistic, Multistage, Probit, Log-Probit, Quantal-Linear, Quantal-Quadratic, Weibull), continuous data (Linear, Polynomial, Power, Hill) and nested developmental toxicology data (NLogistic, NCTR, Rai & Van Ryzin). Results from all models include a reiteration of the model formula and model run options chosen by the user, goodness-of-fit information, the BMD, and the estimate of the lower-bound confidence limit on the benchmark dose (BMDL). Model results are presented in textual and graphical output files which can be printed or saved and incorporated into other documents.

2. Categorical Regression

Comments—Commenters expressed reservations regarding use of the categorical regression methodology. They stated that the methodology presents difficulties in that it requires distinction of diverse endpoints and definition of severity categories, not as they apply to the animal studies, but as they apply to human health effects. Commenters also stated that categorical regression would allow the Agency to consider several endpoints simultaneously rather than use data for only the most sensitive endpoint. Some commenters believed that the major limitation of the approach is the need for classifying effects into categories (mild, moderate, frank).

Other commenters believed regression analysis offers attractive advantages but does not seem well enough developed at the present time to be incorporated into the Methodology. They suggested that because the approach makes better use of all data, the Agency should continue to work on its development. They also stated that when the data indicate that one of the new methodologies is clearly superior to the NOAEL/LOAEL/UF approach, it should be utilized.

Response—As stated in the response on BMD above, EPA does not anticipate that either of the new approaches, benchmark or categorical regression, will soon replace the NOAEL/UF approach. Both new approaches require more extensive data than the NOAEL/UF approach, and in many cases the data required by the methodology will not be available. We agree that the categorical regression methodology is less well developed than the benchmark method. However, we also anticipate that the number of chemicals evaluated with this approach will grow over time. Including the categorical regression methodology among the available options in the 2000 Human Health Methodology provides an opportunity for its application in appropriate situations.

3. Integrated Approach

Comments—Commenters stated that an integrated approach to assessing both cancer and noncancer effects for substances that are carcinogenic has merit, particularly when the systemic effects of concern occur at very low doses. However, they believed it is unclear how the nonlinear cancer assessment and the noncancer assessment would differ if the tumors were considered secondary to the systemic toxicity upon which the RfD is based. They stated that such considerations become more important when the systemic toxicity is unrelated to tumor formation, as in the case of lead and mercury. Some indicated that because EPA recommends different design flows to account for exposure scenarios that are appropriate for carcinogenic and systemic effects, the Methodology should develop and adopt similar criteria for both carcinogenic and systemic effects when appropriate. Some further stated that for some waters and pollutants, it will not become clear whether the systemic or carcinogenic criterion is more protective until the limits are developed using the different design flows. This was not previously a concern because a single human health design flow was used in most locales.

Response—The 2000 Human Health Methodology is not a stand-alone methodology. It depends on established or proposed Agency risk assessment guidelines for cancer and noncancer endpoints. We do not have the latitude to change Agency-wide risk assessment guidelines through the AWQC Methodology. Any changes must first be made to the supporting documents (*e.g.,* 1999 draft revised cancer guidelines, RfD methodology).

4. Integrated Risk Information System (IRIS)

Comments—Concern was expressed that EPA does not update the IRIS files in a timely manner. States use these assessments for their risk assessment work and do not have the resources to perform the types of detailed consensus risk assessment done under the IRIS process, according to comments received. They additionally pointed out that many IRIS assessments are more than 10 years old and suggested that EPA should update these assessments on a 3- to 5-year cycle.

Response—We realize the importance of the IRIS program and dedicate a portion of our resources to preparation of IRIS documentation for regulated chemicals. However, competing priorities throughout the Agency limit the effort that can be expended on IRIS by program offices and by the IRIS program.

5. NOAEL/LOAEL Approach

Comment—A commenter called attention to the facts that the NOAEL/LOAEL/UF approach is the current approach for establishing an RfD and that many present regulatory values are based on this approach. They stated that use of newer techniques that account for severity of effects and sample size seems reasonable, as long as the new techniques have been extensively reviewed and have wide acceptability among practitioners. However, the commenter also said that in some cases, the data needed to use the newer techniques may not be available, in which case it seems entirely appropriate to use the NOAEL/LOAEL approach as a default.

Response—See our responses to Comments D.1 and D.2, the benchmark dose and categorical regression comments, respectively.

6. Nonthreshold Approach for Noncarcinogens

Comments—The Agency requested comments on the suitability of using a nonthreshold approach for noncancer endpoints. Although open to the concept, commenters stated that a threshold should be considered the norm and a nonthreshold approach should be applied only if there are substantial scientific data supportive of a nonthreshold mechanism of toxicity. They stated that when receptor interactions are a component of the response, it is important that EPA differentiate between the receptor binding that might be without a threshold and subsequent biological responses such as enzyme induction or frank toxicity that would be expected to exhibit threshold dose-response relationships.

An additional concern was the use of nickel as an example of a chemical without a threshold. It was pointed out that double-blind studies indicate that there is a threshold for dermatological responses to nickel even in sensitized individuals.

Response—The Agency made modifications to the recommendations regarding a threshold approach for noncarcinogens, most specifically using lead as an example rather than nickel. We incorporated the commenters' suggestions in making the revisions.

7. RfD Range

Comments—The concept of establishing a range around the calculated RfD from which an alternative RfD might be selected in certain circumstances received considerable comment from the public. The primary criticism was the lack of a scientific basis for the breadth of the range and its correlation to the net uncertainty factor/modifying factor (UF/MF) product. The comments are summarized below.

The span of the range as described by EPA seems to be arbitrary and without any scientific support. It would be useful for the Agency to analyze a substantial number of past RfD determinations using the ranges the Agency has proposed to see whether they make practical sense. The Agency should provide more examples on how the factors that are to be considered in selecting a point within the range (i.e., bioavailability differences, sensitive populations, and slope of the dose-response curve) are related to the magnitude of the proposed range. Scientific data should be gathered and presented to support the use of these factors in influencing the range.

The Agency should give serious consideration to the possibility that the ranges of uncertainty surrounding the point estimate are not symmetrical. In particular cases, it may well be that most of the RfD uncertainty is on the high side of the point estimate.

The proposal to use a range is inconsistent with the purpose of the RfD. The proposal to use a range rather than a point value for the RfD would lead to the potential for double counting uncertainty. The UFs and MFs presently applied in calculation of the RfD allow for many of the factors that are presented as justifying selection of a point within a range as an alternative to the calculated RfD.

The range for the RfD would create more problems than it would prevent. The RfD, by nature, cannot be used to calculate the risk at a given level of exposure and is essentially a safety estimate that should be expressed as a single point estimate. The definition of the RfD recognizes the uncertainty in this assessment. The proposed approach would be difficult to implement, create unnecessary confusion and controversy regarding the RfD, and could result in prolonged unproductive debates between parties with differing interests.

If EPA chooses to define a range, the range should be developed by the scientists undertaking the RfD development. If a range is used, it is also strongly recommended that it be accompanied by detailed guidance on the factors for choosing a point estimate within the range. The uncertainty surrounding the point estimate of an RfD will be different for each chemical and study and should be clearly stated in any revised RfD.

An advantage of the range is that it would make more apparent to States the uncertainty in the RfD and the flexibility that now exists surrounding its use in the regulatory context. However, it is preferable to retain the presentation as a single point value but provide in accompanying text substance-specific information such as steepness of the dose-response curve that States can use in deriving standards based on other than the default single point RfD.

A range is useful to a risk manager or other decision-maker because actions can be taken with greater confidence in how likely it is that adverse health effects will be manifest at a particular point concentration. For example, slightly exceeding the MCL of 1 mg/L for nitrite with a UF of 1 is more likely to result in adverse health effects upon exposure than slightly exceeding a guideline of 70 μg/L for MTBE with a UF of 10,000.

Some of the factors EPA recommends in selecting a point within an RfD range should be used in determining the RfD itself rather than for deviating from it after it is derived. These include the seriousness and reversibility of the effect, whether it is based on a LOAEL,

and bioavailability within humans. The issue of considering the presence or absence of sensitive segments of the population is impractical and inappropriate in deriving an ambient water quality standard. EPA should delete this option and understand that States generally set water quality standards on a statewide level. It is impractical to ascertain whether infants or pregnant women live near and consume fish or water from a particular waterbody. It is not practical from an administrative standpoint to set different, separate standards for each waterbody.

The Agency should provide guidance regarding the development of scientific rationales for departure from the default RfD. The Agency should provide a methodology for deriving the range, along with supporting examples, and subject that methodology to peer review before using the concept in developing AWQC.

Response—EPA agrees that the method used to quantify the range from which an alternative to the calculated RfD can be chosen is not based on specific scientific or statistical data. It is purely an equal partitioning of a default, 10-fold uncertainty factor into four equal quarter log segments.

It is important to note that the range around the calculated RfD only establishes a domain from which a risk assessor can select a single point to use as an alternative to the RfD for a specific circumstance. The 2000 Human Health Methodology criteria for using a point within the range other than the calculated RfD when calculating AWQC clearly require the State to provide a detailed justification for that decision.

One example of a situation where a point other than the calculated RfD might be applied would be where there is a difference in the bioavailability of the contaminant in the water component of the AWQC as opposed to the fish component. In such an instance, the decreased bioavailability from fish tissues could be used to support selection of an alternative value greater than the calculated RfD if the critical study were one where the contaminant had been administered through drinking water. Most inorganic contaminants, particularly divalent cations, have bioavailability values of 20 percent or less from a food matrix, but are much more available (about 80 percent or higher) from drinking water. Accordingly, the external dose necessary to produce a toxic internal dose would likely be higher for a study where the exposure occurred through the diet rather than the drinking water. As a result, the RfD from a dietary study would likely be higher than that for the drinking water study if equivalent external doses were used.

The exposures considered in deriving AWQC include fish (food) and water. Thus, one might be able to justify an alternative value to the RfD point estimate that was slightly higher than the RfD estimate in cases where the NOAEL that was the basis for the RfD came from a drinking water study, but slightly lower than the RfD estimate if the NOAEL came from a dietary study.

Several commenters suggested that there would be value in applying the range concept to several relevant RfD values and then to evaluate the results. The range concept was considered in the peer review of the 1998 draft Methodology revisions, and the peer reviewers had many of the same concerns regarding the range. The revised Risk Assessment TSD gives examples of how one could justify an alternate RfD value that was lower or higher than the RfD estimate.

8. Severity of Effects

Comments—Several commenters supported consideration of severity of effects in determining AWQC, although there was considerable diversity in the opinions expressed, as follows.

Some believed that there was no science behind use of different UFs (*i.e.,* 3, 10) in making intraspecies decisions based on severity of effect. Some stated that EPA should provide a methodology that will define a severity scale prior to adopting use of severity in deriving RfDs and associated AWQC. Others commented that the severity scale could be alphanumeric, similar to that used for carcinogens under the EPA 1986 cancer guidelines, and the severity rating could be presented along with the RfD value. However, any severity scale must also consider whether it is consistent with the definition of an RfD as a dose below which no adverse effects are anticipated to occur in exposed populations.

Other commenters believed that making adjustments in the RfD value for severity of effects only confounds regulatory policy with toxicological science, and the Agency should explore alternative approaches to the problem of differences in severity of various toxicological endpoints. The Agency should not have considered severity in calculating an RfD because this practice could result in double counting of uncertainty. Severity should be considered in selection of a UF only when the RfD is based on a LOAEL. If the NOAEL were used, concerns for severity should be reflected in the MF.

Response—There are several situations in which EPA has considered the severity of effect in selection of the UF. The Risk Assessment TSD cites zinc as an example. The LOAEL used in establishing the RfD for zinc was a change in the activity of the enzyme superoxide dismutase. This effect compromises the ability of the individual to avoid damage to macromolecules, such as proteins and polynucleotides, in the presence of free radical oxygen. Although clearly adverse, this effect is not as severe as tissue necrosis or impaired organ function. Thus, a UF of 3 was used rather than the default of 10 for the adjustment of a LOAEL to a NOAEL. The nutritional requirements for zinc relative to the RfD supported the use of a UF of less than 10 in this instance.

As monitoring of molecular biomarkers of toxicity increases, the number of situations will most likely increase in which a LOAEL is early enough in the progression toward overtly adverse effects that factors of less than 10 can be used for the RfD calculation and will be supported by mode of action data. Past EPA practice is consistent with the suggestion that severity be considered where the RfD is based on a LOAEL and that an MF be used, if the data warrant, when calculating from a NOAEL.

We do not believe that establishing a scale for severity is necessary at this time. It would be extremely difficult to establish a scale for rating toxicological endpoints that could be easily applied to the spectrum of endpoints monitored in more recent toxicological studies. The present flexibility in UFs and MFs provides ample opportunity for severity adjustment.

9. Stochastic Modeling

Comments—Commenters encouraged EPA to use a stochastic approach (Monte Carlo and/or Latin square modeling) for setting RfDs. The commenters stated that this would allow EPA to better ''quantify the uncertainties and separate them from the variability in the data.'' They believed such methods would provide a sounder, more quantitative approach to determining whether a range of RfD values is needed.

Response—The guidelines for determination of the RfD are based on previously published, Agency-wide guidelines. The suggestion to use a stochastic approach has been noted and will be considered in the context of the Agency revisions to its risk assessment guidelines. Revisions to fundamental Agency guidelines are beyond the scope of the AWQC Methodology.

10. Synergistic Effects

Comment—Several commenters encouraged the Agency to consider multiple exposures to various chemicals and persistent bioaccumulative toxicants when establishing AWQC. For substances that do not persist or bioaccumulate in the environment, or do not cause reproductive, developmental, or neurological effects, EPA's risk assessment methodologies were deemed in need of reconsideration. However, as part of the reconsideration, EPA was asked to apply best science on synergistic impacts from exposures to a combination of chemicals. Other comments suggested sensitive subpopulations, such as Native American Tribes and other susceptible populations, may have significant confounding, underlying health problems that must be recognized with any synergistic assessment.

Commenters also stated that EPA should give specific attention to certain categories of contaminants: persistent organic pollutants and endocrine disruptors. The commenters identified two aspects to consider in applying this recommendation: (1) Individual contaminants with a similar mode of action whose cumulative effects may reach an unacceptable level; and (2) selection of specific biologic endpoints to use as the basis of an RfD. They also believed that tissue effects are valid measures of injury and should be used in addition to organ-level effects in people and biota. It was also considered important to include immunological, reproductive/developmental, and neurological effects to derive RfDs.

Response—The Risk Assessment TSD encourages States to consider synergistic and additive effects of individual chemicals in mixtures when establishing AWQC. The HI approach is suggested and described for situations where the chemicals have the same effect by similar modes of action. The Risk Assessment TSD also acknowledges that methods are not presently available for evaluating risk from mixtures where the individual chemicals have dissimilar health effects and recommends that chemicals in such mixtures be evaluated individually. Specific recommendations are found in EPA's Draft Guidance for Conducting Health Risk Assessment of Chemical Mixtures published in May 1999 (USEPA, 1999b).

The 2000 Human Health Methodology accommodates concerns regarding persistent bioaccumulative toxicants primarily through use of bioaccumulation factors in the calculation. Situations in which ambient waters may contain a group of chemicals that are persistent and bioaccumulative and have additive or synergistic effects can in some cases be factored into the HI approach. The description of the treatment of mixtures in the TSD was expanded to encourage States to consider persistence, bioaccumulation, and mixtures concerns in their risk assessments. The references to Agency mixtures guidelines were updated to include the most recent draft of the mixtures guidelines.

11. Target Population Adjustments

Comments—EPA was asked to consider the characteristics of the target population when determining AWQC. Commenters suggested that when the chemical is a carcinogen, it is appropriate that the target population consist only of residents of the United States. In cases where the effect is an acute reproductive effect, the commenters believed it is appropriate to specify adult women as the target population and to use short-term consumption rates and exposure parameters.

Response—The default input parameters for determining AWQC for human health apply to lifetime exposures and the adult population of the United States. However, the equations used for the calculation provide the flexibility to use body weight, water intake, and fish intake parameter values that are specific to other target populations.

12. Uncertainty and Modifying Factors

Comment—Additional guidance was requested on factors to consider in selecting UFs, particularly a UF for an incomplete database.

Response—In revisions to the Risk Assessment TSD for the 2000 Human Health Methodology, we increased the number of examples given to illustrate how UFs were selected in establishing RfDs included in the IRIS.

Comment—The suggestion was made to replace the interspecies UFs with a body weight to the three-quarters power and thereby harmonize the cancer and noncancer approaches.

Response—The peer reviewers of the 1998 draft Methodology revisions also suggested harmonizing the cancer and noncancer approaches with regard to the use of the body weight to the three-quarters power. This can be accomplished only through changes to the Agency documents on which the methodologies presented in the 2000 Human Health Methodology are based. The Agency currently is working on harmonizing the cancer and noncancer methodologies.

In addition, as pointed out by the peer reviewers, a body weight to the three-quarters power conversion adjusts for allometric differences between laboratory animals and humans. It does not reflect toxicodynamic differences between species that must still be included when adjusting for interspecies differences. The use of the scaling factor cannot totally replace the interspecies UF.

Comment—Another comment requested EPA to adopt more rigorous quantitatively supportable methods such as PBPK models to replace the more arbitrary and less well founded use of numerical scaling factors identified in UFs and MFs.

Response—The revisions to the Methodology clearly support use of toxicokinetic modeling when the data are available and use of the modeled data in lieu of the toxicokinetic portion of the interspecies UF.

13. Use of Less-Than-90-Day Studies in Determining an RfD

Comments—In general, commenters agreed with the scientific review board that false-negatives might result from use of less-than-90-day studies to develop an RfD. It was suggested that EPA evaluate data sets for groups of chemicals for which there are both chronic and less-than-90-day studies and compare RfDs. Any comparison of chronic and less-than-90-day studies should consider the purpose for which the less-than-90-day studies were conducted and whether they provide evidence relevant to the results of longer term experiments. A commenter agreed with the scientific review board that any RfD based on a less-than-90-day study should be used only temporarily.

Other comments pointed out that the Great Lakes methodology allowed use of less-than-90-day studies for determining an RfD but required a duration UF of 30 rather than 10. This factor when combined with a 10 for intraspecies variability and a 10 for interspecies variability would yield a total UF of 3,000, the maximum that is said to support RfD derivation. The commenter believed very few situations would qualify to use less-than-90-day studies, but their use should be allowed as long as the total UF is 3,000 or less.

Additional comments stated that reproductive, developmental, immunotoxicological, and neurotoxicity data provide an appropriate basis for determining an RfD even if they come from studies of less-than-90-day duration. However, one commenter also urged that data must be collected using

methods of sufficient accuracy and validity. It was also emphasized that evaluations should be conducted to determine how dose-response relationships developed for these toxic effects, particularly immunotoxicity, are related to modifications in function and evidence of overt pathology.

Response—In several instances, the Agency has developed an RfD based on data from studies of less-than-90-day duration (*e.g.,* nitrite, zinc), particularly where the data were from humans and evaluated endpoints of chronic as well as acute significance. Data from less-than-90-day studies of reproductive, developmental, immunotoxicological, and neurotoxicity data are also considered appropriate for an RfD if they identify the critical effect. However, such data are used for RfD determination only when supported by a rather complete database and a good understanding of the mode of action. The Agency does not use data from less-than-90-day studies purely because they are the only available data. When the database is inadequate to support an RfD determination, no RfD is calculated.

E. Exposure Assessment

Default Intakes

1. Assumption That All of the Drinking Water Consumed Is Contaminated at the Criteria Level

Comment—A commenter questioned the assumption that all drinking water consumed has been contaminated to the maximum extent allowed by the criteria.

Response—Refer to response on this same issue for Comment E.2, Assumption That All Fish Consumed Is Contaminated at the Criteria Level.

2. Assumption That All Fish Consumed Is Contaminated at the Criteria Level and All Fish May Come from One Waterbody

Comments—Commenters questioned the assumption that all fish consumed have been contaminated to the maximum extent allowed by the criteria. They state the assumption that all of the 17.8 g/day (now 17.5 g/day) could come from one source is unrealistic, and that EPA should specify ways to adjust the fish intake rates to reflect a *contaminated fish* consumption rate.

Response—As required under Section 304(a) of the CWA, EPA develops water quality criteria that reflect the latest scientific knowledge on effects of pollutants on human health. The Agency's recommended 304(a) water quality criteria are used by States and authorized Tribes to adopt enforceable water quality standards including designated uses of a waterbody consistent with Section 101(a) of the CWA (*e.g.,* fishing, swimming, propagation of aquatic life, recreation). In developing the 2000 Human Health Methodology, we have made assumptions about exposure to contamination from eating fish taken from surface waters of the United States. The purpose of the assumptions is to ensure that if criteria are met in a waterbody designated with the uses specified in Section 101(a) of the CWA, fish consumers can safely eat fish from that waterbody. In addition to the assumption that 17.5 g of fish are consumed per day based on the most recent U.S. Department of Agriculture (USDA) survey data (a value reflecting the 90th percentile of the general population), EPA also assumes that fish and shellfish are taken from water with pollutants present at the criteria level. In order to ensure that people can safely eat fish from waters designated with Section 101(a) uses, it is necessary to assume that all of the consumed fish is taken from waterbodies at the criteria level (*i.e.,* contaminated to the maximum safe level).

We recognize that fishing patterns (*i.e.,* extent and location of fishing) and the degree to which fish and shellfish bioaccumulate contaminants from waters across the United States may differ from the exposure assumptions used to calculate national 304(a) water quality criteria. However, the degree and frequency of such variation are not clearly known, and these potential differences do not relieve EPA from its CWA obligations to develop national water quality criteria (which States and authorized Tribes may modify) that are protective for the general population. Furthermore, we note that not all of these differences would lead to less restrictive (higher) AWQC. For example, some subpopulations may consume fish at a higher rate than the 17.5 g/day assumed in the national 304(a) criteria, and bioaccumulation might occur to a higher degree than the central tendency assumptions used in calculating the national default BAF. As indicated above, EPA believes that the data do not exist to enable us to account reliably for the myriad of spatial and temporal differences in fishing patterns and bioaccumulation and subsequent differences in exposure to fish contaminants at the national level. In addition, we have not received information from any stakeholder that would allow us to make such fine distinctions. Our goal is to ensure that populations who rely on a particular waterbody as the predominant source of their fish and shellfish are adequately protected, thus protecting the designated use of that waterbody. For these reasons, we believe that these assumptions are appropriate for the development of 304(a) criteria. Where States and Tribes have concerns regarding the level of protection afforded by EPA's national 304(a) criteria, we encourage States and authorized Tribes to make appropriate adjustments to reflect local conditions affecting fish consumption and bioaccumulation. Guidance for making such modifications is provided in the 2000 Human Health Methodology.

3. Body Weight Assumptions

Comments—Numerous comments were submitted on issues regarding the adequacy of the body weight default values recommended in the 1998 draft Methodology revisions and what age-based body weight categories are appropriate. Several commenters stated the proposed default body weights were appropriate and that the 70 kg default for adults is appropriate. One commenter stated that the difference between 70 kg and the 65 kg value for women of childbearing age is so small that to distinguish between the two is unimportant. Another believed that the recommended children's body weights are sufficient and that finer age categories would not be useful at this time. However, other commenters addressed the potential need to use finer age-category body weights if it is known that the adverse health endpoint affects a particular age group sensitive at that developmental stage, and one commenter stated that the broad-age default (*i.e.,* for 0- to 14-year-olds) would be inappropriate for an infant. Another commenter pointed out that the default assumption for children ages 1 to 3 (*i.e.,* 10 kg) is too low compared with data from EPA's Exposure Factors Handbook. Other comments advocated that EPA specifically define the percentile value associated with the defaults or recommended that EPA not specify default body weights for children.

Response—We believe it is useful to provide default parameters for various population groups of concern, where possible, and have received support for this from States and from the recent peer review workshop panel. The difference between the general adult default body weight and the weight for women of childbearing age is statistically significant and, therefore, we are providing this value for situations where the critical health endpoint is an *in utero* developmental effect. All parameters used for an exposure evaluation should reflect the specific population group of concern.

As stated in the 1998 draft Methodology revisions, EPA has not provided finer age group defaults for children because the fish intake data do not permit breakouts other than the broader age category. However, in spite of this limitation, we have included finer age group body weights for State and Tribal use (when they have local or regional fish intake data that allow for their use) in the Exposure Assessment TSD. In most cases, we have indicated the specific percentile from each data source for the default value chosen (based on the surveys used and not in the context of the total population because data are not available to conclusively describe the entire population), but we have clarified this in the 2000 Human Health Methodology. Associating a derived criterion with a specific percentile is not possible because such a quantitative descriptor would require more detailed distributional exposure and dose information than is available.

EPA acknowledges that the proposed value of 10 kg for a child ages 1 to 3 is lower than the values reported in the Exposure Factors Handbook (USEPA, 1997a). The 2000 Human Health Methodology uses default body weight values based on the more recent NHANES III data. Contrary to the one commenter's suggestion, the data were not chosen to overestimate exposures; we intended to choose the average body weight as a default. In all cases (*i.e.,* for the adult, childbearing woman, children aged one to ten, and infant/toddler categories), we chose average (mean) body weight values as defaults and do not believe these are overly conservative.

4. Combining Consumption Intakes and Body Weights

Comments—Several commenters stated that when possible or where appropriate, the intake values and body weight data should be combined to generate a ratio/correlation of consumption to body weight, in order to provide better estimates. One commenter requested that EPA consider deriving a 95th percentile value of the water consumption to body weight ratio as the basis for the national 304(a) criteria. However, the opposite opinion was also expressed; that is, several commenters supported the use of separate parameters in the derivation equation. One commenter stated that, based on mean intake and body weight rates in EPA's Exposure Factors Handbook, differences in fish and water intakes between pregnant women and adults in general are so insignificant that they are not worth distinguishing. Opinion was also expressed that differences in intake rates per unit body weight can be more significant for children. EPA was cautioned to make sure that if differences in body weight are considered for different age groups, then the variation of intake by each specific group also needs to be considered.

Response—EPA agrees that the intake rates and body weights for the specific population groups should match (*e.g.,* a body weight for women of childbearing age should be matched with a drinking water intake assumption for women of childbearing age). However, we believe that the exposure parameter choices should be based on the population of concern, regardless of how small the change in the resulting criterion might be compared with a general adult population default. We also believe that there is not always a direct relationship between consumption and body weight. When EPA presented the issue for review by the Agency's SAB, they provided the following advice:

> In theory it would be better to develop standards on a per kilogram body weight basis. However, in practice the results are not different enough to make much difference in the magnitude of AWQCs. In particular, data should not be rejected because individual body weights are not available, and funds should not be allocated for collecting such data since no conceivable benefit would accrue.

EPA has also received input from its State stakeholders regarding potential confusion over combining the two parameters. Most believe that the difference in accuracy is negligible but that the difficulty in associating the units of mg/kg-BW/day with a meal size, especially for public communication and understanding, is great and, therefore, not particularly useful. Several stakeholders believed that if the data were combined as part of a study, or if a strong, demonstrated correlation between intake and body weight exists, the combined parameter should be used. We have evaluated recent information on both drinking water intake and fish intake from the 1994 to 1996 CSFII data and have assessed the differences between the two units of measure—including an emphasis on the differences that result with smaller age categories and drinking water consumption rates for children when mL/kg-BW/day are used (USEPA 2000c,d). [**Note:** SAB's comment on the unavailability of individual body weights is not an issue with the CSFII; that is, this information is available.] EPA intends to base its national 304(a) criteria on the separate intake values and body weights because of the strong input received from its State stakeholders. However, we have also provided tables in the final Exposure Assessment TSD of all fish/population categories for both g/day and mg/kg-BW/day, if States or Tribes prefer their use. The TSD will also provide examples on deriving criteria using either, including identifying situations where the latter estimate may provide substantively more accurate estimates. Additionally, the TSD will provide tables listing comparable values in mg/kg-BW/day (fish) or mL/kg-BW/day (drinking water).

5. Combining Fish Intake and Body Weights

Comments—Several commenters recommended the use of separate fish intake and body weight assumptions because of clarity, familiarity among the States, and data availability. Specifically, the option of combining these values was not considered practical because most studies do not provide such information, even if potentially more accurate. Furthermore, it was suggested that this complicates the derivation process or introduces error (an example was cited), and States and Tribes have the flexibility to use intake values other than the default values provided. Another commenter stated that there is a direct proportional relationship between fish consumption and body weight and that selection of the 90th to 95th percentile value of fish consumption per unit body weight is an appropriate basis for deriving the criteria.

Response—EPA agrees that the use of separate fish intakes and body weights is more easily understood and provides reasonable and protective default estimates. For additional discussion, see our response to Comment E.4, Combining Consumption Intakes and Body Weights. We do not agree that there is necessarily a direct relationship between fish intake and body weight, especially in the context of intake on a per-unit-body-weight basis.

6. Default Drinking Water Intake Rates

Comments—One commenter stated that EPA has overestimated the amount of untreated surface water consumed by the population. However, another commenter believed that the 2 L/day rate is reasonable. A commenter stated that drinking water intake rates in hot, arid climates may be higher than the recommended default rate. Numerous commenters stated that incidental water ingestion should not be considered in deriving AWQC or that it is unimportant. One called for empirical data to support its use and believed that

EPA has implied that incidental ingestion occurs every day. However, other commenters believed that this route should be considered for waters not designated as drinking water sources. One of these requested that EPA provide additional guidance on incidental ingestion relevant to acute toxicity and exposures. Another recommended that EPA evaluate the circumstances to determine whether the incidental ingestion rate would make a difference. A commenter recommended that EPA use a 30 mL/hour assumption in cases where short-term effects may be considered in criteria derivation. One commenter stated that the 10 mL/day value would be too restrictive for use in all nonpotable waterbodies and would conflict with existing State guidance on incidental ingestion.

Response—EPA acknowledges that much of the population consumes water from public water supplies that receive treatment. However, we intend to continue including the drinking water exposure pathway in deriving AWQC for the reasons clearly stated in the 1998 draft Methodology revisions. Refer to that discussion for clarification on this issue [see **Federal Register** Notice, August 14, 1998; Appendix III, C.1.(b)]. We encourage States and Tribes to use alternative intake rates if they believe that water consumption is higher in arid climates than the recommended default rate. We have not assumed that incidental ingestion occurs every day. We have estimated an averaged rate based on available study information. When initiating the process to revise the methodology, several stakeholders identified recreational or accidental water ingestion as a potential health concern. A couple of States have indicated that they already have established incidental ingestion rates for use in developing water quality criteria. EPA agrees that the averaged amount is negligible and will not have any impact on the chemical criteria values representative of both water and fish ingestion. The lack of impact would likely also be true for chemical criteria based on fish consumption only, unless the chemical exhibits no bioaccumulation potential. However, we believe that the issue could be important for the development of microbial contaminant water quality criteria, and for either chemical or microbial criteria for States where recreational uses such as swimming and boating are substantially higher than a national average would indicate. Although we will not use the incidental ingestion intake parameter when deriving our 304(a) national chemical criteria, we will leave the guidance language in the final Exposure Assessment TSD in order to assist States and authorized Tribes that face situations where this intake parameter would be of significance.

7. Default Fish Intake Rates

Comments—EPA received strong support for its hierarchy of preferences regarding fish intake values; that is, use of local or regional studies, and studies characterizing similar populations and/or geography, over default values. EPA also received support for encouraging decisions on intake rates to be made at the State or Tribal level. EPA generally received support for its default fish consumption rates, including the national 304(a) criteria value of 17.8 g/day (now 17.5 g/day based on the 1994–96 CSFII data). There was support for the new default rates as more accurately representing current levels of fish consumption among the general population than the old assumption of 6.5 g/day. Support was also received for providing the variety of default values to protect highly sensitive or highly exposed population groups. One commenter advocated that EPA clearly state that using the 90th percentile value is a risk management decision. However, others stated that EPA has overestimated fish consumption for the population at large. A commenter stated that EPA should use the intake value that its Superfund program utilizes (*i.e.*, 54 g/day). EPA also received support for the default of 86.3 g/day for subsistence fishers (now 142.4 g/day based on the most recent USDA survey data). Some commenters disagreed with the use of a subsistence default as contrary to the purpose of AWQC (while conceding its use for site- or region-specific criteria) or recommended that EPA caution against the use of subsistence values without risk management decisions balancing risk benefits and costs. One commenter stated that subsistence populations are very rare and cannot generally be defined by socioeconomic factors and, thus, EPA's assumption of 86.3 g/day may be over-or underprotective. Several commenters stated their support for the subsistence default but also advocated that EPA should require States to consult with Tribes in order to select an adequate fish consumption rate. Other comments expressed the opinion that a Tribe would be obligated to use EPA's default value if the Tribe could not conduct its own survey or expressed concern over the extrapolation of data from the general population to subsistence populations. Several commenters questioned EPA's choice in selecting a value to represent the 90th percentile of the general population, in contrast to selecting average values for sportfishers and subsistence fishers. A commenter stated that the assumption of 17.8 g/day as a default for sport anglers was not supported by peer-reviewed studies and contradicts the EPA's Exposure Factors Handbook. Another commented that because 17.8 g/day is recommended to represent the general population, it should not be used to represent sportfishers and indicated that 39 g/day may be more appropriate. Other comments advocated the use of actual sportfisher/subsistence population data or making sure that the defaults chosen appropriately correspond to these groups.

Two commenters stated that the recommended values for children and women of childbearing age were overly conservative and inappropriate because developmental effects would not result from short-term exposures. However, another commenter stated that evidence on reproductive/developmental effects should make EPA take the most conservative approach to protect pregnant women, fetuses, and young children. Other commenters found these values acceptable and believed that the approach is consistent with EPA developmental toxicity guidelines. One commenter noted that single meal or short-term consumption for these groups could easily exceed the EPA defaults. Other comments cautioned EPA to make sure that the exposure assumptions to protect against developmental health effects be used only with chemicals causing acute toxicity, or believed the defaults are unrealistically high and favored an averaged daily equivalent (mean or median value). Two commenters believed that basing both national and regional criteria on a fish consumption rate in the 90th to 95th percentile would be most appropriate, and one stated that the high-end percentile should be used with rates for children and women of childbearing age to protect against reproductive or developmental effects. Another commented that criteria to protect subsistence fishers or pregnant women should be left to the States and Tribes to consider. Still another suggested that EPA develop special fish consumption rates for populations that consume much higher amounts than average and, thus, not be overly conservative in its default assumptions. Two commenters questioned EPA's assumption that children consume more fish on a body weight basis than adults, and one commenter advocated use of childhood fish consumption rates. Concern was also expressed that all of

the default rates assume that consumers eat from a single source only, and that the RSC factor results in a double-counting of fish intake rates. One commenter said that EPA should not establish default values. Finally, one commenter advocated using mean consumption rates (not the 90th percentile) if the Agency intends on retaining its RSC factor.

Response—EPA acknowledges the support for the default fish intake rates. Our national 304(a) water quality criteria serve as guidance to States and authorized Tribes, who must in turn adopt legally enforceable water quality criteria into water quality standards. States and authorized Tribes have the option to develop their own criteria and the flexibility to base those criteria on population groups that they determine to be at potentially greater risk because of higher exposures, yet, EPA cannot oblige the States to specific consulting agreements because, again, criteria are guidance, not enforceable regulations, and do not impose legally binding requirements. Therefore, we recommend that States and Tribes give priority to identifying and adequately protecting their most highly exposed population by adopting more stringent criteria, if the State or Tribe determines that the highly exposed populations would not be adequately protected by criteria based on the general population. In all cases, States and authorized Tribes have the flexibility to use local or regional data that they believe to be more indicative of the population's fish consumption—instead of EPA's default rates—and we strongly encourage the use of these data. In most instances, using alternate fish intake rates should not be difficult, once the value has been determined, in that the criteria calculation is performed by substituting the State/Tribal intake rate in place of EPA's default rate. We believe that the assumption of 17.5 g/day (again, based on the recent 1994–96 CSFII data) will protect a majority of the population of consumers of fresh/estuarine finfish and shellfish, especially population groups who rely on a particular waterbody for most or all of their fresh/estuarine intake. It is our goal to utilize an intake rate that represents more of the population than would a central tendency value. Thus, we intend to derive our national 304(a) criteria using this 90th percentile assumption, based on the updated analysis of the 1994–96 CSFII data. EPA also acknowledges that other Agency programs may utilize different default assumptions. In the case of the Superfund program, the value used (54 g/day) represents a default used for recreational fishers. It reflects total fish consumption from both marine and fresh/estuarine sources; however, it includes only finfish, not shellfish. As such, it cannot be directly compared to our default based on the general population for finfish and shellfish from fresh/estuarine sources only. [*Note*: The comparable 90th percentile CSFII value from the 1994–96 data, if marine species were included, would be 74.87 g/day.] For the AWQC program, EPA believes it has selected an appropriate, not overly conservative default value, given the goals of the CWA and the criteria program.

For the rationale stated above, we strongly believe that providing a default rate for subsistence fishers is important for States and Tribes, if they choose to use it in lieu of their own study data. We disagree with the commenter that the concept is contrary to the purpose of AWQC. Moreover, the commenter appears to have incorrectly assumed that EPA would base its national 304(a) water quality criteria on the subsistence fishers intake value. We intend to base our national criteria on the recommended value for the general population. We emphasized in our 1998 draft Methodology revisions that States and Tribes should consider developing criteria based on highly exposed populations when those populations would not be adequately protected by criteria based on the general population. This is, in fact, consistent with the purpose of AWQC. We also acknowledge that there is variation in fish consumption patterns, especially among subsistence fishers. For the purpose of providing one national intake rate for subsistence fishers, we believe that the value of 142.4 g/day (an estimated national average value based on comparing the CSFII 1994–96 data with subsistence fisher studies) is appropriate. Although the exact percentile represented by the arithmetic mean varies from survey to survey, we believe this value is more appropriate and protective than a median or central tendency value—which we cautioned against using in the 1998 draft Methodology revisions, because median values in the available short-duration surveys may be zero. However, as indicated above, EPA strongly encourages the use of site or regional-specific studies instead of this default value, and the State's/Tribe's discretion in considering higher intake rates than an arithmetic mean. We reemphasize here our four-preference hierarchy, which is designed to give States and Tribes more options than simply conducting a survey or using our default. EPA's national 304(a) criteria are health-based values only and are not intended to account for cost/benefit analyses. As indicated in our 1998 draft Methodology revisions, risk management decisions regarding balancing risk benefits should be made at the State or Tribal level.

EPA believes it is appropriate to offer default fish intake rates for children and women of childbearing age for States and authorized Tribes to consider if exposures resulting in health effects in children or developmental effects in fetuses are of primary concern. We have recommended a 90th percentile from the 1994–96 CSFII for this potential situation, in order to protect a majority of these population groups. As stated in the 1998 draft Methodology revisions, EPA is not recommending the development of additional water quality criteria, similar to the drinking water health advisories, which focus on acute or short-term effects because these are not seen routinely as having a meaningful role in the water quality standards program. However, we disagree with the commenter that developmental effects cannot result from short-term exposures. To the contrary, we believe there may be instances where the consideration of acute or subchronic toxicity and exposure in the derivation of AWQC is warranted—specifically when such toxicity and exposure are the basis of an RfD, not a chronic effect. Only in this situation would EPA consider such a basis for its national 304(a) criteria. Using long-term consumption rates to evaluate potential developmental effects would not accurately reflect meal size and would be inappropriate for use in such assessments. The separate distribution of short-term (*i.e.*, consumers-only) consumption estimates represents the amount of fish an individual consumes in a day, or multiple days in a short time period, if the person eats fish on that day. The consumers-only consumption estimate approximates a serving size for women of childbearing age or for children. The intent is to characterize consumption over a very short period of time, not as an average or per capita value over a longer period of time. We recommend the use of the short-term (consumers-only) consumption values in assessing developmental risks to children or women of childbearing age. However, we intend to routinely base our national 304(a) criteria on the recommended fish intake rate for the general population. One commenter appears to have incorrectly assumed that EPA would normally base its national criteria on

acute toxicity scenarios. EPA acknowledges that it may have overstated the likelihood that children are more highly exposed in terms of the frequency of their consumption of freshwater and estuarine fish, although this may certainly be true for various subpopulation groups. However, the CSFII data clearly show that children do consume more fish per unit body weight than do adults. Therefore, as stated above, we believe it is useful to provide intake defaults to States and authorized Tribes for children, and we have specifically used childhood fish consumption rates (to the extent allowable by the CSFII data) as advocated by the commenter.

EPA disagrees with the comment that the sportfisher default assumption (*i.e.*, that 17.5 g/day based on the 1994–96 CSFII data represents average consumption rates for this population group) is not supported by available studies or by the Exposure Factors Handbook. The value of 17.5 g/day falls within the range of mean values from sportfisher/angler studies reviewed by EPA. The Exposure Factors Handbook indicates that mean intakes from recreational freshwater studies ranged from 5 to 17 g/day, with mean values from the key West *et al.* studies used in the GLI between 12.1 and 16.7 g/day (USEPA, 1997a). Furthermore, the default rate recommended here for the AWQC is representative of consumption of both freshwater and estuarine fish species, not freshwater species only. We are also aware that some of the sportfisher studies that support higher estimates (*e.g.*, 39 g/day) include marine species.

EPA's fish intake assumption is that all of the consumed fish is taken from one particular waterbody. This is to ensure that any population can safely eat fish from waters designated for fishing, including those who may rely on a single source for their fish (for additional discussion on this issue, see response to Comment E.2, Assumption That All Fish Consumed Is Contaminated at the Criteria Level).

EPA disagrees with the idea that using a 90th percentile value as a default is inappropriate because of the RSC factor. The RSC is used to account for other sources of exposure and, thus, is independent of potential exposures from fresh/estuarine fish. The fresh/estuarine species are not double-counted, as the commenter suggests. (For additional discussion on RSC, refer to the responses in the RSC section below.)

8. Effect of Cooking on the Contaminant Concentration

Comments—Commenters stated that the concept of changes in contaminant level caused by cooking is important to recognize. They recommended that a loss from cooking should be accounted for and that EPA should provide factors in order to calculate this loss into criteria. However, one commenter did not believe that increases caused by cooking should be factored into criteria. One commenter stated that it is not appropriate to assume no loss as a default when no data exist to account for it. Another recommended that the chemical structure be assumed as constant before and after cooking. One commenter stated that the relevance of cooking methods is not clear.

Response—EPA has stated its intention to assume no loss from cooking unless there are adequate data to characterize such a loss. We are aware of some studies on cooking loss and provide reference to quantified information in the 2000 Human Health Methodology. However, we believe it is important to consider both losses and gains in the chemical contaminant from cooking. EPA has also received input from several States regarding the difficulty in making such adjustments on a routine basis. We continue to evaluate this issue in the context of the national 304(a) criteria. We believe that providing guidance on making such adjustments may be useful in the Exposure Assessment TSD volume for States or Tribes that wish to modify their criteria accordingly. However, EPA does not intend to provide specific cooking loss default factors.

9. Inclusion of Marine Species in the Default Rate

Comments—A commenter stated that coastal States have a need to derive water quality criteria for saline waters under their jurisdiction and, therefore, requested additional consideration of marine fish consumption. Another commenter requested that EPA provide greater clarification on its policy not to include marine species, again believing that States and Tribes need to include this in their criteria development.

Response—In the 1998 draft Methodology revisions, EPA recommended inclusion of fresh/estuarine species only for the intake parameter, and accounting for the intake of marine species as part of the RSC. We consider this appropriate because the 304(a) water quality criteria are applicable to discharges from fresh and estuarine waters, not deep marine waters. EPA's 304(a) water quality criteria apply to navigable waters of the United States up the three miles off-shore. However, EPA also says that coastal States and authorized Tribes could consider total fish consumption (fresh/estuarine and marine species) when appropriate for protecting the population of concern. It is important that the marine intake component not be double-counted with the RSC estimate. We maintain our default policy decision and the flexibility afforded to a State or authorized Tribe to base its criteria on alternative assumptions.

10. Precision of the Drinking Water Parameter

Comments—A commenter interpreted EPA's discussion on significant figures as indicating that the drinking water intake should not be factored into that determination because the number represents a science policy value. The commenter also requested that EPA specify a level of protection represented by the AWQC.

Response—The commenter has misunderstood EPA's discussion in the 1998 draft Methodology revisions on significant figures; they have extended the discussion to an evaluation of overall criteria conservativeness via statistical analysis. We stated that the AWQC should not necessarily always be limited to one significant figure because the 2 L/day drinking water value, although supported by data, represents a science policy decision. The discussion only addresses the issue of significant figures, not characterization of criteria protectiveness. For discussion of the issue regarding the population protected by the criteria level, refer to the response for Comment B.3, Protectiveness of the Methodology.

11. Redesignation of Salmon as a Marine Species

Comments—Some commenters disagreed with EPA's reclassification of salmon to the marine category. They stated that EPA has ignored salmon biology and life history, that salmon is an anadromous species, and that salmon eggs, fry, and juveniles take up chemicals. Commenters specifically criticized EPA for ignoring steelhead salmon's life history. Three commenters thought the redesignation is reasonable. One had no objection to the redesignation for threshold toxicants but did object for carcinogenic effects based on a linear low-dose extrapolation, because it would not account for exposures of salmon to ubiquitous chemicals (*e.g.*, PCBs) contributing a substantial portion to total exposure. Another commenter who supported the redesignation advocated flexibility

regarding coastal sportfisher consumption.

Response—EPA has not ignored the life history of salmon. We provided information on the known biology and life history of the species consumed that were included in the CSFII survey, the basis of the default values, in our 1998 draft Methodology revisions. The term anadromous generally refers to a species that spawns in fresh water or near-fresh water and then migrates into the ocean to grow to maturity. It can also refer to an ocean species that spawns in fresh/near-fresh waters. The life cycles of anadromous species vary as to whether they remain in fresh/near-fresh waters until they die or whether they return to ocean waters after spawning. As such, the description provided by EPA in the 1998 draft Methodology revisions is correct and does not conflict with the term anadromous. The CSFII food codes for salmon do not indicate the source of the salmon (*e.g.*, land-locked freshwater, farm-raised, or wild). We based our allocation of salmon between freshwater and marine habitats on commercial landings data provided by the National Marine Fisheries Service for the period 1989–1991. All landings of Pacific salmon, including chum, coho, king, pink, or sockeye, were assigned to the marine habitat. All land-locked Great Lakes salmon and farmed salmon received the classification of fresh water. The resulting apportionment for salmon was 1.18% to the fresh-water habitat and 98.82% to the marine habitat. We believe this is appropriate for our national default intake rates.

EPA understands that steelhead salmon, also known as steelhead trout (*Oncorhynchus mykiss*), is an oceangoing version of rainbow trout with a complicated life history, and may spend a significant portion of its lifetime in fresh waters. States and authorized Tribes have the flexibility to use different assumptions in deriving their water quality criteria, as we stated in the 1998 draft Methodology revisions. That is, States and authorized Tribes could make alternative assumptions to specifically account for steelhead salmon intake. We strongly encourage States and authorized Tribes to do so, as reflected by the recommended fish intake hierarchy of preferences. However, we do not intend to ignore the contribution from salmon in the calculation of our 304(a) criteria. We recommended accounting for this as part of the RSC, thereby ensuring that the criteria would account for the contribution of a contaminant from marine salmon.

12. Studies on Sportfishers and Subsistence Fishers

Comments—Two commenters stated that in summarizing various sportfisher and subsistence fisher studies, EPA failed to provide direction on how States or Tribes can use and interpret the information. One commenter requested additional guidance on the use of local data, while cautioning about such data's reliability. Commenters also listed errors, discrepancies, or missing information from numerous studies that appear in the 1998 draft TSD. One commenter recommended separating studies by type, population, and basis for consumption rate (presumably referring to habitat designations of fish), along with providing comments on the studies. Another stated that many angler studies are biased because the respondents are more ''avid'' in their fishing habits, and a study of fresh-water anglers from Maine might serve better as the basis of EPA's default for sportfishers.

Response—It is EPA's intention to provide summaries of various studies for States and Tribes to consider using and, as such, the Agency is merely providing information, not critiquing or endorsing particular studies. We do not intend to rank the studies because there are significant differences in the purposes and limitations of each study, in addition to the fact that consumption rates vary significantly throughout the country. Therefore, any particular study may be most appropriate to the State or Tribe's particular circumstances. However, we are committed to providing accurate information and intend to correct errors or missing information that would make the summaries of greater use to States and Tribes. We have reviewed the commenters' listed errors or omissions and made appropriate changes. EPA disagrees that any of the sportfisher studies are biased from ''avidity'' among recreational anglers. Although the rates may vary significantly from study to study, the studies specifically sample fishing patterns of these groups and are the most appropriate data for prospective use by States and Tribes. We considered the Maine angler study along with the others presented in the 1998 draft TSD to evaluate the range of mean values before recommending the default value. However, we do not believe this particular study is necessarily best suited for deriving a national default value. Just as with EPA's national 304(a) criteria, States and Tribes always have the flexibility to use other local- or regional-specific studies. We have provided additional guidance on how to consider the studies included in the Exposure Assessment TSD.

13. USDA Continuing Survey of Food Intake by Individuals (CSFII)

Comments—Some commenters believed that the CSFII data are appropriate for deriving AWQC and supported their use in the hierarchy of choices. Others stated that the CSFII data are not appropriate because they include marine species, and combine recreationally and commercially acquired species. One commenter suggested that a significant fraction of the default rate would include farm-raised fish, which would not bioaccumulate the same as wild fish. One commenter stated that the default inappropriately assumes consumption from a single waterbody. Two commenters stated that the CSFII data are biased toward individuals consuming large quantities of fish (assuming constant consumption every day and failing to consider those people who consume less frequently). One of these stated that the CSFII assumes that participants who did not eat fish during the study period are not fish eaters. Several commenters recommended that longer term studies be used, one specifically stating the difficulty in estimating the upper end of the distribution. Comments also referred to or recommended data from NPD Research Inc. or the Tuna Research Institute, presumably referring to the National Purchase Diary (NPD). One commenter assumed that the CSFII default estimates exclude individuals who consume fish but did not report consumption during the sampling period. Another questioned dividing reported consumption by the days of the survey and incorporating nonconsumption. Instead, this commenter recommended using the positive values only (''acute consumers'') for determining default intake rates, which it believed to be consistent with the concept of identifying the population to be protected. One commenter also indicated that intake rates do not vary significantly for fish obtained from different sources—that is, fresh or marine waters. Another stated that the CSFII data assume short-term consumption is representative of long-term consumption. One commenter advocated that EPA use probabilistic methods to derive AWQC.

Response—The comments are incorrect about the exclusion of respondents who did not report fish consumption during the CSFII sampling period. The general population,

recreational fisher, and subsistence fisher default values all include both CSFII respondents who reported eating fish during the sampling period and respondents who reported zero consumption (what the commenter referred to as ''non-consumers''). The CSFII mean values are not biased. Specifically, the intraindividual variation does not bias estimates of the mean intake of the population. The estimates of the upper percentiles of per capita fish consumption based on the short sampling period data may be biased upward, thereby resulting in a conservative estimate of risk. However, the extent to which this is overestimated is not knowable. We note that we did not rely exclusively on the CSFII data; rather, the data were analyzed with those from other studies (especially for recreational fisher and subsistence fisher estimates) to evaluate and corroborate our decision. We believe the CSFII data are representative of fish intake rates among the general population. As part of the CSFII analysis, sampling weights were adjusted to account for nonresponse and were subsequently reweighted using regression techniques that calibrated the sample to match characteristics correlated with eating behavior.

EPA generated mean and percentile estimates of daily average per capita fish consumption based on the USDA 1994–96 CSFII. The strengths of this survey for supporting estimates of per capita food consumption are twofold. First, the survey design is structured to obtain a statistically representative sample of the U.S. population. Second, the survey is designed to record daily intakes of foods and nutrients and to support estimation of food consumption. These features are in direct alignment with the objective of producing current, per capita fish consumption estimates for the U.S. population. The 1994–96 CSFII collected two non-consecutive days of food consumption data from a sample of 11,912 individuals in the 50 states and the District of Columbia. The method employed to collect dietary intake data also strengthened the CSFII design for supporting per capita consumption estimates. For example, the survey was administered by an interviewer on both days of data collection. For these reasons, we believe that the 1994–96 CSFII is the best source of data on a nationwide basis for estimating fish consumption by the U.S. population.

The NPD study was conducted over 25 years ago. The NPD is the basis of the 6.5 g/day default value that EPA has historically used for fresh/estuarine fish consumption. We have received consistently strong input from many of our stakeholders (including States and Tribes) who consider the 6.5 g/day value inadequate and advocate the use of much more recent data. The Agency also believes that such an update is needed. We are not aware of any subsequent major survey conducted during a 30-day period as was done by the NPD. The Agency does not believe that the year-long study of 29 people mentioned by one commenter is appropriate to use for a national default value. The use of probabilistic methods was discussed earlier in our response to Comment B.3, Protectiveness of the Methodology.

EPA also believes that its discussion of identifying population groups to protect is not contradicted by its combining positive and zero values to estimate long-term or average consumption. We reiterate here that we believe the summation of the amounts of fish consumed by each individual across the 2-day reporting period for the CSFII 1994–96 data (formerly a 3-day reporting period), followed by dividing that total individual consumption by 2, is a reasonable approach to estimating average consumption. The CSFII did not specifically ask questions on whether respondents consume fish or how often and, therefore, it is not possible to distinguish fish consumers from fish nonconsumers. EPA is aware from other major surveys that most people consume fish—at least episodically—and, therefore, believes that using the positive and zero values from the CSFII is a reasonable method of estimating average intake. We contrast this to using only the subset of survey responses where fish was actually consumed as a method to estimate an ''acute consumer,'' that is, to provide an estimate of the amount of fish consumed in the context of acute or short-term exposures (not in the context of average or long-term exposures).

The commenters are also incorrect about the inclusion of marine species. The proposed default rates for the general population, as well as for children and women of childbearing age, are based on freshwater and estuarine species only. The CSFII study does include marine species and EPA has additionally provided States and Tribes with these data in the Exposure Assessment TSD; however, they are not included in the default estimates of national freshwater and estuarine fish consumption. According to the CSFII data, most persons in the general population appear to consume more marine species than fresh/estuarine species. However, EPA supports State/Tribal use of local or regional data that indicate otherwise. We have not made any specific assumptions regarding farm-raised fish and their contribution to the default intake rate, nor have we received any information that would allow us to characterize (or discount) the amount that farm-raised fish contributes to the national default value or to differentiate bioaccumulation levels.

14. Use of Uncooked or As Consumed Fish Weight for Default Intake Rates

Comments—One commenter stated that either raw weight or cooked weight can be appropriate as long as the effect of cooking on the contaminant is accounted for. Some commenters stated that the cooked weights are the most technically defensible, because they are the basis for the consumption estimates. However, others believed the default intakes should be adjusted to reflect uncooked weights, with one commenter concerned that a cooked weight would result in incomplete accounting of exposure to threshold toxicants. One commenter also pointed out the difficulty of making appropriate adjustments to the BAF because of uncertainties in concentration levels of contaminant due to cooking and that many cooking techniques result in retention of fish fluids. Another commenter stressed the need to use uncooked weights in order to be consistent with fish tissue studies and BAF values. One commenter expressed concern that use of cooked weights would produce an inadequately protective criterion for mercury, while another believed that cooked values introduce a source of uncontrolled variability.

Response—We have considered the pros and cons of using uncooked/as consumed weights on several levels. First, the intake parameters of the criteria derivation equation are intended to capture ingestion—that is, what people actually consume and are exposed to. By and large, people consume cooked fish, and if raw shellfish or sushi was consumed by the CSFII respondents, those intakes were included in the as consumed weights. This assumption is also consistent with the dietary estimates based on prepared foods (not raw commodities) that are made by both EPA's pesticide program and the Food and Drug Administration (FDA) Total Diet Study program. We also considered the ''consistency'' issue in the context of the fact that the CSFII survey respondents estimated the weight of fish that they consumed. Similar to the CSFII, EPA's GLI was based on a consumption survey of fish intakes for prepared meals. EPA additionally considered the effect of the

cooking process. There are comparatively few chemicals for which measurements are available, and the process is complicated further by the different parts of a fish where the chemical may accumulate, the method of preparation, and how the cooking process may transform the chemical. What is certain is that the mass of the contaminant will either remain constant or be reduced. The resulting concentration is harder to predict. In the 1998 draft Methodology revisions, we recommended the use of as consumed weights and an adjustment of the bioaccumulation factor for cooking loss, if information was available. Otherwise, we recommended using the as consumed weight along with the full bioaccumulation factor (unadjusted for cooking loss), which would produce slightly more stringent AWQC. We have also received input from stakeholders regarding potential confusion over the fact that uncooked weights are used in the Agency's fish advisory program and that having two sets of values may prove confusing to States and Tribes, as well as the general public. Furthermore, the measures of a contaminant in fish tissue samples that would be applicable to either compliance monitoring or the permitting program are related to the uncooked fish weights.

Therefore, EPA has reconsidered its position based on these facts and despite the fact that the as consumed values more accurately represent actual intake, we will derive our national 304(a) criteria on the uncooked weight fish intakes. The approach of using an uncooked weight in the calculation will result in somewhat more stringent AWQC (studies indicate that, typically, the weight loss in cooking is about 20%). We will also provide guidance on site-specific modifications in the Exposure Assessment TSD. Specifically, we will describe an alternative approach for calculating the AWQC using the as consumed weight (again, more directly associated with exposure and risk) which is subsequently adjusted by the approximate 20% cooking loss to a resultant uncooked equivalent. Thus, the AWQC conversion to an uncooked equivalent can be consistently used between State/Tribal standards programs and still represent the same relative risk as the as consumed value. It is important to understand that the two approaches will not result in the same AWQC value. Whereas the as consumed approach is more scientifically rigorous and represents a more direct translation of the as consumed risk to the uncooked equivalent, it may be too intensive a process to expect of State and Tribal organizations whose resources are already constrained.

Relative Source Contribution (RSC)

15. Default Percentages and RSC Floor of 20% and Ceiling of 80%

Comments—A commenter criticized EPA's recommended RSC default rate in the face of uncertainty about other routes of exposure. Another commenter considered the ceiling of 80% to be a redundant uncertainty factor. Other comments suggested the use of an 80% RSC for bioaccumulative chemicals so that the contribution from fish consumption would not be underestimated, did not support the range of 20% to 80%, or requested additional justification for the assignments of 20%, 50%, or 80%.

Response—EPA has recommended using the 20% RSC default when routes of water exposure other than oral or sources of exposure other than fish and water are anticipated, but adequate data are lacking to quantify those exposures. When data are adequate, they should be used instead of the default. If it can be demonstrated that other sources and routes of exposure are not anticipated for the chemical in question (based on information about its known/anticipated uses and chemical/physical properties), then the 80% ceiling is recommended. The ceiling is intended to provide adequate protection for those who experience exposures (from any or several sources) higher than available data indicate. For many of the chemical contaminants that EPA evaluates, data are not available on multipathway exposures. It is possible that as we progress with our development of a cumulative risk policy, we may find an 80% RSC to be underprotective. This concern was expressed during the scientific peer review workshop on the Methodology. One commenter misunderstood the application of lower ceilings (*i.e.*, 50%, 20%) when existing information indicates no other media-specific uses or sources. Also, some chemicals that bioaccumulate in fish also bioaccumulate in other meat and dairy products (*e.g.*, dioxins). Therefore, to simply assume an 80% default in all cases would not be appropriate. The RSC approach allows for an apportionment of 80% when information indicates that other exposures are not relevant for the chemical being evaluated. EPA has added discussion in the final Methodology to address these situations and to better explain the application of the lower ceilings.

16. Duplication of Fish Intake Assumptions

Comments—Commenters stated that applying an RSC factor results in a double-counting of fish from other sources.

Response—The commenters are incorrect. The fish intake default used in the equation accounts for fresh and estuarine species only. The RSC factor potentially applies to nonfish dietary intake, air exposures, and marine fish species. To protect humans who additionally consume marine species of fish, the marine portion should be considered as part of the ''other sources of exposure,'' that is, part of the RSC or dietary value. EPA specifically emphasized in the 1998 draft Methodology revisions that States and authorized Tribes need to ensure, when evaluating overall exposure to a contaminant, that the marine fish intake is not double-counted with the dietary intake estimate used. This applies if the State or authorized Tribe chooses to account for total fish consumption (*i.e.*, fresh/estuarine and marine species) in the fish intake parameter used in the AWQC equation.

17. Exposure Route Differences

Comments—EPA received support for its rationale on accounting for differences in bioavailability and absorption between exposure routes when data are available, and assuming equal rates when data are absent.

Response—We acknowledge this support.

18. Need for an RSC Factor/Considering Multiple Routes of Exposure

Comments—Commenters supported the greater emphasis on RSC, including the use of empirical data. Some stated that EPA should give full consideration to multiple routes of exposure (*i.e.*, ingestion, inhalation, dermal), with emphasis on the variety of water-related activities, cultural practices, and lifestyles. Several commenters pointed to published studies on assessing inhalation and dermal exposures, and two commenters advocated that EPA determine when there is a need to factor in these exposures, based on available information on the chemical. One commenter stated that there are circumstances where inhalation exposures can be a significant portion of total exposure (*e.g.*, for some chemicals during showering). However, another suggested that consideration of inhalation and dermal exposures is premature. Two commenters stated that uncertainty factors, severity of effects, essentiality, and additive/synergistic

effects should be factored into the RfD apportionment, with one believing that this should also include the option of developing less stringent criteria when there is great uncertainty in the data. Five commenters stated that they believe the RSC/Exposure Decision Tree concepts represent an unnecessary safety factor or should not be considered. One suggested that the water quality criterion should relate only to water exposures. Two commenters suggested that factoring in other exposures is ''penalizing'' the AWQC and makes them overall environmental exposure criteria. Another questioned the need to apportion the RfD, but focused on drinking water regulations, stating that accounting for other sources of exposure would likely have no benefit, presumably due to conservatism in the RfD derivation (yet acknowledging that those uncertainty factors are independent of the exposure assessment). Several commenters recommended that EPA reconsider the SAB's advice not to routinely apportion the RfD. Others believed that the RSC should be used only for site-specific criteria, or that States should have the flexibility to make adjustments for local conditions. Two commenters also stated that the Exposure Decision Tree is unclear, is overly complicated, or has unrealistic data requirements. Another stated that the approach is generally desirable but that EPA needs to provide a greater and more easy-to-follow explanation of the rationale, indicating policy judgments where they occur. However, other commenters supported the Decision Tree approach for its facilitation of identifying the decisions necessary to select the most appropriate RSC value and considered it scientifically valid. One commenter cautioned that if probabilistic analysis techniques are used, their application must be valid and underlying assumptions clearly indicated. Commenters expressed the need for data to avoid the 20% default, others stated that defaults should be avoided altogether, and one recommended a 100% RSC for highly bioaccumulative chemicals. One of the supporters believed that the approach is a reasonable compromise between avoiding problematic increases in exposures to substances and not setting unduly restrictive requirements. A commenter questioned how new data would be considered in the context of RSCs based on older data. Another recommended that non-zero values for other exposure sources not be assumed unless a significant number of samples are positive. It was also recommended that EPA coordinate the RSC policy with other Agency programs.

Response—EPA disagrees that the RSC represents an excessive or unnecessary safety factor. The purpose of the RSC is to ensure that the level of a chemical allowed by a criterion or multiple criteria, when combined with other identified sources of exposure common to the population of concern, will not result in exposures that exceed the RfD or POD/UF. The policy of considering multiple sources of exposure when deriving health-based criteria has become common in EPA's program office risk characterizations and criteria and standard-setting actions. Since the SAB expressed concerns in 1993, numerous Agency workgroups have evaluated the appropriateness of factoring in such exposures and concluded that it is important for adequately protecting human health. Consequently, Agency policy has evolved significantly over the last 6 years. Various EPA program initiatives and policy documents regarding aggregate exposure and cumulative risk have been developed, and include consideration of inhalation and dermal exposures. Additionally, accounting for other exposures has been discussed in recent mandates (*e.g.*, the Food Quality Protection Act) and, thus, is becoming a requirement for the Agency. The RSC approach has been shared with other EPA offices, and efforts to coordinate policies on aggregate exposure, where appropriate, have begun. EPA intends to continue developing guidance on the RSC issue and guidance to address the concern that human health may not be adequately protected if criteria allow for higher levels of exposure that, combined, may exceed the RfD or POD/UF. We also intend to refine the 2000 Human Health Methodology in the near future to incorporate guidance on inhalation and dermal exposures. As stated previously, we are required to derive water quality criteria under Section 304(a) of the CWA and do not intend to derive site-specific criteria for individual waterbodies. However, States and authorized Tribes do have the flexibility to make different exposure and RSC estimates based on local data.

Uncertainty factors used in the derivation of the RfD to account for intra-and interspecies variability and the incompleteness of the toxicity dataset(s)/animal studies are specifically relevant to the chemical's internal toxicological action, irrespective of the sources of exposure to humans. The Agency's policy is to consider and account for other sources of exposure in order to set protective health criteria. We disagree that uncertainty in the data should result in less stringent criteria. However, we have provided additional clarification on the guidance allowing less stringent assumptions when multiple sources of exposure are not anticipated.

The adequacy requirements for the Exposure Decision Tree are not unduly restrictive. The ideas of representativeness, quality assurance, and sampling size are fundamental to properly conducted monitoring studies. Furthermore, the minimal requirement of samples to make an (at least, nominally) acceptable estimate of average and high-end exposure from that relative source (*i.e.,* 45 samples) is not unreasonable guidance. EPA also believes that the number of decision points in the Decision Tree for any particular chemical are not excessive. We have provided additional discussion in the 2000 Human Health Methodology in order to clarify numerous issues on the Decision Tree approach, including the discussion on the use of defaults. We believe that probabilistic techniques are potentially appropriate for use and agree that they must be valid, appropriately applied, and clearly presented.

Regarding changes in ambient chemical concentrations that would affect the RSC calculation, States and authorized Tribes have the opportunity to make changes in their water quality standards during triennial reviews, and EPA would evaluate those changes based on information submitted with the proposed changes. Similarly, EPA would consider changes to AWQC when significant changes in sources of exposure occur that affect the default values.

19. Use of RSC With Carcinogenic Effects Based on Linear Low-Dose Extrapolation

Comments—A commenter advocated the use of an RSC factor with carcinogenic effects based on linear low-dose extrapolation in order to account for other sources of exposure.

Response—EPA does not apply the RSC to carcinogenic effects based on linear low-dose extrapolation because the AWQC are being determined with respect to the incremental lifetime cancer risk posed by a substance's presence in the exposure sources relevant to the specific criterion, not in terms of an individual's total cancer risk from all sources of exposure. In the case of carcinogens based on nonlinear low-dose response extrapolation or a noncancer endpoint where a threshold is assumed to exist, non-water

exposures (*i.e.*, non-drinking water and non-fish ingestion exposures, and inhalation or dermal exposures) are considered when deriving the AWQC. The rationale for this approach has been that for pollutants with effect thresholds, the objective of the AWQC is to ensure that an individual's total exposure does not exceed that threshold level. Health-based and medium-specific criteria values for carcinogens based on a linear low-dose extrapolation typically vary from other medium-specific criteria values in terms of the concentration value, and often the associated risk level. Therefore, the RSC concept could not apply unless all risk assessments for a particular carcinogen based on a linear low-dose extrapolation used the same concentration value and same risk level; that is, an apportionment would need to be based on a single risk concentration value and level.

20. Use of Subtraction or Percentage Methods in RSC Apportionment

Comments—One commenter advocated the subtraction method instead of the percentage method for RfD apportionment, and advocated the use of central tendency values. This commenter criticized the percentage method as irrational and likely to produce overly stringent criteria. In addition, it was stated that the percentage method would allow criteria that could result in exposure levels that exceed the RfD when combined exposures are high. Other commenters expressed concern over basing the RSC on current levels of contamination. However, one believed that the percentage apportionment was reasonable given the difficulty in alternative apportionment methods (for example, an apportionment that would minimize the costs of reducing total exposure to/below a certain amount). One commenter suggested using a multiple default system.

Response—The first commenter has significantly misunderstood EPA's policy goals. The argument against use of the percentage approach is based on the idea that the maximum possible amount of chemical concentration, after subtracting other sources, should be allocated to drinking water criteria or standards. This is not EPA's goal nor is it stated in any relevant mandate. The rationale of deliberately removing the entire cushion between precriteria levels (*i.e.*, actual levels) and the RfD, and thereby setting criteria at the highest levels short of exceeding the RfD, is counter to the goals of the CWA for maintaining and restoring the nation's waters. It is also directly counter to Agency policies, explicitly stated in numerous programs, regarding pollution prevention. EPA has advocated that it is good health policy to set criteria such that exposures are kept low when current levels are already low. The subtraction method generally results in prospective criteria values for a contaminant in a particular medium at significantly higher levels than the percentage method and, in this respect, is contradictory to these Agency goals. In fact, many chemicals have existing levels in environmental media, based on available monitoring data, substantially lower (compared with the RfD) than the resulting criteria allow. This is the case with most of the theoretical examples that one commenter provided to refute the method.

The Agency has modified its policy with the Exposure Decision Tree approach to allow use of the subtraction method when multiple media criteria are not relevant. The Agency RSC Workgroup recommended that, although combined exposures above the RfD may or may not present an actual health risk, a combination of health standards exceeding the RfD may not be sufficiently protective. Therefore: (1) Maintaining total exposure below the RfD is a reasonable health goal; (2) there are circumstances where health-based criteria for a chemical should not exceed the RfD (either alone or in combination); and (3) the best way to prevent exceedance of the RfD is to apportion it when multiple health criteria are relevant to a given chemical. We believe that the percentage method is rational in the context of the above goals when multiple media criteria are at issue. However, as a commenter suggested, the percentage method does not simply depend only on the amount of the contaminant in the prospective criterion source. It is not a set amount. It is intended to reflect health considerations, the relative contribution of other sources, and the likelihood for ever-changing levels in each of those multiple sources (due to ever-changing sources of emissions and discharges). The percentage method does not break any ''logical link,'' as a commenter suggested (the commenter referenced an unpublished report from discussions prior to the development of the Exposure Decision Tree approach). EPA is interested in knowing the amounts of current exposures, including water, and is always cognizant of their relationship to the RfD (one commenter suggested that EPA does not compare actual exposures to the RfD; this comparison is always known). We have historically evaluated chemicals in the context of their current levels (*i.e.*, ambient levels prior to either criteria development or regulatory activity). Evaluating these levels, along with the hazard identification, has historically formed the basis for prioritization and whether the Agency would pursue criteria or standards development. We disagree with the comment that criteria should be set without regard to the actual level of the contaminant. Actual levels are advocated by a commenter for use with the subtraction method. In the case of multiple criteria for a given chemical, the commenter's claim that the subtraction method will ensure that ''an individual's exposure to a chemical does not exceed the RfD'' is not necessarily guaranteed if criteria for other media allow for concentrations in environmental media that, combined, may result in exposures greater than the RfD. EPA acknowledges that the percentage approach outcome varies depending on the magnitude of current exposures, and we have sought to provide greater clarification on this policy issue in the 2000 Human Health Methodology. Of course, depending on the levels from each source, the subtraction method can also produce unstable values—that is, they could vary from very high, to moderate, to very low, even to a negative number.

As previously indicated, probabilistic analyses are appropriate when they are validated techniques that are applied correctly and supported by adequate data. However, much of the time, the amount of data available to describe distributions of exposure from various known sources to the U.S. population—for use in setting nationwide criteria—is inadequate to support meaningful probabilistic analyses. Nevertheless, rather than simply using a default value in every instance, the Agency attempts to compare exposure intakes based on available data to estimate their relative contribution to the total—given that understanding the degree to which their concentrations vary, or making any distributional analysis, is not possible. When multiple criteria are at issue, the criteria values are based on the best available information, with an assumption that there may be enough relative variability such that an apportionment (relating that percentage to the RfD) is a reasonable way of accounting for the uncertainty regarding that variability. Again, in the context of making an estimate of potential national exposures, there is great uncertainty in the range of exposures, and as previously stated, the goal is not to allow a water criterion to use up the

''space'' between the total exposure and the RfD. An example of the percentage apportionment's potential use is when pesticides are at issue. It does not make sense to allow the water criterion to use up that space when (in terms of the chemical's intended uses) the dietary route is obviously the ''direct'' source of exposure. When the course of pesticide tolerance-setting activities may, over time, vary the exact amount of the RfD taken up, an apportionment may also be best for pesticide program planning. The Exposure Decision Tree has allowed for the use of the subtraction approach when only one criterion is relevant. Also, given the future need to develop cumulative risk policies, the subtraction method in these cases could be a short-lived option.

Finally, one commenter incorrectly assumed that the percentage method would allow criteria that could result in exposure levels that exceed the RfD when combined exposures are high. Again, this commenter incorrectly assumed that EPA is not aware of the relationship of the estimated exposures to the RfD. The Exposure Decision Tree approach states that, in these situations, a risk management decision would be made in order to reduce exposures to levels that would prevent exceedance of the RfD. We have provided greater clarification on this issue in the 2000 Human Health Methodology. We have also provided clarification on the use of central tendency values when estimating exposures, which we do not believe to be fully adequate for protection of human health when setting national 304(a) criteria.

F. Bioaccumulation

1. Use of Bioaccumulation Factors (BAFs) in General

Comments—Overall, commenters were not adverse to incorporating bioaccumulation into criteria derivation, but were concerned with the methodology EPA proposed to use. Most comments received were focused on the general use of BAFs. Because of the site-specific nature that BAFs can take, several commenters are concerned with applying national BAFs developed from a limited set of data and array of aquatic systems, or from a model, to all waterbodies in the United States. Some commenters did not agree with EPA's proposed BAF tiered hierarchy. These commenters stated that EPA should not derive single national BAFs because there is substantial variation among waterbodies in factors that influence bioaccumulation (*e.g.*, food chain, metabolism, bioavailability, loading history). They recommended that BAFs be calculated on a site-specific basis, or that field-derived BAFs be used in conjunction with modeled BAFs in a weight-of-evidence approach to select a final BAF. Some commenters also wanted the BAF guidance to more clearly state how it applies to different groups of compounds (*e.g.*, nonionic organics, ionic organics, metals, organometallics). Several commenters did agree with EPA that field-derived BAFs better reflect potential exposure to chemicals from all sources than BCFs and incorporate factors in the field (*e.g.*, food chain, metabolism, chemical loading history, temperature) that can affect bioaccumulation.

Response—Although EPA acknowledges there are site-specific factors that affect bioaccumulation, we disagree that national BAFs should not be derived. For some pollutants (*e.g.*, PCBs, methylmercury), biomagnification through the food chain can be substantial. Using a BCF, which only accounts for exposure from the ambient water, could substantially underestimate the potential exposure to humans for some chemicals and result in criteria that are underprotective of the designated uses. Since publishing the 1980 Methodology, there has been a growing body of scientific knowledge that clearly supports the observation that bioaccumulation and biomagnification occur and are important exposure issues to consider for many highly hydrophobic organic compounds and certain organometallics (Russell *et al.*, 1999; Fisk *et al.*, 1998; USEPA, 1998d; Watras and Bloom, 1992; Oliver and Niimi, 1988; Swackhammer and Hites, 1988; Niimi, 1985; Oliver and Niimi, 1983). For highly persistent and bioaccumulative chemicals that are not easily metabolized, BCFs do not reflect what the science indicates. For this group of chemicals, bioaccumulation (*i.e.*, accumulation of a chemical in aquatic biota from all routes of exposure) should be accounted for in the derivation of water quality criteria in order to protect against unacceptable risks from contaminated biota. The use of properly derived BAFs will enable chemical exposure from all sources to be accounted for in water quality criteria. The lack of national BAFs would greatly hinder the development of water quality criteria because many States and authorized Tribes may not have the resources to develop site-specific BAFs. We continue to believe that using national BAFs is the most scientifically valid approach to deriving national AWQC.

EPA acknowledges that data available to derive national BAFs and to validate the overall bioaccumulation methodology are primarily limited to persistent, hydrophobic chemicals from selected locations (*e.g.,* Lake Ontario, Green Bay, Bayou d'Inde, Hudson River). However, we believe these chemicals and sites encompass a reasonable range of chemicals, locations, and ecosystems from which to evaluate the appropriateness of the bioaccumulation methodology. To obtain better representation of lotic (*e.g.,* river) systems, we also performed evaluation of the predictive BAF methods with PCB, pesticide, and chlorinated benzene data from the Hudson River and Fox River/Green Bay. In the vast majority of comparisons between the predicted BAFs and field-measured BAFs using all four methods, the predicted BAFs were in very good agreement with the field-measured BAFs. We further acknowledge commenters' concerns that certain portions of the methodology may not be applicable to some types of chemicals. As a result, we have developed additional guidance that restricts some aspects of the methodology to certain types of chemicals. For example, we have revised the 1998 draft Methodology revisions to remove the use of K_{ow}×FCM to estimate BAFs for chemicals that have been consistently shown to be metabolized substantially in aquatic biota (*e.g.,* certain PAHs) and have clearly differentiated which methods apply to ionizable chemicals and which do not.

We also recognize that there were some uncertainties in the 1998 draft Methodology revisions on how the BAF methodology would be applied both nationally and on a site-specific basis. In response to this, we made substantial revisions to the 1998 draft bioaccumulation methodology which we believe makes the revised methodology applicable on a national basis. First, we improved the readability and guidance presented in the bioaccumulation methodology based on public and peer reviewers' comments. Specifically, we separated guidance for developing national BAFs from guidance for developing site- or region-specific BAFs and revised the Methodology document to make it more clear to the reader on how EPA will derive national BAFs. Second, EPA expanded the guidance for deriving site- or region-specific BAFs to better enable such adjustments to be made by States and authorized Tribes. For example, we updated, expanded, and made more accessible the databases used to develop national values for lipid content in aquatic biota and organic carbon content

in water. Third, we plan to develop detailed guidance to assist States and authorized Tribes in designing and conducting field studies to measure site-specific BAFs and BSAFs (biota-sediment accumulation factors). This guidance will specify our recommendations for how, when, where, and how often one should sample water, biota, and sediment for producing reliable measurements of BAFs and BSAFs.

In addition to improved clarity and expanded guidance, EPA believes the changes we made to the national BAF methodology address concern indicated by some public commenters about uncertainty in various aspects of the methodology. We believe the changes we have made reduce the uncertainty in several components of the national BAF methodology. For example, development of separate procedures for deriving BAFs for different chemical classes (*e.g.,* high vs. low hydrophobicity, high vs. low metabolism in biota, ionic vs. nonionic organics) will reduce uncertainty in national BAFs and simplify procedures. As part of these revisions, we recommended that K_{ow}-based estimates of BAFs and food chain multipliers (FCMs) not be used for nonionic organics that are known to be metabolized substantially in targeted biota (*e.g.,* some PAHs). Restrictions have also been placed on the use of the BSAF methodology so that the method is used for the chemicals for which it is most appropriate.

We clearly recognize that even with these revisions incorporated into the national BAF methodology, significant uncertainty might exist in the assessment and application of national BAFs at some sites throughout the United States because of the influence of site-specific factors. Therefore, we have more clearly indicated that development of site-specific BAFs is encouraged and supported when it can be shown that a national BAF is inappropriate, or when a State or authorized Tribe prefers to derive a site-specific BAF.

EPA agrees with commenters that in some cases it may be appropriate to derive a BAF using several of the recommended methods (Methods 1–4), with the final BAF chosen using a weight-of-evidence approach. We have provided general guidance on the assessment of uncertainty in using field-measured BAFs (and BAFs derived using the other methods) when deriving national BAFs. However, we do not believe that the mere existence of uncertainty means that national BAFs (and resulting national 304(a) water quality criteria) cannot be implemented effectively throughout the United States. For more than two decades, we have developed and implemented our national 304(a) water quality criteria (aquatic life and human health) through State, Tribal, and on occasion, Federal water quality standards programs. Implementation of this program has relied on the use of national 304(a) criteria as a cornerstone but has evolved to allow the use of procedures to modify national criteria by States and authorized Tribes where appropriate. EPA's national bioaccumulation methodology is consistent with this programmatic practice, by enabling States and authorized Tribes to readily adopt national 304(a) water quality criteria into standards (based on National BAFs) that achieve the CWA goals of protecting public health while also allowing site- or State-specific adjustments in situations where national AWQC may be considered overprotective or in some cases, underprotective.

Comments—Some commenters questioned the application of the BAF prediction approaches (Tiers 2–4; referred to as Methods 2–4 in the revised Methodology) on a national scale because the data used to validate the approaches and develop predicted BAFs come primarily from chemical partitioning relationships observed from a limited set of studies (*e.g.,* Great Lakes region).

Response—EPA agrees that the locations for which the BAF methodology has been fully applied are limited in number (*e.g.,* Lake Ontario, Green Bay). To address this concern, we have conducted additional assessments and comparisons among the bioaccumulation approaches (Methods 1–4) to further validate their usefulness and have validated the methods using other locations (*e.g.* Bayou d'Inde, LA, Fox River/Green Bay, Hudson River, NY). We acknowledge that a model prediction is not a perfect simulation of what occurs in a natural aquatic ecosystem and that uncertainty exists in the BAFs. However, this does not invalidate the usefulness of models validated using data from the Great Lakes and Hudson River in predicting bioaccumulation in other ecosystems. Results of analyses that support using a predictive bioaccumulation approach for a variety of chemicals and aquatic ecosystems can be found in Burkhard et al. (1997), Burkhard (1998), Oliver and Niimi (1988), Swackhammer and Hites (1988), and Oliver and Niimi (1983). Data from these studies clearly indicate that the food web is a dominate exposure route for many highly hydrophobic chemicals and that use of BCFs only underestimates exposure. EPA's proposed BAF methodology does account for some site-specific differences in bioaccumulation (an issue expressed by commenters) by considering factors such as percent lipid in the fish consumed and the freely dissolved concentration of the chemical in the ambient water (*i.e.,* a baseline BAF). This allows a BAF developed from one set of data and location(s) to be ''normalized'' and applied to another location. We believe the approach in the 2000 Human Health Methodology appropriately balances protectiveness with the uncertainties surrounding the science currently available to predict bioaccumulation. Comparisons of field-measured and predicted BAFs demonstrate agreement within an order of magnitude in the vast majority of cases, and often within a factor of two to five. Burkhard (1998) observed good agreement between measured and predicted BAFs for the Lake Ontario food web using the Gobas and Thomann food web models. For individual commonly detected PCBs and chlorinated pesticides, the BAFs estimated using the two Gobas and Thomann models were on average within a factor of 1.2 and 2.5 of the observed (*i.e.* field-measured) BAFs, respectively (Burkhard 1998). The overall uncertainties in each of these two bioaccumulation models (expressed as the ratio of the 90th to 10th percentile predicted BAF for each model) were a factor 3.6 and 4.0 for the Gobas and Thomann models, respectively (Burkhard 1998). Furthermore, Burkhard et al. (1997) reported that predicted BAFs (using EPA's national BAF methodology) were within a factor of 5 for 94% (n=32, using laboratory measured BCFs and FCMs) and 90% (n=48, using predicted K_{ow}s and FCMs) in Bayou d'Inde (Lake Charles, LA). These data comparisons show the good predictability of the methods used in the national BAF methodology. Should States or authorized Tribes have information to suggest that a national BAF is inappropriate for their situation, the 2000 Human Health Methodology specifically allows and encourages development of site-specific BAFs. With this in mind, we will be developing guidance on how to collect and interpret field data for the purpose of deriving site-specific field BAFs. This guidance will specifically address major sources of variability, including spacial and temporal factors and species life history.

Finally, to further address concerns that the predictive approaches used to derive BAFs may not be applicable at a

national scale, we revised the 1998 draft Methodology to clarify and limit for which chemicals and under what conditions BAFs based on Methods 2 to 4 are most applicable. For example, chemicals were grouped into broad categories based on their persistence and bioaccumulation potential (*e.g.,* high vs. low hydrophobicity, high vs. low biota metabolism, ionic vs. nonionic), and we have limited the use of predicted BAF approaches to selected groups of chemicals for which the data reasonably support their use (*i.e.,* highly hydrophobic chemicals that are not expected to be metabolized appreciably). The national BAF methodology was also changed to indicate that for those chemicals with sufficient data to indicate they are metabolized, model-predicted BAFs are not recommended; rather, field BAFs or laboratory BCFs are recommended. The use of the BSAF methodology has been restricted to chemicals that are highly hydrophobic (*e.g.,* log $K_{ow} \geq 4$).

EPA believes these revisions to the 1998 draft Methodology have improved the Methodology and have addressed many of the commenters' concerns and questions about uncertainty in applying the various approaches and BAFs on a national scale.

Comments—One commenter suggested that it is ''scientifically indefensible to use the field-measured BAF procedure to derive BAFs for benthic systems.'' They commented that in a benthic-based aquatic food web, the water column concentration of a chemical is not directly related to aquatic organism exposure potential for that chemical. Therefore, their view is that a field-measured BAF may over- or underestimate bioaccumulation in benthic-based systems.

Response—EPA acknowledges that the concentration of a chemical in the water column is not directly related to what pelagic organisms (*i.e.,* fish) are exposed to in a benthic-based system. However, the concentrations of a chemical in water, sediment, and fish are interconnected, although they may not be equally partitioned into each compartment, and residues in fish can be predicted equally well using either a sediment or water concentration as the starting basis. In the revised TSD on Bioaccumulation, the relationships between BAFs and BSAFs have been shown more clearly in order to demonstrate this interconnectedness. In the BAF methodology, we are assessing exposure through all routes (*i.e.,* from water, sediment, and contaminated food) in the aquatic ecosystem. By including all routes of exposure, the BAFs do not assume simple water-fish partitioning; rather they are an overall expression of the total bioaccumulation using the concentration of the chemical in water column as a reference point. Thus, a field-measured BAF or BASF at any given time is reflective of historic chemical loadings and bioaccumulation that has occurred. EPA does agree that a BAF may change over time because of differential chemical loadings; however, some frame of reference has to be chosen as the starting point to assess bioaccumulation. EPA has chosen to use the water concentration as that reference point. Science has shown that bioaccumulation occurs and is an important exposure pathway to humans for many chemicals, and EPA cannot ignore bioaccumulation in development of its AWQC simply because variability and uncertainty exist. In situations where chemical loadings are highly variable or are reduced substantially, EPA believes that a field-measured BAF will still be predictive of what will bioaccumulate in fish until the concentrations in sediments and benthic organisms are reduced enough to lead to reduced bioaccumulation. In situations such as this, a revised site-specific field BAF can be developed to reflect the change in chemical loading and partitioning.

This issue of field-measured BAFs and benthic-based food webs was also brought up in public comments made at the stakeholders meeting held in May 1999. At that time, we asked commenters if they could recommend another approach to assess bioaccumulation in benthic-based systems. No other approaches were suggested. We have concluded that in the absence of any other approaches, field-derived BAFs are good predictors of bioaccumulation because they integrate biological, chemical, and physical factors that influence bioaccumulation.

2. Guidance for Deriving Field Bioaccumulation Factors (BAFs)

Comments—Several commenters agreed with EPA that field-derived BAFs should take precedence over modeled BAFs. However, many commenters discussed the need for guidance on how to collect and review field data so that high-quality, field-based BAFs can be derived. Commenters noted that there are numerous site-specific biological, chemical, and physical factors that affect bioaccumulation, which should be considered during design of field sampling programs.

Response—We agree that properly derived field BAFs should take precedence over modeled BAFs; we have clearly indicated in the 2000 Human Health Methodology that this is our preferred approach for deriving a BAF. We also acknowledge that, as with any field measurement, there can be errors in determining field-measured BAFs. In the development of national BAFs, EPA will attempt to minimize potential errors or uncertainties by carefully screening the data based on the criteria outlined in the Bioaccumulation TSD. Furthermore, an additional validation of national BAFs will be conducted as part of the external peer review process that occurs for all published 304(a) water quality criteria. We continue to assert that for many chemicals, a field-measured BAF is a better gauge of what is occurring in nature than a laboratory-measured or predicted BCF; the BAF measures the actual effects of bioavailability, concentration in the water or sediment, growth dilution, metabolism, and biomagnification rather than predicting them through use of a model. We do agree with commenters concerned about the difficulty of collecting and interpreting field-measured BAFs; however, we believe that States and Tribes can adequately design and interpret field studies. To assist them in this task, we will be developing guidance concerning field data collection and interpretation for site-specific field-measured BAFs and BSAFs.

3. Use of Biota-Sediment Accumulation Factors (BSAFs)

Comments—Several commenters stated that the use of the BSAF approach for deriving a BAF is inappropriate. Some comments centered around the perceived lack of validation and peer review of the BSAF approach, and others focused on the relationship between the water column concentration of a chemical and its sediment concentration, represented by the factor Π_{socw}. One commenter noted that the BSAF method is simply a means to predict a water concentration of a chemical of interest from the sediment concentration of that chemical, the water and sediment concentration of a reference chemical(s), and the ratio of K_{ow} for the chemical of interest and the reference chemical(s). A commenter indicated that loading history of a given chemical directly affects what the value of Π_{socw} would be at any given time, and that Π_{socw}/K_{ow} (disequilibrium ratio) for the chemical in question and the reference chemical has to be constant under the assumptions of the BSAF approach. The commenter stated, however, that Π_{socw}/K_{ow} will not be constant because of

differential loading histories, and that because the concentration of the chemical of interest cannot be measured in water, the assumptions about Π_{socw}/K_{ow} cannot be verified. In their view this made the use of BSAFs invalid.

Response—The method of predicting BAFs from BSAFs has been evaluated for certain pesticides, PCBs, chlorinated benzenes, and dioxins using two data sets from Lake Ontario (Oliver and Niimi,1988;USEPA, 1990) and one from Green Bay (USEPA, 1992b). EPA has also recently completed further evaluation of this method for certain PCB congeners, pesticides, and chlorinated benzenes in Lakes Ontario, Green Bay, and the Hudson River. This additional evaluation and validation work is included in the Bioaccumulation TSD. The evaluations show that in the vast majority of situations, the BSAFs predict field-measured BAFs very well.

EPA agrees with the commenter who noted that the BSAF method is structured to predict water concentrations for chemicals that cannot be measured for the purpose of directly measuring a field BAF. However, the BSAF method is more important for its ability to capture the net effect of biomagnification, food web structure, hydrophobicity, bioavailability factors, and metabolism on a specific chemical's net potential for bioaccumulation. The BSAF method is needed to predict BAFs for chemicals with nondetectable and difficult-to-predict concentrations in water (*e.g.,* dioxins). No alternative methods to predict BAFs for such chemicals were identified by either public commenters or peer reviewers. The BSAF method equation has been modified (see below) in the Bioaccumulation TSD to clarify the essential data components of the method. The revised BSAF equation shows that measured concentrations in water and surface sediment, not a complete BSAF, are needed for the reference chemical. The equation also shows that a measured BSAF for the chemical of interest is the most important component for determination of a BAF when the concentration in water cannot be measured.

EPA agrees with commenters that the BSAF method should not be used for all organic chemicals that may be addressed through the 2000 Human Health Methodology, and accordingly have restricted application of the method to nonionic organic chemicals with log K_{ow}s $\geq$ 4.0. We have also provided more specific guidance on selection of reference chemicals and use of multiple reference chemicals to secure the most accurate estimate of a chemical's BAF.

One commenter contended that the BSAF approach for deriving BAFs is seriously flawed. The concern is that the approach is valid only if a reference chemical (chemical r) can be found with a sediment-water fugacity ratio (which represents the differential partitioning of a chemical between water and sediment) equal to that of the chemical for which the BAF is being determined (chemical of interest). The commenter contends that the BSAF approach could validly be used only if it could be shown that the fugacity ratio is a constant for the chemical of interest and the reference chemical. The commenter submitted figures to demonstrate conceptually that two chemicals with radically different loading histories will have dissimilar fugacity ratios. EPA disagrees that in order for the BSAF to work, the fugacity ratio has to be constant, but does agree that in order to best use the BSAF approach, a general knowledge of chemical loading histories to an ecosystem is needed to help provide a basis for choosing appropriate reference chemicals. Such information may be obtained from chemical production records, historical fish residue monitoring data, or dated sediment core analysis. We recognize that due to various factors (loading histories, microbial degradation, etc.) fugacity ratios for both chemical (i) and (r) may shift over time, leading to the potential for temporal variability of sediment-water distributions of nonpolar organic chemicals. Although it was not shown explicitly in the 1998 draft TSD, an important benefit of the BSAF approach is that it can account precisely for such differences in sediment-water distributions of nonpolar organic chemicals. The BSAF method is robust to the extent that the choice of reference chemicals is based on meeting the sediment-to-water fugacity ratio condition: That the ratios be similar—they do not have to be constant. The extent that these ratios for chemicals with log K_{ow}s $\geq$ 4 may change with chemical loading over long periods of time after sediments become contaminated, and thereby contribute to small shifts in BSAFs and larger shifts in BAFs, is an issue of possible concern that EPA recognized in the 1998 draft TSD. EPA noted on page 188 of the TSD (USEPA, 1998d) that ''BSAFs measured for systems with new chemical loadings or rapid increases in loadings may be unreliable due to underestimation of steady-state C_{soc}s.''

To better address the water-to-sediment relationship issue, EPA has revised the equations that serve as the basis for deriving a BSAF. In the revised equations, a factor $D_{i/r}$ has been added, which is defined as the ratio of the fugacity gradient (modeled as Π_{socw}/K_{ow}) between sediment and water for chemical (i) in comparison to that of a reference chemical (r). The revised equations are as follows:

$$\frac{\left(\prod_{socw}\right)_i}{\left(K_{ow}\right)_i} = \left(D_{i/r}\right)\frac{\left(\prod_{socw}\right)_r}{\left(K_{ow}\right)_r} \qquad (1)$$

$$\text{thus, } \left(\prod_{socw}\right)_i = \frac{\left(D_{i/r}\right)\left(\prod_{socw}\right)_r\left(K_{ow}\right)_i}{\left(K_{ow}\right)_r}$$

By definition, Π_{socw} can be used to relate chemical i's BSAF to its BAF_{ℓ}^{fd}:

$$\left(\prod_{socw}\right)_i = \frac{\left(C_{soc}\right)_i}{\left(C_w^{fd}\right)_i} = \frac{\left(BAF_l^{fd}\right)_i}{(BSAF)_i} \qquad (2)$$

$$\text{thus, } \left(BAF_l^{fd}\right)_i = (BSAF)_i\left(\prod_{socw}\right)_i$$

By substituting rearranged Equation 1 into rearranged Equation 2:

$$\left(BAF_l^{fd}\right)_i = (BSAF)_i \frac{\left(D_{i/r}\right)\left(\prod_{socw}\right)_r \left(K_{ow}\right)_i}{\left(K_{ow}\right)_r} \qquad (3)$$

where:

$(BAF_{\ell}^{fd})_i$ = BAF expressed on a freely dissolved and lipid-normalized basis for chemical of interest ''i''.

$(BSAF)_i$ = Biota-sediment accumulation factor for chemical of interest ''i''.

$(C_{soc})_i$ = Concentration of chemical of interest ''i'' in sediment normalized to sediment organic carbon.

$(C_{soc})_r$ = Concentration of a reference chemical in sediment normalized to sediment organic carbon.

$(C_w^{fd})_i$ = Concentration of chemical of interest ''i'' freely dissolved in water.

$(C_w^{fd})_r$ = Concentration of the reference chemical freely dissolved in water.

$D_{i/r}$ = ratio between Π_{socw}/K_{ow} for chemicals ''i'' and ''r'' (normally chosen so $D_{i/r} = 1$).

$(K_{ow})_i$ = octanol-water partition coefficient for chemical of interest ''i''.

$(K_{ow})_r$ = octanol-water partition coefficient for the reference chemical ''r''.

$(\Pi_{socw})_i$ = sediment organic carbon to water freely dissolved concentration ratio of chemical of interest ''i''.

$(\Pi_{socw})_r$ = sediment organic carbon to water freely dissolved concentration ratio of reference chemical ''r''.

Equation 3 is intended to provide an improved representation of how the BSAF method/model works. By using $D_{i/r}$, the new equation accounts for differences in sediment to water column concentrations that might exist between the chemical of interest and the reference chemical because of factors such as loading histories or degradation. Unlike one commenter's analysis, in which an equation was derived without the BAF or BSAF, equation 3 shows these quantities as central to the model; that is, the BSAF is measured and then transformed into a BAF by estimating the chemical's Π_{socw}/K_{ow}. This model could alternatively be described as a determination of $(C_w^{fd})_i$ from a measured value of $(C_{soc})_i$ combined with a measured value of $(C_{\ell})_i$ to give an accurate measure of $(BAF_{\ell}^{fd})_i$. However, we believe that equation 3 best describes the BSAF method as allowing measured BSAFs to be transformed into BAF_{ℓ}^{fd}s for the specific purpose of developing either national or a site-specific water quality criteria when directly measured BAF_{ℓ}^{fd}s cannot be obtained.

When good-quality data are available for reference chemicals (r) that should have equal or similar sediment-water fugacity ratios as a chemical (i) whose $(BAF_{\ell}^{fd})_S$ cannot be measured directly, then $D_{i/r} = 1$. When $D_{i/r} \leq 1$, it may be estimated based on properties of the chemicals and knowledge of their loading histories to the ecosystem. Equation 3 provides a greater degree of flexibility for use of the BSAF method than the original equation. This flexibility highlights a logical stepwise transition from measured to fully modeled site-specific BAFs that can incorporate estimates of $D_{i/r}$ through fate modeling, should interested parties choose to do so. In such a situation, if the uncertainty associated with choice of $D_{i/r}$ is perceived to be too great, a determination of a site-specific $(BAF_{\ell}^{fd})_i$, which still takes advantage of measured values of $(C_{\ell})_i$ and $(C_{soc})_i$, could be accomplished if a mass balance model, specifically calibrated with $(C_{\ell})_i$ and $(C_{soc})_i$, is used to predict $(C_w^{fd})_i$. Such an approach would be time consuming and expensive but would allow prediction of $(BAF_{\ell}^{fd})_i$ over time as a function of changes in $(\Pi_{socw})_i$ associated with anticipated changes in mass loading of the chemical into an ecosystem. In cases where the intended use of the site-specific criterion is to determine permit conditions or establish a TMDL, a mass balance model presumably would have to be developed, and thus use of the model for providing a $(BAF_{\ell}^{fd})_i$ would not require an extraordinary effort. However, as with the BSAF method, it should be noted that mass balance model predictions of $C_w^{fd}{}_i$ also cannot be directly validated through measurements. EPA's appreciation for the value of hybrid models comes from recognition that incorporation of measured bioaccumulation potentials, including those provided by the BSAF method, are especially advantageous for those chemicals with transformation rates, such as metabolism throughout the food chain, that are presently not accurately known or incorporated into mechanistic bioaccumulation models.

Finally, we disagree with the circular argument that the BSAF approach has ''extremely limited utility'' because ''it will not be possible to demonstrate that Π_{socw}/K_{ow} is a constant'' because Π_{socw}/K_{ow} cannot be measured directly for one chemical. The inherent limitation for validation of a predicted BAF because of the inability to measure the concentration of freely dissolved chemical in water (C_w^{fd}) applies to any approach/model available and is not a just criterion for rejection of a BAF method. Validation may be based on the ability of the BAF to predict concentrations in fish from predicted values of C_w^{fd}. Data from the Great Lakes clearly show that such predictions are possible, and accurate (USEPA, 1998d). It should also be noted that during the external peer review of the BSAF approach, the peer reviewers stated ''for the chemicals examined (persistent and bioaccumulative), extrapolation to other circumstances may be reasonable,'' thereby disagreeing with public commenters. EPA believes that restricting the use of the BSAF method to highly hydrophobic chemicals, clarifying the use of reference chemicals, elaborating on the primacy of the sediment-water fugacity equivalence

condition for use of the method, and validation with additional data sets alleviates concerns about using this new method.

4. Dissolved Organic Carbon (DOC) and Particulate Organic Carbon (POC)

Comments—Two comments were received on the DOC/POC approach used to determine the bioavailable fraction of organic chemicals in surface water and sediments. Rather than solely use default organic carbon values, commenters wanted to the ability to select DOC/POC values they believe are more representative of their waterbody type or site-specific conditions.

Response—In the 2000 Human Health Methodology, EPA allows use of site-specific DOC and POC data when normalizing the BAF to organic carbon content. One can either conduct studies to generate the necessary site-specific data or modify the national organic carbon database to their particular site and conditions. To facilitate the latter, we have updated and expanded the organic carbon database used to develop the national default POC/DOC values to enable the regulated community to choose which values best represent their site conditions and will provide defensible site-specific DOC and POC estimates. The national DOC/POC database will be made available for use by all States, Tribes, and other members of the regulated community.

5. Fish Lipid Content

Comments—A commenter stated that lipid content can affect the results of the Gobas model used to derive national default FCMs. The commenter noted that the model is relatively insensitive to fish lipid content but more sensitive to benthic invertebrate lipid content. They believed this should be considered in the development of FCMs.

Response—EPA agrees that lipid content can affect the results of the Gobas model and is only using the Gobas model with default lipid values to derive national BAFs when there are no data to derive a field-measured BAF. In cases where a State or authorized Tribe has site-specific data on fish lipid content, the revised methodology allows input of those site-specific data to estimate bioaccumulation. Furthermore, to facilitate the generation of site-specific lipid values, we have updated and expanded the lipid database used to develop the national default values based on a whole range of organisms commonly consumed by persons in the United States. We will include additional guidance for States and authorized Tribes on how to adapt the national default lipid values to reflect State and local consumption patterns. To enable such adaptions, EPA will make the raw data available to States and authorized Tribes.

6. Use of Food Chain Multipliers (FCMs)

Comments—Several commenters stated that the use of model-derived FCMs (Gobas 1993) to calculate a BAF from either a BCF or a K_{ow} (Methods 3 and 4) is inappropriate. The commenters noted issues with several of the default input parameters (*e.g.*, food web, lipid, Π_{socw}, temperature). The primary concern of commentors is that Gobas model-based national default FCMs do not account for site-specific factors that influence bioaccumulation, such as food web structure, nor does the current use of the model account for metabolism. Commenters expressed concern that use of default FCMs in predictive approaches may lead to overestimates of bioaccumulation. Some commenters preferred the use of field-based FCMs or direct use of the Gobas model, which allows for input of site-specific data and metabolism rates if available, rather than uses of model-derived default FCMs.

Response—EPA is using a state-of-the-art food web model for deriving FCMs, which incorporates the latest thinking and knowledge on the processes occurring in aquatic food webs. Commenters suggested that the assumptions used in constructing these models are not appropriate. We recognize that any modeling formulation of contaminant behavior in aquatic food webs requires simplification of a very complex biological system in order to assemble a tractable model. These simplifications do not imply or mean that our scientific understanding of all processes occurring in food webs is complete. As documented in the scientific literature, these simplifications provide reasonable model formulations with good predictive power. The suggestion that every modeling assumption has to be completely understood and validated under all circumstances before using or constructing a useful modeling tool is unreasonable. EPA has performed a detailed analysis of the importance and sensitivities of individual input parameters for food web models and of the overall uncertainties associated with predictions from food web models (Burkhard 1998). We have provided a discussion in the Bioaccumulation TSD of the Gobas model and implications that uncertainties in their respective input parameters have on derived FCMs. EPA has retained the use of Gobas model to derive default FCMs.

To address national versus site-specific concerns expressed by some commenters, the methodology has been revised to separate the BAF methodology into national and site-specific guidance. The national methodology for deriving national BAFs retains the use of default FCMs based on a mixed benthic/pelagic food web and national averages of various model input values. We believe this food web is the most broadly applicable food web encountered in nature; its use results in FCMs that are midway between pure benthic and pure pelagic structures. The revised guidance includes a brief discussion of the uncertainties associated with our selection of the mixed benthic/pelagic food web. In the site-specific guidance, the 2000 Human Health Methodology provides guidance on which of EPA's recommended FCMs to use depending on the situation. In addition, we encourage direct use of the Gobas model by stakeholders so that changes could be made to the default food web inputs to reflect site-specific factors that influence bioaccumulation, and also encourage derivation of field-based FCMs. States and authorized Tribes have the option to generate site-specific FCMs by conducting site-specific field studies, reviewing published literature, or using other scientifically defensible models.

Although several commenters criticized the national application of the Gobas model because metabolism rate is set equal to zero, the peer review panel acknowledged EPA's position that there are currently no acceptable methods available to adequately determine species and chemical-specific metabolism rates for use in the Gobas model. Because EPA agrees that for certain chemicals metabolism can be an important factor in bioaccumulation, the revised methodology does not use FCM-based predictions for chemicals that are expected to be metabolized substantially. To assist users of the 2000 Human Health Methodology in determining for which chemicals or groups of chemicals metabolism should be of little concern, we have developed a table of chemicals that are not substantially metabolized or are likely very slowly metabolized. This table has been put in the Bioaccumulation TSD. The table is not all inclusive because there are numerous chemicals (*e.g.*, hundreds of thousands in use commercially today) for which few or no metabolism data exist, but is representative of chemicals or groups of chemicals that are likely to be commonly encountered in aquatic systems. When metabolism is suspected,

users of the 2000 Human Health Methodology might be more inclined to use or develop field data and/or measure a BCF in the laboratory in these situations. It should also be noted that in the future, should appropriate chemical and species-specific metabolism data become available, the Gobas model can incorporate it with little effort.

Finally, EPA partially agrees with commenters that certain procedures of the 1998 draft Methodology revisions (*e.g.*, K_{ow} and FCM-predicted BAFs) might lead to overestimates of BAFs for certain types of pollutants, such as those that are metabolized substantially to chemical forms not addressed by the AWQC. In response to this issue, and as discussed previously, additional guidance and limitations have been placed on several of the procedures in the revised methodology. However, EPA does not agree with the notion that our methodology would lead to a general over prediction for all BAFs. We use central tendencies where possible for all inputs in the Gobas model, and a geometric mean BCF for chemicals that have more than one BCF for a given trophic level. Thus, we know of no reason why laboratory-measured BCFs multiplied by a FCM would always result in overestimates of BAFs, or why the BSAF and K_{ow} * FCM-predicted BAFs applied to highly hydrophobic contaminants that do not metabolize substantially would be biased a priori toward overestimating BAFs. These views are supported by information in the 1998 TSD (Exhibits 2.4.1, 2.4.3, and 2.4.6 for BSAFs), Burkhard *et al.* (1997) for the K_{ow}*FCM method, and information presented in the Bioaccumulation TSD.

7. Fish Tissue Criteria

Comments—A few commenters suggested that for selected highly bioaccumulative chemicals that are difficult to measure in water, criteria based on fish tissue concentration may be more appropriate than ambient water column concentration criteria.

Response—Regarding fish tissue criteria, EPA agrees that the development of human health criteria for highly bioaccumulative chemicals which are expressed in terms of tissue residues in aquatic organisms is worthy of consideration. However, such tissue residue criteria would still require a mechanism to relate chemical loads and concentrations in water and sediments to concentrations in tissues of appropriate aquatic organisms (*i.e.*, bioaccumulation factors or bioaccumulation models). EPA is presently exploring the feasibility of developing tissue-based criteria and is evaluating numerous issues associated with implementation of tissue-based criteria. At an appropriate in the future, EPA will consider development of additional guidance on tissue residue criteria pending the outcome of this evaluation.

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This Notice finalizes revisions to EPA's 1980 Methodology for the development of water quality criteria to protect human health. The revisions reflect scientific advancements since 1980 in a number of areas, including cancer and noncancer risk assessments, exposure assessments and bioaccumulation. The revised Methodology provides guidance to States, Tribes, and the public on the approach that EPA expects to take in developing recommended human health criteria. The revised Methodology also provides guidance to States and Tribes that they may use in developing human health criteria as part of their water quality standards; States and Tribes use such standards in implementing a number of environmental programs, including setting discharge limits in NPDES permits. The revised Methodology does not substitute for the Clean Water Act or EPA's regulations; nor is it a regulation itself. Thus, the revised Methodology cannot impose legally-binding requirements on EPA, States, Tribes or the regulated community, and may not apply to a particular situation based upon the circumstances. EPA and State/Tribal decision-makers retain the discretion to use different, scientifically defensible, methodologies to develop human health criteria on a case-by-case basis that differ from this guidance where appropriate. EPA may change the Methodology in the future through intermittent refinements as advances in science or changes in Agency policy occur.

This criteria Methodology incorporates scientific advancements made over the past two decades. The use of this Methodology is an important component of the Agency's efforts to improve the quality of the Nation's waters. EPA believes the Methodology will enhance the overall scientific basis of water quality criteria. Further, the Methodology should help States and Tribes address their unique water quality issues and risk management decisions, and afford them greater flexibility in developing their water quality programs.

Dated: October 24, 2000.

J. Charles Fox,

Assistant Administrator for Water.

[FR Doc. 00–27924 Filed 11–2–00; 8:45 am]

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Making appropriations for Agriculture, Rural Development, Food and Drug Administration, and Related Agencies programs for the fiscal year ending September 30, 2001, and for other purposes. (Oct. 28, 2000; 114 Stat. 1549)

H.J. Res. 118/P.L. 106–388

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H.J. Res. 119/P.L. 106–389

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H.R. 2348/P.L. 106–392

To authorize the Bureau of Reclamation to provide cost sharing for the endangered fish recovery implementation programs for the Upper Colorado and San Juan River Basins. (Oct. 30, 2000; 114 Stat. 1602)

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H.R. 3995/P.L. 106–397

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H.R. 4205/P.L. 106–398

To authorize appropriations for fiscal year 2001 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes. (Oct. 30, 2000; 114 Stat. 1654)

H.R. 4828/P.L. 106–399

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